ICDDR,B

BOARD OF TRUSTEES MEETING

27-29 Nov 2004

PROGRAMME OF THE

BOARD OF TRUSTEES MEETING

27-29 Nov 2004

Flights:
BA: arrives and departs Mondays, Thursday, Saturday (early AM)
Emirates: Arrives and departs Tuesday, Wed, Thursday, Sunday (9.35 am)
Thai: arrival/departure all days
Singapore Airways: late night daily.
Malaysian air: on all days except Friday & Sunday (late night)
Biman from New York: arrival & departure on Monday & Thursday (mid afternoon)

DRAFT – 30 Oct 2004

PROGRAMME
MEETING OF THE BOARD OF TRUSTEES
25-29 November 2004

Wednesday 24 November	Board Members Arrive
Wednesday 24 November	
6:30 pm	Board members leave for Rajendrapur
___ pm	Dr I Kaye Wachsmuth & Prof Jane Anita Kusin leave for Rajendrapur on arrival from Jessore)
PM	Dinner at Rajendrapur
Thursday 25 November	
8.30 am	Retreat Commences
Friday 26 November	
AM:	Board Retreat continues
11:00 am	CD & ERID to join Retreat
PM:	BoT & CD return to Dhaka

Saturday 27 November
Programme, Fund Development, National Liaison Committee meetings

Saturday 27 November

8.30 - 9.00 am	Meeting of the Programme Committee - Approval of the Minutes - Response to Nov/June Board Resolutions - Response to BoT Teleconference	BoT, CD

09.00 – 11.00 am	Executive Director's Report Presentation by Division Directors: - Clinical Sciences (Dr M A Salam) - Health Systems and Infectious Diseases (Dr Charles P Larson)	BoT. Scientific staff: GS6 & above, donors
11.00 – 11.15 am	TEA	
11.15 – 12.30 pm	- Laboratory Sciences (Dr G B Nair) - Public Health Sciences (Dr Marge Koblinsky)	
12.30 - 01.30 pm	LUNCH	BoT, SC
01.30 – 02.30 pm	Response to CSD Review	BoT, SC & CSD members
02.30 – 3.30 pm	Meeting of the Fund Development Comm.	BoT, SC
03.30 – 03.45 pm	TEA	BoT, SC
03.45 - 04.45 pm	Meeting of the National Liaison Comm.	BoT. SC
04.45 - 05.30 pm	Change of Name – ICDDR,B	BoT, CD, ER&ID

Sunday 28 November 2004
Human Resources, Finance and Full Board meetings

Sunday 28 November

08.00 – 09.30 am	Meeting of the Finance Committee	BoT, SC
09.30 – 10.45 am	Meeting of the Human Resources Comm.	BoT, CD
10.45 – 11.00 am	TEA	BoT, CD
11.00 – 12.30 pm	Human Resources meeting continued	BoT, CD
12.30 – 1.00 pm	Staff Welfare Association	BoT
01.00 – 02.00 pm	Lunch with invited staff	BoT & invited staff

02.00 – 04.00 pm	Meeting of the Full Board - Approval of the Minutes - Response to Resolutions - Selection of new Trustees/ Process for selection of Board Chair - Dates of next meetings - ISD Review – Dr. T. Hull - Finalize resolutions - Any Other Business	BoT Closed
04.00 – 04.15 pm	TEA	
04.15 – 05.15 pm	Development Partners Group Meeting	BoT, SC
06.30 pm	Reception	

Monday, 29 November 2004
GUEST LECTURE

08.00 – 09.00 am	Board Pending Issues	BoT
09.00 – 10.00 am	Guest Lecture "DOTS expansion and Operational Research". Speaker: Dr Nobukatsu Ishikawa	Auditorium (Open)
10.00 – 10.15 am	TEA	
10.15 – 11.30 am	Report to staff by Chair, BoT and Executive Director, ICDDR,B	Auditorium (Open)
12.00 noon	LUNCH	BoT

1/BT/NOV 2004

APPROVAL OF THE AGENDA

Programme, Fund Development, National Liaison Committee meetings
Saturday 27 November 2004

Agenda:

8.30 – 9.00 am	Meeting of the Programme Committee - Approval of the Minutes - Response to Nov/June Board Resolutions - Response to BoT Teleconference	BoT, CD
9.00 – 11.00 am	Executive Director's Report Presentation by Division Directors: staff: NOA and - Clinical Sciences - Health Systems and Infectious Diseases	BoT, Scientific above, donors
11.00 – 11.15 am	TEA	
11.15 – 12.30 pm	- Laboratory Sciences - Public Health Sciences	
12.30 – 01.30 pm	LUNCH	BoT, SC
01.30 – 02.30 pm	Response to CSD Review	BoT, SC & CSD members
02.30 – 3.30 pm	Meeting of the Fund Development Committee	BoT, SC
03.30 – 03.45 pm	TEA	BoT, SC
03.45 – 04.45 pm	Meeting of the National Liaison Committee	BoT. SC
04.45 – 05.30 pm	Change of Name – ICDDR,B	BoT, CD, ER&ID

2/BT/NOV 2004

APPROVAL OF THE DRAFT MINUTES

OF THE MEETING

HELD ON 11-13 JUNE 2004

MINUTES OF THE BOARD OF TRUSTEES MEETING
11-13 June 2004

Minutes
Programme Committee Meeting
11 June 2004

The Executive Committee of the Board of Trustees held its meeting in Dhaka, Bangladesh from 11 to 13 June 2004. 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, Secretary, ERD, GoB
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Prof. Azad Khan (Chair, Finance)
Dr. Claudio Lanata (Chair, HR)
Prof. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:
Dr. Kul Gautam (Chair, Fund Development Committee)

Invited:
Centre Directorate (Ms Ann Walton, Mr. A Neogi, Dr. G B Nair, Dr. Charles Larson, Dr. Abbas Bhuiya, Dr. M A Salam, Mr. Peter Thorpe).

Minutes: Ms. Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT welcomed the Executive Committee (EC) and the Centre Directorate (CD) to the meeting. He joined Dr. David Sack in welcoming Mr. Beg for participating and thanked him and the ERD for their support to the Centre; and declared the meeting open.

1. **Approval of the Minutes**

The Minutes were approved with one correction: "CSD Reviewer, Dr. I Kabir should read Dr Ahmed-AI Kabir".

2. Review of Resolutions (November 03 Full Board Meeting)

Prof. Marcel Tanner, Chair, Programme Committee (PC) guided the resolutions related to the Programme Committee (PC):

Response to Resolution 5: Yearly plans based on Strategic Plan:

Prof. Marcel Tanner clarified that a more precise translation of the yearly plans was requested. Dr. David Sack queried whether another set of plans would be productive. He said, the Centre has no intentions of rejecting the Board's proposal; if the Board

would like to have a formal progress report on specific areas (exceptions), the Centre's plans for the future in relation to the funding, this may be possible once the new system (Suchona) is stabilized.

It was agreed that resolutions 5 & 6 be discussed in greater detail at the November meeting in relation to the two tools: Suchona, and ii) Strategic Plan (consolidate Suchona with the SP).

[Resolution 5: responded to by Dr Sack in the Executive Director's report in November 2003.]

"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."

*(**10/BT/Jun 03:** That the Centre Directorate make further progress in defining the core (essential) support required by the Centre to fulfill its mission in accordance with the Strategic Plan and report their analysis to the November 2003 BoT meeting.*

***11/BT/Jun 03:** The BoT analysed the pattern of distribution of unrestricted funds and noted that it will be important to monitor at future meetings the inter- and intra-divisional distribution of these funds and the rationale used.)*

[Resolution 6: to be discussed in detail in the Finance Committee meeting.]

Resolution 10: CSD Response to Review Recommendations

This item was deferred for discussions as a separate agenda item following the Finance Committee meeting. (The Board suggested that in order to allow time for these discussions that the HR Committee meeting be held prior to the Finance Committee).

It was also agreed that the suggestion to include a "Review of Resolutions" was extremely helpful, especially at this meeting since it allows for a report to be made to the Full Board prior to the teleconference.

The EC resolved that:

- items that require substantial discussion should be presented at the November (Full Bo T) meeting;
- "selection of new Trustees" - it would desirable to reach a consensus at this meeting (obtaining the approval of the entire Board) to enable the "new Trustee" to participate in the Retreat.
- That the format for future Executive Committee meetings be discussed at the Retreat - the EC meeting may be different from the Full Board meeting - agenda items should relate/include matters of immediate relevance.

- The Centre Directorate should provide issues that they consider should be discussed at the Board Retreat - one major item being discussions on the "6-year rule".

The Programme Committee reconvened at 9.00 am in the Sasakawa Auditorium.

Present: Executive Committee of the Board
Invited: Representative - Development Partners Group, Centre scientific staff

Dr. Uauy opened the meeting and welcomed those present. He said, the past months have brought a lot of good news for the Centre, most importantly the health of the Director; the Centre has also made considerable progress in several ways. He said the Board agreed on the Executive Committee meetings not only to cut costs, but they are satisfied by the presence of the members of the Standing Committees in Dhaka and have the EC confer with the rest of the Board thus accomplishing the work of the Board.

Specially referring to the HNPSP meeting held in Dhaka in January, Dr. Uauy commended the Centre not only for its science but also on its application whereby the science produced at the Centre will also be applied to the rest of Bangladesh.

Referring to the Gender Policy and the efforts made by Prof. Carol Vlassoff for aggressively pursuing this objective, Dr Uauy said the Gender Policy is not just a document produced by the Centre, but a document that will be put into practice.

Finally, referring to the very appropriate cartoon in the Annual Report on the Strategic Plan he said, the Board and the Development Partners are committed and interested to see ICDDR,B in the center stage of global public health efforts.

Dr. Uauy invited Dr. David Sack to present his report to the Board.

1. Dr. David Sack provided an overview of his presentation which included a review of major events and changes during the year; highlights on major future trends and/or changes, especially with regard to relations with MOHFW and NGO partners; review of progress on the Strategic Plan and a review of developments for Master Plan. The presentation also included a list of activities conducted to celebrate 25 years of the Centre as n international center, transitions of staff, new Management Information System (Suchona), HR update, an overview of finance (good/bad news), expected accomplishments during the coming decade, new programmes to be added to the Strategic Plan, division updates (new international initiatives, new initiatives, major initiatives), ongoing education and sharing, and provided the goals for the HNPSP workshop held in January which was attended by senior planners of the GoB along with national institutes and WHO. He said the Development Partners (DP) currently fund development research on a bilateral basis and that there may be support from the DP 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

Dr Sack said that in setting research priorities for HNPSP, these need to be guided by

MDG's, national goals and targets, opportunities based on available resources and that priority setting needs to involve many stakeholders. He explained that the conclusions from the January meeting could be made real with funding from DRGA and additional collaborations with the Ministry.

Dr. Sack reported on his participation at the Gates Award for Global Health Ceremony in Washington won this year by BRAC He said Bangladesh should be proud that this award has come back twice in four years to Dhaka. He reported on the status of the new ICDDR,B collaboration with the BRAC School of Public Health (James P Grant School) whereby faculty will be shared, joint courses will be held, and sharing of library resources and facilities. Plans are being developed to host the School in a newly constructed ICDDR,B building and to jointly raise construction funds to complete the master plan.

In conclusion Dr. Sack reported that the anniversary year was productive and demanding; Suchona will provide benefits for years to come, the Centre is financially stable with several key donors. Relations with the Government pf Bangladesh has improved and partnership with Development Partners has increased.

He thanked the Centre scientists and support staff, the Ministry of Health, ERD and the National Institutions, the GoB as a key "development partner" and the external development partners who make it all possible.

Dr. Uauy thanked Dr. Sack for an impressive account of the Centre's activities.

Dr. Uauy introduced Prof. Marcel Tanner as Chair of the Programme Committee replacing Prof. Carol Vlassoff, and invited him to Chair the proceedings of this meeting.

New Findings and Directions in Cholera - Dr. G B Nair.

Dr. G.B. Nair presented the urban and rural scenario of Cholera. He said some research is being influenced by the riverine conditions and that future studies are directed to predict and prevent Cholera. Dr. Nair reported on the leading causes of diarrhoea at the ICDDR,B Dhaka Hospital in 1999 presenting a fortnightly surveillance in 4 widely separated geographic locales. Showing the burden of Cholera in Bangladesh he said WHO Yearly Global Cholera statistics are gross underestimates since many countries either do not report or under-report Cholera. He presented new insights into the epidemiology of cholera stating that following the deployment of a sari filtration procedure from September 1999 in about 133,000 individuals yielded a 48% reduction in cholera compared with the control. Future directions included environmental studies to increase understanding of the impact of the acquatic environment on the incidence of disease caused by waterborne pathogens. Dr. Nair reported on the immunological aspects of cholera and the search for better oral rehydration solutions and newer antimicrobial regimens for the treatment of cholera.

Prof. Marcel Tanner thanked Dr. Nair for the fascinating insights on what the Centre does in the area of Cholera, what it has done, and where it plans to go. He said Dr. Nair and his team were able to present a harmonic and balanced view of the work carried out at the desk, at the bench and in the field.

Dr. Shams-el-Arifeen was invited to give his presentation.

Community based interventions to Reduce Neonatal Mortality (Projahnmo) - Dr. Shamsel-Arifeen

Dr. Shams-el-Arifeen began by presenting the infant mortality rate (neonatal/post-neonatal) for the period 1997-2001 in Bangladesh. He said most investment in ensuring safe delivery has been the supply side -limited efforts on modifying family/community behaviours; none or limited focus on the newborn-newborn care; practices remain poor even though health-care behaviours have improved; many practices are based on deeply entrenched beliefs, however, health services are now ready to meet the needs of the sick newborn.

Presenting the objectives of the study being carried out in Mirzapur and Sylhet, Dr. Shams said that the study was conducted in 3 phases: research and design of intervention; intervention implementation and evaluation; analysis, write-up, dissemination and policy advocacy. The study outcomes were also presented together with comparative selected findings from Sylhet and Mirzapur. He said the recommended behaviours were pretested, and proceeded to present the summary of results. The study also included health system strengthening, intervention delivery strategies at the household, community and health facility levels; who does what? training and orientation (topics covered), monitoring and quality assurance. Reporting on the present status of the project, Dr. Shams concluded by presenting a list of unique features of the study.

Prof. Marcel Tanner congratulated Dr. Shams for his concise and clear presentation, and for what and how he and his team do the work presented.

Dr. Kim Streatfield was invited to make his presentation.

Plateauing of the Bangladesh Fertility Decline - Dr. Peter Kim Streatfield

Dr. Kim Streatfield began by presenting the trends in fertility in Bangladesh for the period 1980-2000 providing information collected from various sources, and population projections for Bangladesh 1990-2150. TFR halves to 0.5 for 2 years 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. Presenting the trends in family planning use between marriage and subsequent births, he said there is very little or no family planning between marriage and first birth. He said exposure, deliberate marital fertility control and natural marital fertility control, are factors which determine fertility levels. Presenting Matlab data he said girls are still marrying at the age of 16. Fertility rate is flat and contraceptive use is rising, and this is probably due to abortions. Concluding this section he said, the halving of fertility (TFR) during the 1980s and 1990s, and plateau since then is genuine; there has been a "tempo effect" due to rising age at childbearing; the "tempo effect" is now mostly out of the system which is due to shit in low parity births, which do not show rising age at childbearing and the paradox of flat TFR but rising CPR is probably due to the declining MR/abortion.

He said it is predicted that though population growth will be ten-fold in two centuries we are still halfway- future growth (1996-2051) is estimated to be 107 million.

Unwanted birth rate is rather low. However, misuse of pills, discontinuation rates, are rather high. Presenting interventions to reduce unwanted births Dr. Streatfield said that we must continue to focus on the quality of family planning. Listing factors that drive high desired family size, he said parents want only 2½ kids, however, it has been 3 or more than 3. Most families have 1 son surviving to adulthood - but this has changed - 2½ kids now survive to adulthood. With regard to gender preference he said parents prefer two sons and 1 daughter, however, preference is now declining. Also, the numbers of girls going to school are increasing. Dr. Streatfield said that the population growth (107 million) will have 3 components: unwanted fertility, which requires effective family planning; high desired family size, which requires change in '(economic) value of children', gender preference, improved child survival; and population momentum - the need to minimize impact of 'young' age structure by raising average age of childbearing through delaying marriage and first births and a strong family planning program.

Prof. Marcel Tanner thanked Dr. Streatfield for providing very important insights into this critical issue for Bangladesh and globally, and commended him for the impressive work in this area.

Prof. Tanner thanked all the presenters for their impressive presentations varying from laboratories to applications in public health. He said that though the Board is interested in these issues, not much time is given to these discussions. The Board will seriously rethink the planning of the EC and Full Board meetings to give full weight not only to management issues but also the science. He said the Programme Committee would pay more attention to the programmatic issues at the November Board meeting.

[This has been included for discussion in the Retreat.]

Prof. Tanner thanked the Centre, on his behalf and that of the Board, for maintaining high standards and excellence in its scientific activities.

The Board reconvened in the Seminar Room for the meeting with the Development Partners Group.

June 11, 2004 - 5.15 pm

Following the meeting of the Finance Committee the Executive Committee and the Centre Directorate met for discussions with regard to the CSD Response to the External Review.

Dr. M A Salam, Director, Clinical Sciences Division presented his response to the Review. Before moving to the "Bullet Points" he said the process by which the response has been reached has not been reflected in the response. Summarizing his response he said not enough funding opportunities are available, however scientists continue to explore funds in the traditional areas as well as studies in newer fields. With regard to dividing time between service and research, Dr. Salam said that despite recognition of inefficiencies in the 50:50 system more time will be required to change this system to an efficient one. The clinical services have been divided into three areas: short stay ward; longer stay ward and the special care unit.

In response to what assistance the Board can provide, Dr. Salam mentioned that the Board could assist with forming teams - as changes are made these need to be discussed within the Centre. The Board can also help in the recruitment of international scientists (ALRI research).

The EC felt that the Division has not made much progress and that the actions implied should go much beyond the division, and that this has not happened. It is important to recognize that the Centre should take a closer look at the recommendations and develop a plan to reflect the changes.

Dr. Salam agreed that most of the time has been invested in the structure of the Division. It was also reported that physical facilities have changed which will help to change attitudes.

The Board felt that the Division needs to be more explicit and needs the CD to assist with the thought process. These discussions should be held at the CD level and not at the Board meeting. The recommendations should be reflected in a plan and a budget for the activities which could be presented to a donor. Endowment Funds should not be used to fill "gaps".

The Board felt that more commitment is required on steps to be taken in collaboration with the CD on what can be accomplished before the November Board meeting.

It was agreed that in within the next few weeks, Dr. Salam/Centre Directorate provide the Board with a short document prioritizing the task list.

[This will be discussed as a separate agenda item in the November meeting.]

The meeting concluded at 6.15 pm.

BOARD RESOLUTIONS
June 2004
Programme Committee

Res/1/BT/June 04

The Board welcomed the Director's report and the three scientific presentations that provided an excellent insight into the most recent achievements at all levels in relation to the Strategic Plan and MDGs. The presentations also flagged the key issues of vital importance for the Centre.

Res/2/BT/June 04

The Board congratulates the Centre for the fine achievements that are of great national and international importance at the scientific, strategic level.

Res/3/BT/June 04

The Board welcomed the Centre's efforts to develop new programmes such as "HIV/AIDS', Health & Poverty: and "Safe Water" to become part of the Strategic Plan. Detailed discussions will be held at the November Board meeting.

Res/4/BT /June 04

The Board was most satisfied to see that the Gender-Policy is published and being implemented by the Centre and requests the Gender Equality Committee to report developments based on the ongoing gender review at the November Board meeting.

Res/5/BT/June 04

The Board reviewed how the recommendations of the November 03 review of the CSD were considered and implemented (Resolution 10/BT/Nov 03) and noted that although some actions have been taken towards implementation, progress has been slow and insufficient to address the major challenges faced by the Hospital and CSD. It was recommended that the Centre's Directorate pay full attention to the pursuit of the implementation of the recommendation and assist the CSD as much as possible, and asks the Directorate to establish a prioritized task list by the November Board meeting.

Minutes
Meeting of the Finance Committee
11 June 2004

A meeting of the Finance Committee of the Board of Trustees (BoT) was held on 11 June 2004 at 4.00 pm in the Sasakawa Training Lecture Room.

Present:

Dr. Ricardo Uauy Dagach (Chair, BoT)
Prof. Azad Khan (Chair, Finance Committee)
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Dr. Claudio Lanata (Chair, HR Committee)
Dr. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:

Dr. Kul Gautam (Chair, Fund Development Committee)

Invited: Scientific Council

Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach welcomed the Scientific Council to the meeting and invited Prof. Azad Khan to Chair the proceedings.

Prof. Azad Khan presented an overview of the items presented for discussion and invited Mr. Aniruddha Neogi, Director, Finance to make his presentation.

Presenting the 2003 Statement of Activity, Mr. Neogi presented detailed information on the revenues (core/project/other), expenditures, surplus before depreciation and shortfall after depreciation. A total of 58 donors supported the Centre in 2003, the largest being USAID/Dhaka, The Netherlands, United Kingdom (DFID), Bangladesh, Sweden/SIDA, Canada/CIDA, Switzerland, Gates-GoB award, USA (other sources) and IVI.

He said the auditor's have qualified the deferment of ERP implementation costs amounting to $320,000. This was deferred as implementation was not completed within 2003. This expenditure will be amortized in two equal installments in 2004 and 2005 against earmarked funds.

The second qualification was for non-inclusion of assets and liabilities of the "Employees Separation Payment Fund" (ESPF). The Management does not agree with those qualifications since these funds belong to the staff and therefore does not constitute an asset of the Centre. Moreover, the inclusion of such funds in the Centre's Statement of Financial Position would materially distort the true financial position of the Centre. The auditors have also issued a management letter to the Board indicating two issues:

1. the formation of the ESPF Trust: following this observation the process of setting up an Independent Trust for this Fund has been initiated which will manage the Fund on behalf of the participating employees. The Board agreed to this decision and requested that a draft of the relevant by-laws after approval of the SWA be presented at the November meeting after considering all legal implications.

2. 62% exposure to equity instruments - Endowment Funds investment with overseas TIAA/CREF Trust Company. The Management responded that it considers investments against Endowment Funds as long-term investment and the objective of these investments is to provide stable returns along with a steady growth of the Corpus and to optimize returns and minimize risks a balanced portfolio is maintained. The Debt Equity ratio of these investments is 40:60.

A snapshot of the 2004 forecast was presented which indicated a shortfall of $ 610,000 before depreciation. Plans to reconcile the shortfall from US$ 926,000 (2004 budget) to $ 610,000 by receipt of more overheads from projects that are in the process of being started and contribution from the Hospital Endowment Fund was also presented.

The Board was pleased to receive information on core costs (net) by Division. Core costs (net) for each division was further segregated into different categories namely, Divisional activity, core funded scientific activity, and service. The major category was further broken down by activities.

A plan for Activity Review was presented as follows:

Essential core activities
Core funded activities
Funded core activities
Funded non-research activities
Services
Self-sustaining activities

The following information necessary for review will be forthcoming from the Divisions:

Does the Programme correspond to an activity
Themes that correspond to the activity
Collaborating institutions, if any,
Relevance to Centre's priority
3-year budget estimates
Activity period – "Sunset Clause"
Brief description and funding source.

The activities will follow an "approval process flow". The following criteria will be followed when reviewing the activity:

Type of activity
Relevance with Strategic Plan

Relevance with Centre's priority
Budget trends and cost effectiveness
Prospects for funding
Possibilities of cost optimization

Apart from this one-time review a mechanism has been built into Suchona to track the progress on a periodical basis.

Mr. Neogi reported on the tasks accomplished under the Sustainability Plan. He said, guidelines have been laid out based on the Centre's Strategic Plan, a broad review of overall costs of the Centre as well as that of each Division has been carried out, strategies for cost optimization which have relevance with Centre's activities have been identified based on "Best Practices", following discussions with all divisions revenue augmentation opportunities have been identified, draft model plans on hospital and diagnostic labs based on various options have been prepared.

During the last six months market research has been completed. Exit interviews of laboratory services were carried out by the Health Systems and Economics Unit of HSID for which the ground work was done in February/March and completed in May. The list of findings is provided below:

- Clients are mostly educated and belong to the upper strata of the society
- Quality factor
- Satisfied clients
- The Centre will be able to retain 84% of clientele if fees are increased in the region of 10-15%
- 75 prefer delivery of report by courier or messenger service on payment basis
- majority feel that fees are comparable with other service providers
- patients felt that physical facilities should be upgraded
- missed opportunities – ECG, X-Rays & Ultrasound
- there are prospects of growth in revenue as well as in margin if we include these services
- 82% preferred ICDDR,B run counters near home.

Mr. Neogi further presented information on the proportion of clients by location and proceeded to show the way forward with regard to the Sustainability Plan as follows:

- Customize strategies for cost optimization and estimate potential savings
- Revisit the Revenue Augmentation Areas and work out feasibility
- Finalize hospital plan based on input 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.
- 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 for BoT for approval
- Roll-out the approved plan in phases and monitor.

The Board recommended that the CD should assist in this exercise.

Mr. Neogi concluded his presentation by providing a brief update on "Suchona". He said so far the implementation is satisfactory and we believe that the users will be able to realize the benefits of Suchona in the near future. It is hoped that in the future a more refined report will be presented to the Board.

Prof. Azad Khan thanked Mr. Neogi for his very clear, concise and informative presentation. Rounding up on the activities to-date he said,

Break-even plan for 2003 has been implemented,
The finances show a small surplus in 2003 – 5th year in a row.
$ 400,000 has been withdrawn from the Endowment Fund (carried over from previous years)
the 2004 forecast shows improved situation
the Endowment Funds are back in the path of growth
Integrated system in operation
Process to determine Essential Core has begun (Activity Review)
Steps have been taken to form the ESPF Trust
Sustainability Plan – Market Research & Exit Interviews have been completed.

Responding to the comment by Dr. Uauy on the utilization of funds from the Endowment Funds the Board queried whether it is easier for the Centre to balance the budget by using Endowment funds and how does the Centre see this practice in the future -- should not some of the structural changes that occur in the budget need to be faced – Mr. Neogi reported that the income from the Endowment Fund is used and not the Capital and that it is important to tell the donors how we have used these funds. He said, we should however use these funds in a prudent manner and within the terms and conditions laid down ijn the by-laws of the Fund. Prof. Azad corrected that the deficit is however getting less without borrowing from the Endowment Funds.

Dr. Uauy also queried whether an investment plan is in place for money expected from prospective donors so as the Centre faces the implementation of the Strategic Plan what would be the financial needs to do this and that this should be a part of the financial plan to accompany the Strategic Plan.

Congratulating the Centre for the progress made with regard to "Suchona" Dr. Marcel Tanner commented that though it is great to see the many elements come together and is a good tool for the management, the Centre should be more active in projecting directions so that the donors are convinced and this should be done at the Directorate level.

Prof. Azad Khan thanked Prof. Marcel Tanner for raising this issue which he strongly felt the Centre should consider.

Prof. Azad Khan thanked the Finance staff on behalf of the Board for having worked extremely hard to achieve the results presented at this meeting.

Resolutions: The suggestions recommended by the Board were incorporated in the draft resolutions formulated.

The meeting concluded at 5.00 pm.

Finance Committee
Resolutions

RES/17/BT/June 04

The Board accepts the audited Financial Statements of the Centre for the year ended December 31, 2003.

RES/18/BT/June 04

The Board accepts the management response to the auditors' letter to the Board of Trustees.

RES/19/BT/June 04

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.

RES/20/BT/June 04

The Board 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 will review the Break-even plan for the operating deficit for 2004 of the Centre Directorate in its November 2004 Board of Trustees meeting.

RES/21/BT/June 04

The Board approves the transfer of $400,000 from Hospital Endowment Fund to the Operating fund in 2003 based on previously authorized (Res/3/Nov 00; Res/4/Nov 01; Res/5/Nov 02) unutilized carried over amounts of $200,000 each from 2001 and 2002.

RES/22/BT/June 04

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.

RES/23/BT/June 04

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.

RES/24/BT/June 04

The Board authorizes the transfer from the Reserve Fund to the Operating Fund of all funds in excess of $2,000,000.

RES/25/BT/June 04

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.

RES/26/BT/June 04

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.

RES/27/BT/June 04

The Board accepts the audited financial statements of the ICDDR,B Employees Separation Payment Fund for the year ended December 31, 2003.

RES/28/BT/June 04

The Board noted the action taken by the Centre with regard to the Employees Separation Payment Fund which will 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;
- the Deputy Executive Director (and in his absence 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 of the relevant by-laws after approval of SWA should be presented to the BoT at the November 2004 Board of Trustees meeting after considering all legal implications.

RES/29/BT/June 04
The Board resolved to authorize to write off $96,804 being irrecoverable old receivables from a Donor in 2004.

Minutes
Human Resources Committee Meting
Friday, 11 June 2004

The Human Resources (HR) Committee of the Board of Trustees (BoT) held its meeting on 11 June 2004 at 2.00 pm in the Sasakawa Training Lecture Room.

Present:

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Claudio Lanata (Chair, HR Committee)
Prof. AK Azad Khan (Chair, Finance Committee)
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Prof. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:

Dr. Kul Gautam (Chair, Fund Development Committee)

Invited: Centre Directorate

Minutes: Ms Loretta Saldanha

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

Dr. Lanata thanked Ms. A Walton and Mr. A Neogi for the briefing provided on "Suchona" and HR, Finance staff and all those who have worked long hours to achieve the results that have been demonstrated to-date.

1. Approval of the Agenda

The agenda was approved.

2. Approval of the Minutes of the November 2003 meeting

The Minutes were approved. Reviewing the resolutions

18: Dr. Lanata said that this will be discussed in detail in the context of the "six-year rule" at the November BoT meeting.

19: It was reported that specific criteria exists. There is only one career path and that is the scientific path.

Dr. Lanata invited Ms. Ann Walton, Director, HR to present the HR agenda.

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.

The HR staff participated in a 2-day retreat which provided an opportunity to work together outside the office environment, to develop a department mission statement and to incorporate some of the training needs identified. The department is now operating under a new framework and is in the transition process from being a "policing" department to one of support to the organization.

Agenda 3.1: Staffing Status

There were 57 additions and 29 separations during the reporting period. The total number of Centre fixed-term staff belonging to all categories thus increased by 28. Information on staffing status was provided by job family, by funding (restricted/unrestricted), and by division, HR has taken an indepth look at the gender balance issue and presented results by gender ratio for the Centre/by Division, by job family and grade. In response to a comment that a better term be used for staff paid from unrestricted funds, it was reported that this would require an analysis of time allocation.

In response to a comment that the Board has in the past given strict instructions not to increase fixed-term staff, but if people are working full-time for years on end the Centre needs to convert these staff to fixed term to enable them to receive benefits. It was clarified that this may have been done due to shortage of funds – if the Centre has funds the Board does not have a problem with staff increases, however the Centre should have a mechanism when the budget shrinks. It was reported that the Centre does have a mechanism. Out of 2000 staff there is only a risk for 300 have contracts without end dates staff and these staff are nearing retirement.

Agenda 3.2aa,b,c: Status of Recruitment of International Professional Staff,
3.3a: Completion of Tenure in International Professional Post;
3.4a,b,c:.Renewal of Contracts,
3.5a Status of Secondaed Staff Contracts,
were discussed in a closed session of the Board and relevant resolutions drafted (attached).

Agenda 4: Human Resources Agenda Update

Although the HR Department has been mandated to implement the HR Agenda, 19 HR staff 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 HR has recruited 281 individuals, processed 727 contracts and 895 daily wagers. This has limited but not made impossible to advance with the HR agenda, which was presented below.

Human Resources Information System

Summarizing the information presented, Ms Walton concluded that to facilitate Centre wide implementation and acceptance of Navision. HR and Finance trained all Principal Investigators as well as all units in using Navision. In addition, HR trained

the staff members with very little or no computer skills in using the system for viewing "self-information" and pay slip as well as leave applications. 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.

Gender Equality

Providing a summary of the activities to-date Ms Walton said that a Gender audit started in April 2004. Key organization structures, procedures, policies and practices are being reviewed to identify whether and how they discriminate against women or man 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 indicators of possible phasing. A two-page summary was presented. The first annual work plan will be presented in November.

The Board recommended that based on the ongoing review an update of activities be presented at the November BoT meeting.

Performance Review System

It was reported that the development of the performance management training module and the behavioural competencies will be completed during the coming months. The roll out of the new performance review system can only be considered once the system has been stable for several months and users are comfortable operating in the new environment.

It was suggested that the Centre develop a pilot programme first and wait for Suchona to be stable. Ms. Walton reported that a tool for performance evaluation does exist but this needs to be refined. In response to the Board's comment that the it is necessary for the performance review system to be in place if the Board is planning on discussing the 6-year rule in November, it was clarified that a framework needs to be identified – tool development is the easy part but culture training is the hard part; a commitment from the CD is necessary to pilot the revised system and that the Centre needs to look at the performance evaluation cycle instead of making it a once a year event.

The Board recommended that the Centre pilot the revised system with international professional staff by November 2004.

Dr. Lanata thanked Ms Walton for presenting the HR agendas and indicated the Board's satisfaction with the progress made on the HR agenda particularly with the implementation of the gender equality policy.
The meeting concluded at 3.30 pm.
Human Resources Committee
Resolutions

Res/6/BT/June 04

The Board confirmed the appointment of Dr. Marjorie Koblinsky as Director, Public Health Sciences Division, effective 1 September 2004 for an initial period of 3 years.

RES/7/BT/June 04

The Board agreed that the Centre continue the search for candidates for the post of Deputy Executive Director

RES/8/BT/June 04

The Board agreed to abolish the post of Director, Policy & Planning.

RES/9/BT/June 04

The Board resolved that the current employment contract of Dr. Gopinath Balakrish Nair with the Centre be extended up to April 08, 2006 to complete 6 (six) years as a fixed term international professional staff, under the same terms and conditions.

RES/10/BT/June 04

The Board resolved that it is in the best interest of the Centre to extend Dr. Kim Streatfield's contract for an additional 18 months on completion of six years service effective 17 July 2005, under the same terms and conditions.

RES/11/BTJune 04

The Board is pleased with progress made on the HR agenda particularly with the implementation of the gender equality policy.

RES/12/BT/June 04

The Board resolves that the current secondment agreement of Dr. Charles Larson between McGill University and ICDDR,B be extended for an additional 3 years effective 1 July 2005.

RES/13/BT/ June 04

The Board wishes to place on record their appreciation for Dr. Breiman's contribution to the Centre as Director, HSID and Head, Infectious Diseases and Vaccine Programme(PIDVS).

RES/14/BT/June 04

The Board approves the appointment of Dr Charles Larson as Director, Health Sciences and Infectious Diseases Division, effective 13 June 2004 for an initial period of three years.

RES/15/BT/June 04

The Board noted the plans for the implementation of the performance review system and encouraged the Centre to pilot the revised system with international professional staff by November 2004.

RES/16/BT/June 04

The Board wishes to place on record its sincere appreciation for the tireless efforts of the
Finance and Human Resources Staff as well as all those who have worked long hours on
the "Suchona" project, alongside their routine responsibilities, to achieve the results that have been demonstrated to-date. The Board is confident that once this system is stable the Centre will have achieved another important "milestone".

Minutes
Full Board Meeting
12 June 2004

A meeting of the Full Board was held on 12 June 2004 at 8.00 am in the Sasakawa Training Lecture Room.

Present:
Dr. Ricardo Uauy Dagach (Chair, BoT)
Prof. A K Azad Khan (Chair, Finance)
Dr. Claudio Lanata (Chair, HR)
Dr. David Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:
Dr. Kul Gautam (Chair, Fund Development Committee)

Invited:
Centre Directorate
Ms V Brooks, Grants & Contracts Administrator
Ms. Hannah Lemon, Senior Associate, ER&ID

Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach opened the meeting.

1. **Approval of the Minutes**

The Minutes were approved.

2. Discussion on November Board Retreat

Dr. Sack reported that Ms. Vanessa Brooks will help him coordinate this retreat. The document jointly prepared in preparation for the Board was earlier circulated for comments. Dr. Sack briefly summarized the 1999 Retreat. Commenting on the evolution Dr. Uauy felt that it is important for the Centre to go through the process and that it would be worthwhile to get a view of how the Centre staff perceives the Board, whether the Board has been effective in supporting the management, in contributing to the Centre's effort in achieving its mission, in providing oversight and anticipating problem areas. It is also important to promote active participation to provide feedback for the Board to reflect upon. The process can be formalized confidentially.

In response to Dr. Sack's query as to whether the Board should be involved in the reviews of the Division's work, the Board felt that a link is required between the external reviewers and the Board and hence it is important for the Board to participate.

Other issues included:

Governance and management issues should not be divided. The question is what kind of Board is needed.
The next retreat should also concentrate on the Strategic Plan and how the Board can assist the Centre in achieving its goals.
The agenda should also include the format for future EC and Full Board meetings;
"parking lot" issues;
The issue of communications;
The Board does provide continuity – how do we build stability and change in an efficient manner – critically how do we build into the system without compromising sometimes the existence of the Centre. The Board also needs to look at the balance of expertise on the Board.

It was also felt that because the Board is largely technical, there is a danger of conflict of interest – how do we handle this. Prof. Azad said that the expertise of the Board Members should be utilized, but the Board should raise themselves above exploiting the Centre for personal gains.
What are the gaps between the EC and the Full Board.
Whether a monitoring system is required to ensure that the resolutions are being followed up step-by-step and the degree of the involvement of the Board.

In preparation for the Retreat and in order not to "reinvent the wheel" the Board with the assistance of the CD updated the document entitled "Formulation of short term and long term critical issues and assignment of responsible individuals and time Frames" outlining the structure of the retreat and asked the senior staff to contribute in defining key issues that should be addressed at the Retreat. The Board also requested Ms. V. Brooks to provide a draft progress report on the status of the issues outlined in this report (p 13-14) to be submitted to the Board by 31 July 2004.

Following some discussion on the venue and logistics, it was agreed that this be left to the discretion of Dr Sack who will explore the most suitable venue to enable the Board to be able to concentrate on their deliberations. Preferably that it be done in Bangladesh but outside Dhaka to allow members of the Bangladeshi government to participate.

SWA Presentation

The EC together with Ms Ann Walton met with members of the SWA Executive Committee. The SWA were assured that their requests will be further discussed at the November meeting.

Name Change for the Centre

An update was provided by Ms. Lemon on the status of actions to date.

Closed Closed meeting of the Board

Appointment to Committees of the Board:

Dr Kaye Wachsmuth and Prof. N.K. Ganguly were appointed as Deputy Chairs of the Fund Development and Finance Committees respectively.

Extension of Term

The Board approved the extension of the term of Professor Marcel Tanner for a second term of 3 years.

Selection of new Trustees

The Board reviewed the CV's received in response to a call for nominations to replace Prof. Carol Vlassoff and resolved that Dr. Margaret Catley-Carlson and Dr. Peter Tugwell be offered the post in this order.

The Board also placed on record its thanks to Prof. Vlassoff for her outstanding contribution to the Centre as a member of the Board since July 1998.

Following the resignation of Dr. Maimunah Bte Hamid due to medical reasons, the Board resolved to accept her resignation and thanked Dr. Maimunah Bte Hamid for her outstanding contribution to the Centre as a member of the Board for a period of 3 years. The Board also reviewed pending CV's. As in the past a request for nominations will be sent and a selection will be made bearing in mind the gender balance.

External Programme Review of the Board

The Board agreed that a Programme Committee Review of the Information Sciences Division be carried out before the June 05 BoT meeting and that Professor Terence Hull act as Chair of the Review Committee and provide advise regarding other members who should participate.

The meeting concluded at 12.30 pm.

Teleconference: 4.00 pm

Report attached.

RESOLUTIONS
Full Board

RES/30/BT/June 04

The Board outlined the structure of the retreat and asked the senior staff to contribute in defining key issues that should be addressed at the November BoT retreat.

The Board also requested the Grants and Contracts Administrator to coordinate with ER&ID and other senior management staff in providing a draft progress report on the

status of issues outlined in the Consultant's report p. 13-17. In doing so, the respective roles of the Executive Committee and the Full Board will be examined and the Centre Directorate shall provide input on Board and Management communications. The draft report shall be submitted to the Board by 31 July 2004.

RES/31/BT/June 04

The Board noted the requests presented by the Staff Welfare Association.

RES/32/BT/June 04

The Board resolved to appoint the following Trustees as Deputy Chairs for the following Committee:

Finance: Prof. N.K. Ganguly
Fund Development: Dr. Kaye Wachsmuth

RES/33/June 04

The Board approves the extension of the term of Professor Marcel Tanner for a second term of 3 years with effect from the date of termination of his first three-year term (June 04).

RES/34/BT/June 04

The Board reviewed the CV's received in response to a call for nominations to replace Prof. Carol Vlassoff (term ending June 2004) and resolved that Dr. Margaret Catley-Carlson and Dr. Peter Tugwell be offered the post in this order.

RES/35/BT/June 04

The Board agreed that a Programme Committee Review of the Information Sciences Division be carried out before the June 05 BoT meeting and resolved that Professor Terence Hull act as Chair of the Review Committee.

RES/36/BT/June

Following the resignation of Dr. Maimunah Bte. Hamid as member of the BoT, for personal reasons, the Board resolved to accept her resignation and thanked Dr. Maimunah Bte Hamid for her outstanding contribution to the Centre as a member of the BoT for a period of 3 years, and wished her good health.

RES/37/BT/June

The Board resolved to extend its thanks to Prof. Carol Vlassoff for her outstanding contribution to the Centre as a member of the Board since July 1998.

EC Teleconference – 12 June 2004, 4.00 pm

Present: Dhaka

Prof. Ricardo Uauy, Chair, BoT
Dr. David A Sack,
Mr. AFM Sarwar Kamal, Chair, National Liaison Commmittee
Prof. Azad Khan, Chair, Finance Committee
Dr. Claudio Lanata, Chair, HR
Dr. Marcel Tanner, Chair, Programme Committee

Prof. N.K. Ganguly, India
Dr. Kul Gautam, New York,
Prof. Terence H. Hull, Australia
Dr. N. Ishikawa, Japan
Prof. Jane Anita Kusin, The Netherlands
Prof. Carol Vlassoff, Washington DC
Dr. I. Kaye Wachsmuth, Rehoboth, Detroit, USA
Dr. Halima Abdullah Mwenesi, South Africa

Regrets:

Dr. Tikki Pang (Travelling), Geneva
Dr. Maimunah Bte Hamid (resigned from the Board)

1. Nomination of Trustees

The Board considered the nomination of Dr. Margaret Catley-Carlson as appropriate and though she had declined that she be contacted again The Board agreed that Dr. Kul Gautam, Professors Carol Vlassoff and Terence Hull) approach her on behalf of the Centre (Dr Kul Gautam and Prof. T. Hull had worked closely with her at UNICEF and the Population Council). The Centre could make a case that:

- this Board is not demanding – only a couple of days in the whole year;
- mention the new "Safe Water" Programme;
- the BRAC's Jim Grant School of Public Health, which would interest her considerably;
- she could accept the nomination even if it is a year later.

Dr. Sack briefly highlighted his presentation to the Board.

Gender Policy:

The Board congratulated the Centre for the Gender Policy and the Publication. It was reported that a full-time "Gender Specialist" was recently recruited.

- The suggestion to include "that an update of activities be presented at the November" in the relevant resolution was accepted. The report will be based on the ongoing gender review.
- It was also suggested that HR take up interventions to balance the gender balance and take up the major issues that affect women.

Finance:

Dr. Sack reported that the finances are looking good in general.

- With regard to a query on lack of funding for major programmes/protocols, it was reported that with "Suchona" such information will be easily available by Division, Donors, Strategic Plan etc.
- It was clarified that all scientists have access to the system (every scientist is assigned a role; every PI has access to information on their protocols; division directors have access to all information relevant to their divisions and the ED has access to all information).

- Whether staff were permitted to approach donors for funds, it was clarified that individuals are encouraged to negotiate for funds but not agreements. A table providing this information will be available at the November meeting.

National Collaboration:

A report on the HNPSP workshop held in January was provided. It is hoped that the Centre will have access to a fairly large amount of funds released by the Government (Japanese Debt Relief) to enable the Centre and the GoB to be able to achieve the recommendations resulting from this workshop.

James Grant School of Public Health

Dr. Sack attended the award ceremony of the Global Health Foundation – the US$ 1 million awarded to BRAC will be utilized for the new JGSPH.
BRAC and ICDDR,B will jointly explore possibilities for further funding for the University (the Centre will not exclude relationships with other NGOs).
Dr. Demissie Habte has been appointed to be the First Dean and Dr. Sadia Chowdhury as the permanent Dean.
The Board congratulated the Centre for this initiative.

Draft Resolutions:

Following the email from Prof. Terry Hull Dr. Uauy clarified that for reasons of governance there is a need for these resolutions (usually house-keeping business) to be passed by the entire Board, and hence this conference call. Issues that required discussion by the Full Board will again be presented at the November meeting. However, if the Board feels that the resolutions are decisions of the EC and cannot be inferred as the decisions of the full Board, the resolutions will be kept "on hold", but if there is a basic view which is shared by the entire Board, the resolutions should be agreed upon.

Governance issues will be re-opened at the November meeting at which time the Board can reach final decisions on these issues.

1. The Retreat is now in the planning stages. Prof. Terence Hull's email (attached) re the Retreat was noted. It was clarified that the nature of the EC and its functions will be fine tuned at the Retreat.

The EC also reported that lengthy discussions were held at this meeting. Ms. Vanessa Brooks will be in charge of formulating the logistics. Sites were explored –. Options included Kathmandu, Matlab, on a boat, BRAC Guest House in Rajendrapur, Kolkata and security and visa issues were considered - the final word will be with Dr. Sack. There are benefits of having it outside Dhaka so that Bangladeshi Trustees are less distracted. Matlab was considered as a good choice due to its role in the Centre's activities and that the Malab staff would be pleased to have the Board there for this Retreat. A boat trip to Matlab was also an option.

- The Board was also informed that the item "Evaluation of the Board" as also added to the agenda for discussion.
- A survey of expectations of staff of the Board will be carried out;
- Where does the Board want to be by 2010 (this should reflect the past).
- The Centre Director and the Scientific Council will complete a form on how they see the work of the Board.
- The role of the EC will also be discussed in detail and,
- What happens between Board meetings are issues for the Board Retreat including fund-raising, conflict of interest, etc.

The EC went through a rating by relative importance (page 13 & 14 of the Consultant's report) – in addition to the "Parking Lot" issues, the EC felt there should be "launching pad" session for new ideas.

The Board raised concern about aggregate interests and external governance (quality control aspects). It was noted that it is the Board's responsibility to ensure that mechanisms for this are in place. Dr. Sack referred to document following a rigorous review document conducted by an NIH auditor(to be circulated to the Board).

Ms. Brooks will be circulating her document to the Board by 31 July 2004.

If the Board wished to express their views, these could be sent to Dr. Sack.

2. Addition of new Programmes:

- what criteria is used ?
- What is the Centre's capability to absorb new programmes/research (SP)?

This will be discussed in detail in November at which time the Centre will provide the criteria. An amendment was requested to Res. 4.

CSD Response to Review: It was queried that when the preliminary results were presented at the November meeting a question was raised regarding the cost of implementing recommendations. It was clarified that following detailed discussions at the Board meeting, the resolution passed at the November BoT meeting was re-enforced (Res 5/BT/June 04).

Director, PHSD: The Board congratulated the Centre for being able to recruit Dr. M Koblinsky.

Deputy Executive Director: It was noted that 20 applications received. The Centre will continue its search. It was suggested that the tasks of the DED will be shared by the Division Directors until the position is filled.

Resolution 9 & 10: The Board will be discussing the 6-year rule at the November meeting which have relevance to these two resolutions.

Suchona: The system is still in the process of being implemented/learning curve. In the long run it will allow the Centre to increase its data management, but will not require an increase in staff.

The Board agreed that the resolutions 20 & 21 were reformulated to specify when the transfer was authorized.

Res 22: The Board agreed that it remain as it is being a "bank requirement".

Res 27: The Board's suggestion to include the Deputy Executive Director (and in his absence one Division director) was accepted.

Res 30: The EC met with the SWA and noted their requests which will be further discussed at the November meeting and financial requests will be examined.

Res 31: Drs. Ganguly and Kaye Wachsmuth agreed to their nomination on the Finance and Fund Development Committees.

Res 34: Prof. Terence Hull agreed to as the Chair of the Review Committee for the ISD Review and provide advise regarding other members who should be invited to participate.

It was suggested that Dr. Kul Gautam contact Dr. Nora Goodwin to be a member of the review committee.

A point was also raised regarding a review of the Nutrition Programme. This will be on the agenda for the November meeting.

Res 35: The Board noted Dr. Maimunah's resignation and agreed that the Board fill the position as soon as possible with a person from the developing country. The EC also reviewed pending applications and will look at the gender balance issue.

It was agreed that an exit interview of "leaving" Board members should be conducted. Prof. Carol Vlassoff thanked the Board and the Centre for having had the privilege to serve on the Board and pledged to continue to support the Centre.

The Board also recorded its thanks to Prof. Vlassoff for her excellent support and contribution to the Centre as a member of the Board and for her efforts in pursuing the Gender Policy issue and also thanked her for pledging her support in the future.

Dr. Uauy thanked all the members for participating the call and for their important input to the deliberations of the EC.

The conference call concluded at 6.00 pm.

3/BT/NOV 2004

PROGRAMME COMMITTEE

Minutes
Programme Committee Meeting
11 June 2004

The Executive Committee of the Board of Trustees held its meeting in Dhaka, Bangladesh from 11 to 13 June 2004. 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, Secretary, ERD, GoB
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Prof. Azad Khan (Chair, Finance)
Dr. Claudio Lanata (Chair, HR)
Prof. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:
Dr. Kul Gautam (Chair, Fund Development Committee)

Invited:
Centre Directorate (Ms Ann Walton, Mr. A Neogi, Dr. G B Nair, Dr. Charles Larson, Dr. Abbas Bhuiya, Dr. M A Salam, Mr. Peter Thorpe).

Minutes: Ms. Loretta Saldanha

Dr. Ricardo Uauy Dagach, Chair, BoT welcomed the Executive Committee (EC) and the Centre Directorate (CD) to the meeting. He joined Dr. David Sack in welcoming Mr. Beg for participating and thanked him and the ERD for their support to the Centre, and declared the meeting open.

1. **Approval of the Minutes**

The Minutes were approved with one correction: "CSD Reviewer, Dr. I Kabir should read Dr Ahmed-AI Kabir".

2. Review of Resolutions (November 03 Full Board Meeting)

Prof. Marcel Tanner, Chair, Programme Committee (PC) guided the resolutions related to the Programme Committee (PC):

Response to Resolution 5: Yearly plans based on Strategic Plan:

Prof. Marcel Tanner clarified that a more precise translation of the yearly plans was requested. Dr. David Sack queried whether another set of plans would be productive. He said, the Centre has no intentions of rejecting the Board's proposal; if the Board would like to have a formal progress report on specific areas (exceptions), the Centre's plans for the future in relation to the funding, this may be possible once the new system (Suchona) is stabilized.

It was agreed that resolutions 5 & 6 be discussed in greater detail at the November meeting in relation to the two tools: Suchona, and ii) Strategic Plan (consolidate Suchona with the SP).

[Resolution 5: responded to by Dr Sack in the Executive Director's report in November 2003.]

"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."

*(**10/BT/Jun 03:** That the Centre Directorate make further progress in defining the core (essential) support required by the Centre to fulfill its mission in accordance with the Strategic Plan and report their analysis to the November 2003 BoT meeting.*

***11/BT/Jun 03:** The BoT analysed the pattern of distribution of unrestricted funds and noted that it will be important to monitor at future meetings the inter- and intra-divisional distribution of these funds and the rationale used.)*

[Resolution 6: to be discussed in detail in the Finance Committee meeting.]

Resolution 10: CSD Response to Review Recommendations

This item was deferred for discussions as a separate agenda item following the Finance Committee meeting. (The Board suggested that in order to allow time for these discussions that the HR Committee meeting be held prior to the Finance Committee).

It was also agreed that the suggestion to include a "Review of Resolutions" was extremely helpful, especially at this meeting since it allows for a report to be made to the Full Board prior to the teleconference.

The EC resolved that:

- items that require substantial discussion should be presented at the November (Full Bo T) meeting;
- "selection of new Trustees" - it would desirable to reach a consensus at this meeting (obtaining the approval of the entire Board) to enable the "new Trustee" to participate in the Retreat.
- That the format for future Executive Committee meetings be discussed at the Retreat - the EC meeting may be different from the Full Board meeting - agenda items should relate/include matters of immediate relevance.
- The Centre Directorate should provide issues that they consider should be discussed at the Board Retreat - one major item being discussions on the "6-year rule".

The Programme Committee reconvened at 9.00 am in the Sasakawa Auditorium.

Present: Executive Committee of the Board
Invited: Representative - Development Partners Group, Centre scientific staff

Dr. Uauy opened the meeting and welcomed those present. He said, the past months have brought a lot of good news for the Centre, most importantly the health of the Director; the Centre has also made considerable progress in several ways. He said the Board agreed on the Executive Committee meetings not only to cut costs, but they are satisfied by the presence of the members of the Standing Committees in Dhaka and have the EC confer with the rest of the Board thus accomplishing the work of the Board.

Specially referring to the HNPSP meeting held in Dhaka in January, Dr. Uauy commended the Centre not only for its science but also on its application whereby the science produced at the Centre will also be applied to the rest of Bangladesh.

Referring to the Gender Policy and the efforts made by Prof. Carol Vlassoff for aggressively pursuing this objective, Dr Uauy said the Gender Policy is not just a document produced by the Centre, but a document that will be put into practice.

Finally, referring to the very appropriate cartoon in the Annual Report on the Strategic Plan he said, the Board and the Development Partners are committed and interested to see ICDDR,B in the center stage of global public health efforts.

Dr. Uauy invited Dr. David Sack to present his report to the Board.

1. Dr. David Sack provided an overview of his presentation which included a review of major events and changes during the year; highlights on major future trends and/or changes, especially with regard to relations with MOHFW and NGO partners; review of progress on the Strategic Plan and a review of developments for Master Plan. The presentation also included a list of activities conducted to celebrate 25 years of the Centre as n international center, transitions of staff, new Management Information System (Suchona), HR update, an overview of finance (good/bad news), expected accomplishments during the coming decade, new programmes to be added to the Strategic Plan, division updates (new international initiatives, new initiatives, major initiatives), ongoing education and sharing, and provided the goals for the HNPSP workshop held in January which was attended by senior planners of the GoB along with national institutes and WHO. He said the Development Partners (DP) currently fund development research on a bilateral basis and that there may be support from the DP 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

Dr Sack said that in setting research priorities for HNPSP, these need to be guided by MDG's, national goals and targets, opportunities based on available resources and that priority setting needs to involve many stakeholders. He explained that the conclusions from the January meeting could be made real with funding from DRGA and

additional collaborations with the Ministry.

Dr. Sack reported on his participation at the Gates Award for Global Health Ceremony in Washington won this year by BRAC He said Bangladesh should be proud that this award has come back twice in four years to Dhaka. He reported on the status of the new ICDDR,B collaboration with the BRAC School of Public Health (James P Grant School) whereby faculty will be shared, joint courses will be held, and sharing of library resources and facilities. Plans are being developed to host the School in a newly constructed ICDDR,B building and to jointly raise construction funds to complete the master plan.

In conclusion Dr. Sack reported that the anniversary year was productive and demanding; Suchona will provide benefits for years to come, the Centre is financially stable with several key donors. Relations with the Government pf Bangladesh has improved and partnership with Development Partners has increased.

He thanked the Centre scientists and support staff, the Ministry of Health, ERD and the National Institutions, the GoB as a key "development partner" and the external development partners who make it all possible.

Dr. Uauy thanked Dr. Sack for an impressive account of the Centre's activities.

Dr. Uauy introduced Prof. Marcel Tanner as Chair of the Programme Committee replacing Prof. Carol Vlassoff, and invited him to Chair the proceedings of this meeting.

New Findings and Directions in Cholera - Dr. G B Nair.

Dr. G.B. Nair presented the urban and rural scenario of Cholera. He said some research is being influenced by the riverine conditions and that future studies are directed to predict and prevent Cholera. Dr. Nair reported on the leading causes of diarrhoea at the ICDDR,B Dhaka Hospital in 1999 presenting a fortnightly surveillance in 4 widely separated geographic locales. Showing the burden of Cholera in Bangladesh he said WHO Yearly Global Cholera statistics are gross underestimates since many countries either do not report or under-report Cholera. He presented new insights into the epidemiology of cholera stating that following the deployment of a sari filtration procedure from September 1999 in about 133,000 individuals yielded a 48% reduction in cholera compared with the control. Future directions included environmental studies to increase understanding of the impact of the acquatic environment on the incidence of disease caused by waterborne pathogens. Dr. Nair reported on the immunological aspects of cholera and the search for better oral rehydration solutions and newer antimicrobial regimens for the treatment of cholera.

Prof. Marcel Tanner thanked Dr. Nair for the fascinating insights on what the Centre does in the area of Cholera, what it has done, and where it plans to go. He said Dr. Nair and his team were able to present a harmonic and balanced view of the work carried out at the desk, at the bench and in the field.

Dr. Shams-el-Arifeen was invited to give his presentation.

Community based interventions to Reduce Neonatal Mortality (Projahnmo) - Dr.

Shamsel-Arifeen

Dr. Shams-el-Arifeen began by presenting the infant mortality rate (neonatal/post-neonatal) for the period 1997-2001 in Bangladesh. He said most investment in ensuring safe delivery has been the supply side -limited efforts on modifying family/community behaviours; none or limited focus on the newborn-newborn care; practices remain poor even though health-care behaviours have improved; many practices are based on deeply entrenched beliefs, however, health services are now ready to meet the needs of the sick newborn.

Presenting the objectives of the study being carried out in Mirzapur and Sylhet, Dr. Shams said that the study was conducted in 3 phases: research and design of intervention; intervention implementation and evaluation; analysis, write-up, dissemination and policy advocacy. The study outcomes were also presented together with comparative selected findings from Sylhet and Mirzapur. He said the recommended behaviours were pretested, and proceeded to present the summary of results. The study also included health system strengthening, intervention delivery strategies at the household, community and health facility levels; who does what? training and orientation (topics covered), monitoring and quality assurance. Reporting on the present status of the project, Dr. Shams concluded by presenting a list of unique features of the study.

Prof. Marcel Tanner congratulated Dr. Shams for his concise and clear presentation, and for what and how he and his team do the work presented.

Dr. Kim Streatfield was invited to make his presentation.

Plateauing of the Bangladesh Fertility Decline - Dr. Peter Kim Streatfield

Dr. Kim Streatfield began by presenting the trends in fertility in Bangladesh for the period 1980-2000 providing information collected from various sources, and population projections for Bangladesh 1990-2150. TFR halves to 0.5 for 2 years 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. Presenting the trends in family planning use between marriage and subsequent births, he said there is very little or no family planning between marriage and first birth. He said exposure, deliberate marital fertility control and natural marital fertility control, are factors which determine fertility levels. Presenting Matlab data he said girls are still marrying at the age of 16. Fertility rate is flat and contraceptive use is rising, and this is probably due to abortions. Concluding this section he said, the halving of fertility (TFR) during the 1980s and 1990s, and plateau since then is genuine; there has been a "tempo effect" due to rising age at childbearing; the "tempo effect" is now mostly out of the system which is due to shit in low parity births, which do not show rising age at childbearing and the paradox of flat TFR but rising CPR is probably due to the declining MR/abortion.

He said it is predicted that though population growth will be ten-fold in two centuries we are still halfway- future growth (1996-2051) is estimated to be 107 million. Unwanted birth rate is rather low. However, misuse of pills, discontinuation rates, are rather high. Presenting interventions to reduce unwanted births Dr. Streatfield said

that we must continue to focus on the quality of family planning. Listing factors that drive high desired family size, he said parents want only 2½ kids, however, it has been 3 or more than 3. Most families have 1 son surviving to adulthood - but this has changed - 2½ kids now survive to adulthood. With regard to gender preference he said parents prefer two sons and 1 daughter, however, preference is now declining. Also, the numbers of girls going to school are increasing. Dr. Streatfield said that the population growth (107 million) will have 3 components: unwanted fertility, which requires effective family planning; high desired family size, which requires change in '(economic) value of children', gender preference, improved child survival; and population momentum - the need to minimize impact of 'young' age structure by raising average age of childbearing through delaying marriage and first births and a strong family planning program.

Prof. Marcel Tanner thanked Dr. Streatfield for providing very important insights into this critical issue for Bangladesh and globally, and commended him for the impressive work in this area.

Prof. Tanner thanked all the presenters for their impressive presentations varying from laboratories to applications in public health. He said that though the Board is interested in these issues, not much time is given to these discussions. The Board will seriously rethink the planning of the EC and Full Board meetings to give full weight not only to management issues but also the science. He said the Programme Committee would pay more attention to the programmatic issues at the November Board meeting.

[This has been included for discussion in the Retreat.]

Prof. Tanner thanked the Centre, on his behalf and that of the Board, for maintaining high standards and excellence in its scientific activities.

The Board reconvened in the Seminar Room for the meeting with the Development Partners Group.

June 11, 2004 - 5.15 pm

Following the meeting of the Finance Committee the Executive Committee and the Centre Directorate met for discussions with regard to the CSD Response to the External Review.

Dr. M A Salam, Director, Clinical Sciences Division presented his response to the Review. Before moving to the "Bullet Points" he said the process by which the response has been reached has not been reflected in the response. Summarizing his response he said not enough funding opportunities are available, however scientists continue to explore funds in the traditional areas as well as studies in newer fields. With regard to dividing time between service and research, Dr. Salam said that despite recognition of inefficiencies in the 50:50 system more time will be required to change this system to an efficient one. The clinical services have been divided into three areas: short stay ward; longer stay ward and the special care unit.

In response to what assistance the Board can provide, Dr. Salam mentioned that the Board could assist with forming teams - as changes are made these need to be

discussed within the Centre. The Board can also help in the recruitment of international scientists (ALRI research).

The EC felt that the Division has not made much progress and that the actions implied should go much beyond the division, and that this has not happened. It is important to recognize that the Centre should take a closer look at the recommendations and develop a plan to reflect the changes.

Dr. Salam agreed that most of the time has been invested in the structure of the Division. It was also reported that physical facilities have changed which will help to change attitudes.

The Board felt that the Division needs to be more explicit and needs the CD to assist with the thought process. These discussions should be held at the CD level and not at the Board meeting. The recommendations should be reflected in a plan and a budget for the activities which could be presented to a donor. Endowment Funds should not be used to fill "gaps".

The Board felt that more commitment is required on steps to be taken in collaboration with the CD on what can be accomplished before the November Board meeting.

It was agreed that in within the next few weeks, Dr. Salam/Centre Directorate provide the Board with a short document prioritizing the task list.

[This will be discussed as a separate agenda item in the November meeting.]

The meeting concluded at 6.15 pm.

BOARD RESOLUTIONS
June 2004
Programme Committee

Res/1/BT/June 04

The Board welcomed the Director's report and the three scientific presentations that provided an excellent insight into the most recent achievements at all levels in relation to the Strategic Plan and MDGs. The presentations also flagged the key issues of vital importance for the Centre.

Res/2/BT/June 04

The Board congratulates the Centre for the fine achievements that are of great national and international importance at the scientific, strategic level.

Res/3/BT/June 04

The Board welcomed the Centre's efforts to develop new programmes such as "HIV/AIDS', Health & Poverty: and "Safe Water" to become part of the Strategic Plan. Detailed discussions will be held at the November Board meeting.

Res/4/BT /June 04

The Board was most satisfied to see that the Gender-Policy is published and being implemented by the Centre and requests the Gender Equality Committee to report developments based on the ongoing gender review at the November Board meeting.

Res/5/BT/June 04

The Board reviewed how the recommendations of the November 03 review of the CSD were considered and implemented (Resolution 10/BT/Nov 03) and noted that although some actions have been taken towards implementation, progress has been slow and insufficient to address the major challenges faced by the Hospital and CSD. It was recommended that the Centre's Directorate pay full attention to the pursuit of the implementation of the recommendation and assist the CSD as much as possible, and asks the Directorate to establish a prioritized task list by the November Board meeting.

Follow-up of Programme Committee Minutes of June 2004:

Resolution 6/BT/Nov 03 to be discussed in detail in the Finance Committee meeting.

"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."

*(**10/BT/Jun 03**: That the Centre Directorate make further progress in defining the core (essential) support required by the Centre to fulfill its mission in accordance with the Strategic Plan and report their analysis to the November 2003 BoT meeting.*

11/BT/Jun 03: The BoT analysed the pattern of distribution of unrestricted funds and noted that it will be important to monitor at future meetings the inter- and intra-divisional distribution of these funds and the rationale used.)

[Resolution 6: to be discussed in detail in the Finance Committee meeting.]

Response to Board Resolutions
June 2004
Programme Committee

Res/1/BT/June 04

The Board welcomed the Director's report and the three scientific presentations that provided an excellent insight into the most recent achievements at all levels in relation to the Strategic Plan and MDGs. The presentations also flagged the key issues of vital importance for the Centre.

Res/2/BT/June 04

The Board congratulates the Centre for the fine achievements that are of great national and international importance at the scientific, strategic level.

Res/3/BT/June 04

The Board welcomed the Centre's efforts to develop new programmes such as "HIV/AIDS", "Poverty & Health" and "Safe Water" to become part of the Strategic Plan.

A criteria for "inclusion of new programmes" will be provided by the Centre for discussions at the November Board meeting.

Response: Criteria attached for Board review.

Res/4/BT /June 04

The Board was most satisfied to see that the Gender-Policy is published and being implemented by the Centre and requests the Gender Equality Committee to report developments based on the ongoing gender review at the November Board meeting.

Response: HR Report.

Res/5/BT/June 04

The Board reviewed how the recommendations of the November 03 review of the CSD were considered and implemented (Resolution 10/BT/Nov 03) and noted that although some actions have been taken towards implementation, progress has been slow and insufficient to address the major challenges faced by the Hospital and CSD. It was recommended that the Centre's Directorate pay full attention to the pursuit of the implementation of the recommendation and assist the CSD as much as possible, and asks the Directorate to establish a prioritized task list by the November Board meeting.

Response: To be discussed as a separate agenda item.

Response to Res/3/BT/June 04
"Criteria for Programmes"

Background.

The BoT requested the Centre to provide criteria for inclusion of new programmes in the Centre. This was following the discussion on the previous decision to add "HIV-AIDS" and "Poverty and Health" to the Strategic Plan and the plan to develop a ninth programme called "Safe Water."

The Centre has already initiated the two programmes with Drs. Tasnim Azim and Abbas Bhyuia as the heads of the programmes respectively. Following the arrival of Dr Steve Luby, the Centre expects to formalize the Safe Water Programme. The growth from the original six programmes to nine raises the concern that perhaps the Centre is expanding into new areas too rapidly. For clarification, there is no consideration being given to initiating any new programmes other than those already defined, at least during the next several years.

While there has been considerable discussion about the roles of the programmes, in relation to the Divisions in the past, this topic continues to be discussed within the Centre and actions are being taken to infuse some additional life into the programmes with bi-monthly meetings of the programmes. In recent discussions with the CD, these were some of the issues that were discussed concerning the programmes.

Criteria.

A programme should, in general meet certain requirements to be considered as a programme in the Centre.

1. It should be consistent with the Vision and Mission of the Centre.
2. It should be consistent with the spirit of the Strategic Plan.
3. It should have logical activities that would include all (or nearly all of) the Divisions.
4. It should be marketable; e.g. attractive to donors.
5. It should have some existing financial base of support.

A programme would not be considered if...

1. The issue was important to only one Division.
2. There was no financial base of support
3. There was little chance of donor interest.

The discussion further led to the possibility that a programme might be closed or merged. This might occur under the following circumstances.

1. A formal review of the programme concluded that the criteria for the programme were no longer being met.
2. There was a lack of financial support for the programme.
3. There was a lack of technical expertise within the Centre to maintain relevant activities.
4. There was a lack of relevance of the programme to the overall mission of the Centre.

Programmes vs Divisions.

In terms of the roles of the Directors of the Divisions vs the Heads of the Programmes, the Division Directors have line authority and supervise the work of their Division. By contrast the Programme Heads have a coordinating and information sharing role, but do not have direct line authority. The Programme Heads should know the different activities that are ongoing or are being planned, and should be a spokesperson for their programme areas, Hopefully they should match expertise in the different Divisions to help put protocols into context. They should see and interpret the "big picture" of their subject area to scientists within the Centre as well as to stakeholders outside the Centre. Understanding this perspective should assist the development of future protocols. The understanding of this larger perspective should result in summary reports, such as annual reports and fact sheets related to their programme.

Being the spokesperson for the Centre for the programme area, the Programme Head has an important role in communicating and coordinating work with other institutions in Bangladesh. This might be in representing the Centre at meetings with the Government of Bangladesh, other national institutions, NGO'S, and donors. For projects that would be jointly carried out between the Centre's scientists and other institutions, the Programme Head may facilitate this collaboration; however, the projects would be carried out by the relevant Division.

Since the Programme Heads do not have direct line authority, they do not have a group of staff that reports to him/her. They have only a minimal budget to carry out coordinating functions, but do not have core funds for projects or foreign travel.

Avoiding Potential Conflicts between Programmes and Divisions

The Programme Heads may sometimes feel that they have considerable responsibility but little authority, and this is true to a large measure. Since the Programme Head is supposed to know about projects within his/her area, the Head may feel discouraged if a project is initiated without his/her knowledge or input. It is expected that the investigators will coordinate the protocols with the relevant Programme Head(s) and with other members of the Programme, but this is not a requirement. Thus, approval from the Programme Head is not required. The Centre's management is attempting to identify mechanisms to facilitate the communication between and within Programmes to simplify coordination. This may be accomplished, for example, by the development of electronic concept papers sent to relevant Programme Heads, as well as frequent meetings of the programmes.

Response to EC Teleconference – 12 June 2004, 4.00 pm

Present:
Dhaka
Prof. Ricardo Uauy, Chair, BoT
Dr. David A Sack,
Mr. AFM Sarwar Kamal, Chair, National Liaison Commmittee
Prof. Azad Khan, Chair, Finance Committee
Dr. Claudio Lanata, Chair, HR
Dr. Marcel Tanner, Chair, Programme Committee
By telephone
Prof. N.K. Ganguly, India
Dr. Kul Gautam, New York,
Prof. Terence H. Hull, Australia
Dr. N. Ishikawa, Japan
Prof. Jane Anita Kusin, The Netherlands
Prof. Carol Vlassoff, Washington DC
Dr. I. Kaye Wachsmuth, Rehoboth, Detroit, USA
Dr. Halima Abdullah Mwenesi, South Africa
Regrets
Dr. Tikki Pang (Travelling), Geneva
Dr. Maimunah Bte Hamid (resigned from the Board)

1. Nomination of Trustees
The Board considered the nominations as presented.

Response: Dr.Peter Tugwell was selected and has accepted. He has however regretted his inability to participate in this meeting.

Dr. Sack briefly highlighted his presentation to the Board.

Gender Policy:
The Board congratulated the Centre for the Gender Policy and the Publication. It was reported that a full-time "Gender Specialist" was recently recruited.

- The suggestion to include "that an update of activities be presented at the November" in the relevant resolution was accepted. The report will be based on the ongoing gender review.
- It was also suggested that HR take up interventions to balance the gender balance and take up the major issues that affect women.

RESPONSE: MS. Walton to respond under HR agenda.

Finance:

Dr. Sack reported that the finances are looking good in general.

- With regard to a query on lack of funding for major programmes/protocols, it was reported that with "Suchona" such information will be easily available by Division, Donors, Strategic Plan etc.

RESPONSE: Mr Neogi to respond under Finance agenda.

- It was clarified that all scientists have access to the system (every scientist is assigned a role; every PI has access to information on their protocols; division directors have access to all information relevant to their divisions and the ED has access to all information).

- Whether staff were permitted to approach donors for funds, it was clarified that individuals are encouraged to negotiate for funds but not agreements.

National Collaboration:
A report on the HNPSP workshop held in January was provided. It is hoped that the Centre will have access to a fairly large amount of funds released by the Government (Japanese Debt Relief) to enable the Centre and the GoB to be able to achieve the recommendations resulting from this workshop.

Response: Update provided in Executive Director's Report to the Board.

James Grant School of Public Health
Dr. Sack attended the award ceremony of the Global Health Foundation – the US$ 1 million awarded to BRAC will be utilized for the new JGSPH.
BRAC and ICDDR,B will jointly explore possibilities for further funding for the University (the Centre will not exclude relationships with other NGOs). Dr. Demissie Habte has been appointed to be the First Dean and Dr. Sadia Chowdhury as the permanent Dean.
The Board congratulated the Centre for this initiative.
Additional information: Dr Habte will be involved but Dr. Mostaque Choudhury, who has recently returned from Columbia University, will be the Dean. Further Update will be provided in the Executive Director's Report to the Board.

Draft Resolutions:
Following the email from Prof. Terry Hull, Dr. Uauy clarified that for reasons of governance there is a need for these resolutions (usually house-keeping business) to be passed by the entire Board, and hence this conference call. Issues that required discussion by the Full Board will again be presented at the November meeting. However, if the Board feels that the resolutions are decisions of the EC and cannot be inferred as the decisions of the full Board, the resolutions will be kept "on hold", but if there is a basic view which is shared by the entire Board, the resolutions should be agreed upon.

Response: Noted.

Governance issues will be re-opened at the November meeting at which time the Board can reach final decisions on these issues.

1. **The Retreat** is now in the planning stages. Prof. Terence Hull's email (attached) re the Retreat was noted. It was clarified that the nature of the EC and its functions will be fine tuned at the Retreat.

The EC also reported that lengthy discussions were held at this meeting. Ms. Vanessa Brooks will be in charge of formulating the logistics. Sites were explored –. Options included Kathmandu, Matlab, on a boat, BRAC Guest House in Rajendrapur, Kolkata and security and visa issues were considered - the final word will be with Dr. Sack. There are benefits of having it outside Dhaka so that Bangladeshi Trustees can fully participate and are not disturbed. Matlab was considered as a good choice due to its role in the Centre's activities and that the Malab staff would be pleased to have the Board there for this Retreat. A boat trip to Matlab was also an option.

- The Board was also informed that the item "Evaluation of the Board" as also added to the agenda for discussion.
- A survey of expectations of staff of the Board will be carried out;
- Where does the Board want to be by 2010 (this should reflect the past).
- The Centre Director and the Scientific Council will complete a form on how they see the work of the Board.
- The role of the EC will also be discussed in detail and,
- What happens between Board meetings are issues for the Board Retreat including fund-raising, conflict of interest, etc.

The EC went through a rating by relative importance (page 13 & 14 of the Consultant's report) – in addition to the "Parking Lot" issues, the EC felt there should be "launching pad" session for new ideas.

Ms. Brooks will be circulating her document to the Board by 31 July 2004.
Response: Retreat discussion (Ms. Brooks).

The Board raised concern about aggregate interests and external governance (quality control aspects). It was noted that it is the Board's responsibility to ensure that mechanisms for this are in place. Dr. Sack referred to document following a rigorous review document conducted by an NIH auditor(to be circulated to the Board).

Response: Summarized NIH Review Report sent to the Board and attached.
If the Board wished to express their views, these could be sent to Dr. Sack.

2. Addition of new Programmes:
– what criteria is used ?

- What is the Centre's capability to absorb new programmes/research (SP)? This will be discussed in detail in November at which time the Centre will provide the criteria. An amendment was requested to Res. 4. (*done*)

Response: Criteria to be discussed in the meeting of the Programme Committee, and a brief document is provided for this committee.

CSD Response to Review: It was queried that when the preliminary results were presented at the November meeting a question was raised regarding the cost of implementing recommendations. It was clarified that following detailed discussions at the Board meeting, the resolution passed at the November BoT meeting was re-enforced (Res 5/BT/June 04).

Response: To be discussed as a separate agenda item.

Director, PHSD: The Board congratulated the Centre for being able to recruit Dr. M Koblinsky.

Deputy Executive Director: It was noted that 20 applications were received. However, the Centre will continue its search. It was suggested that the tasks of the DED will be shared by the Division Directors until the position is filled.

Resolution 9 & 10: The Board will be discussing the 6-year rule at the November meeting which have relevance to these two resolutions.

Suchona: The system is still in the process of being implemented/learning curve. In the long run it will allow the Centre to increase its data management, but will not require an increase in staff.

The Board agreed that the resolutions 20 & 21 were reformulated to specify when the transfer was authorized.

Res 22: The Board agreed that it remain as it is being a "bank requirement".

Res 27: The Board's suggestion to include the Deputy Executive Director (and in his absence one Division director) was accepted.

Res 30: The EC met with the SWA and noted their requests which will be further discussed at the November meeting and financial requests will be examined.

Response: Discussed and presented to the BoT for discussion with the SWA.

Res 31: Drs. Ganguly and Kaye Wachsmuth agreed to their nomination on the Finance and Fund Development Committees.

Res 34: Prof. Terence Hull agreed to as the Chair of the Review Committee for the ISD Review and provide advise regarding other members who should be invited to participate. It was suggested that Dr. Kul Gautam contact Dr. Nora Godwin to be a member of the review committee.

Response: Three individuals have been contacted and have forwarded their CV's to the Centre. Each (including Nora Godwin) appears to have excellent qualifications that will be useful for the review. We still need to identify persons from Bangladesh to serve on the review committee. This will be discussed under the agenda: ISD Review.

Res 35: The Board noted Dr. Maimunah's resignation and agreed that the Board fill the position as soon as possible with a person from the developing country. The EC also reviewed pending applications and will look at the gender balance issue.

Response: Persons from developing countries are being sought for the BoT; however, it is felt that the recruitment and selection may follow the retreat since the discussions there may influence the type of persons being selected.

It was agreed that an exit interview of "leaving" Board members should be conducted. Prof. Carol Vlassoff thanked the Board and the Centre for having had the privilege to serve on the Board and pledged to continue to support the Centre.

The Board also recorded its thanks to Prof. Vlassoff for her excellent support and contribution to the Centre as a member of the Board and for her efforts in pursuing the Gender Policy issue and also thanked her for pledging her support in the future.

Dr. Uauy thanked all the members for participating the call and for their important input to the deliberations of the EC.

The conference call concluded at 6.00 pm.

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

Executive Director's Report

Prepared for the

BOARD OF TRUSTEES MEETING
27-29 Nov 2004

Executive Director's Report
for the
November 2004 Meeting of the ICDDRB Board of Trustees

Headlines During The Last Six Months

Impact of Flood of July - August – September 2004

In July 2004, a devastating flood affected many parts of Bangladesh, including the city of Dhaka and its surrounding areas. This was followed by outbreaks of diarrhoeal diseases in and around the affected areas as well as food shortages for many families. The flood has had a direct impact on the staff of the Centre, the patients who use our services, and our research during the last few months. Because of the flooded homes, the SWA requested some special assistance for the staff and we agreed to provide a cash benefit to the GS1 and GS2 staff and provision for loans for higher level staff who were directly affected by the flood. Additionally, the staff offered to contribute one day's salary to assist with the flood relief efforts. Half of this was donated to the Prime Minister's Flood Relief fund and the other half was used for the Centre's own flood relief efforts.

The floods also brought many patients to the Centre, at times exceeding 700 patients in a day. This required the addition of two extensions to our treatment centre to care for the rush of patients, many of whom were severely dehydrated. We estimate that the Centre's treatment saved the lives of about 5 to 10,000 people during this three month period. They would have died without the care given at the hospital. We generally believe that the cholera season follows floods, but in the case of very severe flooding, the cholera epidemic came during the flood.

There is no question that the floods interrupted some of our research; however, in a crisis like this one, our first responsibility was to the "neighbors" with whom we work. For example, in Kamalapur, the field staff that normally would be collecting data, instead were distributing food to those most in need in this slum neighborhood of 200,000.

Fortunately the Centre had many partners willing to help financially with this crisis including UNDP, WFP, OFDA/USAID Dhaka, Japanese Embassy in Dhaka, and a number of private companies like GrameenPhone, Duncan, Lever Brothers, American Express Bank, Caledonian Society, TMC Japan, Global GHCL, and many other well-wishers who combined to pledge US$760,000 to ICDDR,B's efforts to help the flood victims. We also want to thank the Health Minister for visiting the Hospital during the peak of the epidemic and the media for highlighting the good work of the Centre. Most importantly, the hospital staff deserve much credit for the excellent and dedicated work in this time.

Overview Of The Board Meeting

A schedule for the meeting is enclosed with the materials in the packet. To summarize the general schedule: the retreat will occur from Thursday, Nov 25 until evening Nov 26 in the BRAC Centre, Rajendrapur. This is located about an hour outside Dhaka in a very pleasant rural setting, and we will travel there on Wednesday evening. For those who are arriving prior to the trip to Rajendrapur, you will be able to rest in the guest house or meet staff at the Centre.

The Board meeting starts on Saturday, November 27. On the 29th, Dr Ishikawa has agreed to give a guest lecture (entitle DOTS Expansion and Operational Research) to the staff and other interested people in Dhaka. 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.

As with the last board meeting, the first day (Saturday) 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 and the Division reports. This morning meeting is open to staff and Development Partners.

Saturday afternoon will be devoted to a discussion of the response the CSD review along with meetings of the two new committees (National Liaison and Fund Development Committee).

On Sunday, the Finance Committee and the HR Committee will meet, along with meetings with the Staff Welfare Association, and finally the meeting of the Full Board. Hopefully we can conclude our business by the end of the afternoon in order to have a meeting with the Development Partners Group (DPG) and enjoy a reception with the DPG and others on the Rooftop.

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 these can be reviewed. The Centre's staff have prepared a written response to each of the resolutions. Further clarifications can be discussed at the meeting.

Administrative updates

New Staff Arriving and Others Departing.

The Centre is happy to have a full complement of Division Directors with the arrival of **Dr. Marge Koblinsky** who is the new Director of the PHSD starting in September. She worked at the ICDDRB in the 1980's and has considerable experience in the public health, especially related to reproductive health. Her brief biodata is attached.

After the departure of Dr. Rob Breiman in June, **Dr Steve Luby** joined the Centre in August. Coming from CDC, Dr. Luby is an infectious disease epidemiologist and one of his key interests is in safe water and improving personal hygiene in developing countries. Having worked in Pakistan for five years, he is a very experienced scientist in this part of the world. His brief biodata is also attached.

Ms. Nancy Hugart has joined the Centre to coordinate the Child Health Nutrition Research Initiative (CHNRI) which is now based at the Centre. Ms Hugart was formerly on the faculty of the Department of Population and Family Health at the Johns Hopkins Bloomberg School of Public Health.
Colonel Tajul Islam Ghani, Senior Manager Support Services left the Centre for higher studies in the UK in September. The units in this department are now reporting to either HR or Finance.

Julia Ackley, senior associate in the ERID office left the Centre in June to return to the US with her husband. Recently we learned of the birth of their son who was born on 9 August. The Centre will be seeking her replacement.

Mr. S.K Deb, Senior Manager of HR left the Centre in August and we will seeking his 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 and has been functioning since then. Many of us are still learning how to use many of its features. HR and Finance have become experts and we now are relying on this new system completely. The scientists are still learning what information can be found

Finance

The number of transactions continues to grow as the budget increases. The number of staff has remained the same over the years, though the Department has been reorganized and the physical facilities have been updated last year.

Suchona for Finance Department

This new system has meant a complete change in the procedures for the Finance Department. Through the process of developing Suchona, the Finance staff has had to examine all their procedures and incorporate the needed changes into the new computerized system. Thus, Suchona is much more than a new computer program; it is a new management tool in which the staff actively participated in defining the procedures that have now been computerized and they are implementing. While the Suchona is working well, I expect that the real benefits will mainly be realized during the next three of four years as the entire Centre is able to fully utilize the information available. Suchona is able to present data in a manner that will be very useful in analyzing financial data and using this for better management in the future.

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 a research 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.

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. As we prepare the board papers, we are still projecting a deficit for the year; however, we are assured that the DRGA funds from the Government of Bangladesh, with concurrence from the Government of Japan will be available. By the time of the meeting, we anticipate that these funds will greatly improve our financial situation. Perhaps as important, they also will initiate a new era of cooperation between the Centre and the Ministry of Health

and Family Welfare. Although we have always worked together with the MOHFW in a cooperative spirit, these funds will provide the "fuel for the engine."

In terms of core funding, as reported at the last meeting, the Centre continues to receive core grants from the Government of Bangladesh, The Netherlands, Switzerland, Canada, UK, Sweden and along with others. Unfortunately, USAID is no longer a core donor but USAID/Dhaka is still the largest single donor through project funds. USAID/Washington has always been a major donor for the Centre, but this year, for the first time in the history of the Centre, there were no funds from this source because of a change in their policies and procedures.

HR Update

HR Activities

During the last six months, the HR Department has recruited 284 persons, processed 727 contract extensions, and 895 daily wagers. Thus the department is extremely busy keeping the Centre functioning. During this year, the Department has completed the transition on Suchona and all requisitions and approvals are now occurring online. The number of staff on the payroll has now crossed 2000, with the increase being (nearly) all in project staff.

Gender Policy

The Gender Policy continues to be a priority and a Gender Organizational Review has conducted a gender review to identify areas where the Centre needs to improve its policies, attitudes and performance. The report of this review will be presented at the meeting. The Gender Equality Committee worked with the Gender Specialist to developed an annual work plan to support implementation of the Gender Policy, and will be presented during the HR meeting

Search for Deputy Executive Director

The search has been ongoing for the Deputy Executive Director and there will be an update at the meeting.

External Relations and Institutional Development

Resource Mobilization Strategy

The current annual revenue of the Centre is about US$17 million – an increase from about $12 million just a few years ago. Our Strategic Plan projected that the Centre's budget will need to increase by about $1 to $2 million annually until it reaches $20 million in 2010 to meet the programme priorities and institutional development detailed in the Plan,. To achieve this, a Resource Mobilization Strategy has been developed and is currently implemented by the ER&ID Office in close collaboration with the Centre Director and the Centre Directorate. The broad objective of the Resource Mobilization Strategy is to diversify the Centre's resources so it can become more financially stable and less dependent on a few major donors. While the increase in total budget is needed, there is a need to balance the needs of the specific projects with the sometimes unpredictable intentions of the donors who have competing interests for their resources. By having a more diversified group of donors, some of the "risks" can be minimized. We are fortunate that several government donor agencies have increased or continued their support including the aid agencies of the Netherlands,

Canada, Switzerland, the UK, Bangladesh and Sweden. The expected contribution of the DRGA funds from the Government of Bangladesh will make a huge difference to the prospective sustainability of the Centre.

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. (Special meetings can be called, but none of these have been held in the last year.) 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. Dr Neil Squires recently chaired DPG meeting in June 2004. Dr Squires has since left Bangladesh on expiry of his tenure of services at DFID and has joined the EC in Brussels. The Centre arranged a farewell for three DPG members, who have recently left the country upon completion of their tenure in Bangladesh. They were Dr Neil Squires, DFID; Dr Kayode Oyegbite, Unicef; Mr Hans Rhein, EU.

Communication

The Office responded to press enquiries and publicized the Centre's achievements in scientific forums. During the reporting period, the ER&ID Office arranged press releases for dissemination of breaking news, organized media coverage, and drafted scripts for special radio and TV programme. This was especially important during the recent flood when the work of Centre was highlighted in the press and this coverage also provided reassurance that the flood affected victims of Dhaka were being helped. The visit of the Honorable Health Minister to the Centre during the floods was featured in the press.

Visits from dignitaries

The ER&ID Office arranges for the visits of many dignitaries who appreciate the visit to the ICDDRB. Recent visitors have included the following: They are: Hon'ble Health Minister of GoB Dr Khandker Mosharraf Hossain; Hon'ble Minister for LGRDC of GoB Mr Abdul Mannan Bhuiya; Hon'ble Health Minister of the Kingdom of Saudi Arabia Dr Hamad Bin Abdullah Al-Manea; Hon'ble Deputy Minister for Executive Affairs of the Kingdom of Saudi Arabia Dr Mansour Bin Nasser Al-Hawasi; WFP Country Head Mr Douglas Coutts; HE Mr David Sproule, new Canadian High Commissioner to Bangladesh; HE Mr Matsushiro Horiguchi, Japanese Ambassador to Bangladesh; HE Mr Abdullah Bin Mohammed Al-Obaid Al-Namlah, Saudi Arabia's Ambassador to Bangladesh; Mr AFM Sarwar Kamal, Secretary, MOHFW; Mr Jacques Martin, Deputy Head of UN Development Division and Senior Advisor of Health & Population at SDC, Berne; EU Audit Team led by Mr Baastian Deconinck; Drs Regina Rabinovich, Tom Brewer and Jan Agosti from the Bill & Melinda Gates Foundation; Program Manager Ms Janik Bouchard from Cida, Ottawa; Mr Bill Berger, Regional OFDA Adviser; Mr Markus Waldvogel, Country Director of SDC, Dhaka; Mr Muary Miloff, First Secretary, Cida, Dhaka; Dr Iyorumun Uhaa, Head of Health & Nutrition at Unicef, Dhaka; and many others.

Grants & Contracts Update

Grant and Contract Activities

Between May and October the Centre entered into 22 agreements with foreign universities and research institutes, and an additional 15 agreements with local NGOs largely providing

service components to research initiatives, and two agreements with UN agencies. The Centre has also entered into confidentiality agreements and material transfer agreements with pharmaceutical and research companies in its conduct of vaccine related research. Additionally the Centre has undertaken the role of Secretariat of the Child Health and Nutrition Research Initiative (CHNRI) and negotiated guidelines for the Centre's role, including responsibilities and liabilities as the Secretariat. With local institutions, the Centre primarily drafts the agreements including some cases, where local NGOs are the prime institution and the Centre is the subcontracting party.

Issues Regarding Standard Provisions in the Grants.

The Grants & Contracts Administrator (GCA) negotiates these agreements on behalf of the Centre, but the Executive Director signs the final contract as the only authorized signatory. Although many of the contracts are "standard," often the draft contracts require considerable negotiation to insure a) proper data ownership, b) freedom to publish, and c) indemnification. Most of these issues have now been standardized within the Centre's language; however, new partners generally require additional negotiations. The US Government continues to add new provisions to their contracts related to abortion, terrorism and trafficking.

NIH Review.

An edited version of a recent NIAID/NIH Foreign Organization System (FOS) Review is included in your folders. This review required the Centre to meet international administrative standards for managing an NIAID/NIH subcontract. This review involved an intensive review of administrative, financial, ethical of the Centre's policies and procedures. Each of the units in the Director's Division actively participated in providing documentation for this review. An edited version of the report is included in the board materials because I felt that this information critical to Board functions of insuring that the Centre does meet these standards. In response to the auditor's evaluation, the GCA and ER&ID Office in autumn 2004 will improve some of their administrative procedures to eliminate redundancies in the review process and clarify the distinctive roles undertaken by both offices.

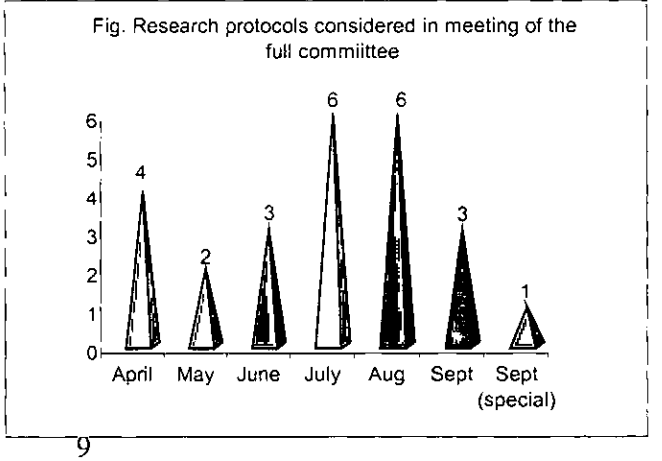
Conflict of Interest

Some key documents prepared by GCA in preparation for the BoT retreat and BoT meeting include a draft Conflict of Interests policy for the Board and the Centre staff. The review from the NIH found that the Centre has an implied Conflict of Interest policy, but this needs to made explicit.

Mandatory Committees

Research Review Committee

The Research Review Committee (RRC) met monthly during the last seven, reviewing and approving 25 research protocols (Fig.) and 12 proposals for addendum to/modifications to the protocols after the protocols were revised by the investigators. The RRC also reviewed and approved 18 requests for time



extension of ongoing research proposals and reviewed 8 completion reports. The formal full-committee review of two research protocols was waived.
Prof. Kamaluddin Ahmed, a long-time external member of the Committee, died on July 4, 2004 after his long association with the Committee, in particular, and the Centre in general.

Ethical Review Committee

The Ethical Review Committee (ERC) met 6 times during the period and considered 30 research protocols. Of them, 21 were approved after satisfactorily addressing of the issues raised by the Committee, and the PIs of 9 research protocols are yet to resubmit the modified version of the research protocols incorporating the observations of the Committee. In addition, 13 proposals for addendum to/modification of already-approved protocols were considered.

Animal Experimentation Ethics Committee

The Animal Experimentation Ethics Committee (AEEC) met once during the reporting period. In the lone meeting, the Committee reviewed the revised version of the AEEC Guidelines, the AEEC Application Form, and the Annual/Completion Report Form, In this meeting, the Committee was provided with updates on the ongoing research protocols involving animals. The Committee reviewed the reports and found that the research protocols were being implemented as per the approved protocols.

Support Services Department

Travel & Estate Unit

The Travel & Estate Unit coordinated the hospitality arrangements for 396 individuals, maintained the Guest House facilities, and provided limited catering services to the Center as well as assisting with many details of living in Dhaka for foreign staff.

Civil Engineering Unit

The Unit routinely maintains the physical facilities. Some recent major renovations include renovation of the Hospital Special Care Unit which is in process. In addition, plans are underway to renovate the 1st and 2nd floor of the HSID area.

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. It has been upgrading the existing electrical work in the main building and has completed upgrading in the LSD. It maintains the standby generator and is preparing for the installation of a new larger generator.

Transportation Unit

The Unit coordinates the transport operations at the using the Centre's vehicles and those hired from contractors. It provides pick-up and drop services for approximately 350 personnel every day. The vehicle maintenance workshop provides minor and major repair facilities for all the vehicles. The unit has undertaken a major task of reconditioning and refurbishing 3 ambulances and 10 vehicles of the Transport Pool in own workshop vehicles, which were about to be back loaded to government. The cost of refurbishment and reconditioning all the 13 transports is less than the cost of importing one brand new ambulance or a Toyota Corolla sedan.

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.

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.

Major meetings hosted by the ICDDR,B since Nov 2003

10th Asian Conference on Diarrhoeal Diseases and Nutrition (10^{th} 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. Diman 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 25^{th} 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 Sadhana, 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.

Director's Travels

During the last six months, The I made one 11-day trip to Canada, the US, UK, Swizerland and Belgium to follow up on relations with donor agencies and collaborative projects with scientists. I also plan to attend the Global 8 conference in Mexico in mid November.

Staff Development Activities

1 April– 30 September 2004

Staff Development has a budget of about $50,000 from core each year to help to develop the skills of the staff working at the Centre. Most of the staff who are able to take advantage of the programme have received scholarship support from another source and the Staff Development fund is then able to cover miscellaneous costs associated with the training. Our policy is that the Staff Development fund is used to build capacity of the Centre; it is not primarily considered a benefit to the staff. Of course many staff do benefit, but it not considered an entitlement for long or good service. The following tables illustrate the activities of the Staff Development over the last period.

Number of staff returned during the period after completing training /study **9**

Degree	Male	Female	Total
Doctoral degree	3	0	3*
Masters	2	0	2
Short focused training (detailed at appendix A)	3	1	4

Number of staff who left for study/training **14**

Degree	Male	Female	Total
Doctoral degree	2	2	4**
Masters	4	1	5
Short focused training (detailed at appendix A)	3	2	5

Total number of staff abroad on study/training **34**

Degree	Male	Female	Total
Postdoctoral degree	2	0	2
Doctoral degree	9	11	20
Masters	9	1	10
Short focused training (detailed at appendix A)	1	1	2

* Three staff returned after completing the partial requirement for the PhD degree to conduct research for dissertation.

** Three left to return after completing partial requirement for PhD degree and one left to do postdoctoral/sabbatical training.

Staff Returned After Completing
Overseas Study/Training, During 1 April – 30 September 2004

Sl #	**Name, designation and working area**	Field of Study/Training and Institution
01	Dr. Sharful Islam Khan Bobby Research Fellow, Social and Behavioral Sciences Unit (SBSU), PHSD	Submitted thesis for PhD degree in Sociology/ Anthropology; yet to complete defense.
02	Mr. Firoz Ahmed Senior Research Officer Immunology Unit, LSD	Completed partial requirement only and now conducting research for dissertation for PhD degree in Immunology.
03	Dr. Anwarul Iqbal Medical Officer, Epidemic Control Prepared Unit (ECPU), PHSD	MPH from Umea University, Sweden.
04	Dr. Kazi M. Rahman Research Investigator Child Health Unit (CHU), PHSD	M. Sc. in Epidemiology from Harvard University, USA.
05	Mr. Md. Ashfaqul Alam Research Officer Immunology Lab, LSD	One year training in microbiology/ immunology from Massachusetts General Hospital and Harvard Medical School, USA
06	Mr. M Aminul Islam Sr. Research Officer Enteric Bacteriology, LSD	Returned after completed partial requirement for a PhD degree in Molecular Biology from Inspectorate for Health Protection and Veterinary Public Health, Zutphen, the Netherlands. Now conducting research for dissertation for PhD degree..
07	Dr. Kaisar Ali Talukder 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.
08	Ms. Nazma Begum Analyst Programmer CHU, PHSD	Two-week long training course on Advanced Data Management Tools and Techniques at the Capital Technology Information Services, Inc. USA
09	Mr. Md. Abdur Razzak Ali Sorker, Database Administrator/Webmaster Computer Information Services Unit, ISD	Training course on MySQL at GlobaLINK Solutions Ptd. Ltd., Singapaore.

Staff Left To Begin Overseas Study/Training,
During 1 April – 30 September 2004

Sl #	**Name, designation and working area**	Field of Study/Training and Institution
01	Mr. Ashraful Alam Neeloy Senior Research Officer, Social and Behavioural Sciences Unit (SBSU) Public Health Sciences Division (PHSD)	To complete his course requirement for Doctoral Programme in Anthropology (focused on health culture) at Australian National University (ANU), Australia
02	Ms. Jinath Sultana Jime Sr. LaboratoryTechnician, RTI/STI Lab Laboratory Sciences Division (LSD)	Training on DNA micro array techniques and bioneumeric at the Bacterial and Enteric Disease Programme, National Microbiology Laboratory, Canadian Science Centre for Human and Animal Health, Canada.
03	Dr. Md. Abdur Razzaque Associate Scientist, Health / Demographic Surveillance Unit (HDSU), PHSD	Postdoctoral fellowship/sabbatical training in Demography at Australia National University (ANU), Australia
04	Ms. Nazma Begum Analyst Programmer Child Health Unit (CHU), PHSD	To attend a two-week training course on Advanced Data Management Tools and Techniques at the Capital Technology Information Services, Inc. USA
05	Mr. Md. Abdur Razzak Ali Sorker, Database Administrator/Webmaster, Computer Information Services Unit, ISD	Training course on MySQL to be organized by GlobaLINK Solutions Ptd. Ltd., Singapaore.
06	Dr. DM Emdadul Hoque Project Research Manager CHU, PHSD	Master's Programme in Public Health at the Department of Public Health and Clinical Medicine, Epidemiology and Public Health Sciences, Umea University, Sweden.
07	Dr. Rubina Shaheen Sr. Medical Officer Reproductive Health Unit (RHU), PHSD	To fulfill partial requirement of Doctoral programme (sandwich model) in Epidemiology and Public Health at the Umea University, Sweden.
08	Dr. Muntasirur Rahman Medical Officer, Child Health Unit, PHSD	Master's programme in Epidemiology at the Harvard School of Public Health, Harvard University, USA
09	Dr. Dipak Kumar Mitra Research Investigator, Child Health Unit, PHSD	Master's programme in Public Health at the Harvard School of Public Health, Harvard University, USA
10	Mr. Md. Ilias Mahmud Senior Research Assistant Nutritional Biochemistry Lab., LSD	Master's Programme (may lead to Doctoral Programme) in Bio and Food Technology, at the University of Newfoundland, Canada.
11	Ms. Shehrin Shaila Mahmood Research Officer, SBSU, PHSD	Master's programme in Economics at the University of Waterloo, Canada.
12	Dr. Md. Anisur Rahman Senior Medical Officer Matlab Health Research Centre, PHSD	To fulfill the partial requirement for study at the doctoral programme (sandwich model) in Epidemiology at Uppsala University and Karolinska Institute, Sweden.
13	Dr. Fahmida Tofail Medical Officer Clinical Sciences Division	M.Phil/Doctoral study in Child Development at the Institute of Child Health, University College, London, UK (completed partial requirement)
14	Mr. Faisal Arif Hasan Chowdhury Research Officer RTI/STI Lab, LSD	To attend a training course on Bioinformatics to be held at the International Centre for Genetic Engineering and Biotechnology, India.

Staff Who Are On Overseas Study Or Training
As Of 30th September 2004

Sl #	Name, designation and working area	Field of Study/Training and Institution
01	Dr. Suhaila H. Khan Sr. Operations Researcher SBSU, PHSD)	Doctoral Programme in Health Economics at the Dept. of International Health, Tulane School of Public Health in New Orleans, USA.
02	Mr. Ashraful A. Neeloy Senior Research Officer, SBSU, PHSD	Doctoral Programme in Anthropology (focused on health culture) at Australian National University (ANU), Australia
03	Mr. Ariful Islam Operations Researcher, FHRP, HSID	Doctoral Programme in Statistics at Southern Methodist University, Dallas, TX, USA
04	Dr. Disha Ali Research Investigator SBSU, PHSD	Doctoral Programme in Health Economics at the Department of International Health and Development, Tulane School of Public Health, USA
05	Mr. Ibne Karim Md. Ali Sr. Research Officer Parasitology Lab, LSD	Doctoral Programme in Molecular Parasitology at the London School of Hygiene and Tropical Medicine (LSHTM), UK
06	Ms. Sabrina Rasheed Research Officer, SBSU, PHSD	Doctoral Programme in Maternal and Child Nutrition at Cornell University, USA.
07	Dr. Quamrun Nahar Sr. Operations Researcher FHRP, HSID	Doctoral Programme in Sociology at the University of Hawaii, USA
08	Ms Parveen A Khanum Operations Researcher, FHRP, HSID	Doctoral Programme in Women's Studies at Monash University, Australia
09	Dr. Kuntal Kumar Saha Assistant Scientist, SBSU, PHSD	Doctoral Programme in Maternal and Child Nutrition at Cornell University, USA
10	Ms. Papreen Nahar Research Investigator SBSU, PHSD	Doctoral Programme in Women's Studies, Medical Anthropology, School of Political & Social Inquiry, Dept. of Women's studies, Monash University, Australia.
11	Dr. Shakil Ahmed Sr. Operations Researcher SBSU, PHSD	Doctoral Programme in Health Economics at Tulane University, USA.
12	Mr. Zahid Hayat Mahmud Research Officer Environmental Microbiology, LSD	Doctoral Programme in Microbiology at the University of Tokushima, Japan.
13	Mr. Md. Maqsud Hossain Research Officer, RTI/STI Lab, LSD	Master's Programme in Bioinformatics at the University of Abertay Dundee, Scotland, UK
14	Dr. Tanvir Ahmed Sr. Research Investigator Immunology Lab., LSD	Postdoctoral training in Nutritional Immunology at Tufts University, USA.
15	Mr. Md. Bakhtiar Hossain Research Officer Parasitology Lab. LSD	Doctoral Programme in Nutrition at University of California Davis, USA.
16	Dr. Rumana A. Saifi Senior Research Officer FHRP, HSID	Doctoral programme in Demography at the Institute for Population and Social Research, Mahidol University, Thailand.
17	Dr. Md. Saifur Rahman Senior Operations Researcher FHRP, HSID	Doctoral Programme in Reproductive Health Epidemiology at the Australian National University, Australia.
18	Dr. Wasif Ali Khan Assistant Scientist Clinical Sciences Division (CSD)	Masters in Clinical Pharmacology at the Division of Clinical Pharmacology, the Johns Hopkins University School of Medicine, USA.

19	Mr. Shakeel Al Mahmood Sr. Administrative Officer FHRP, HSID	Masters programme in Public Administration (specialization in Health Care Administration) at University of Maine, USA.
20	Ms. Shereen Shoma Mohsin Senior Research Officer ARI Laboratory, LSD	Doctoral Programme in Clinical Bacteriology at the Dept. of Microbiology, Graduate School of Medicine, Kyoto University, Japan.
21	Dr. Sirajuddin Ahmed Medical Officer Epidemic Control Prepared Unit (ECPU), PHSD	Master's in International Public Health Programme at University of Sydney, Australia.
22	Dr. Mohammad Enamul Hoque Research Officer, SBSU, PHSD	Master's programme in Public Health at the University of Queensland, Australia.
23	Dr. Kaniz Gausia Medical Officer, Reproductive Health Unit (RHU) PHSD	Doctoral Programme in Public Health at Edith Cowan University, Australia.
24	Ms. Jinath Sultana Jime Sr. LaboratoryTechnician RTI/STI Laboratory, LSD	Training on DNA micro array techniques and bioneumeric at the Bacterial and Enteric Disease Programme, National Microbiology Laboratory, Canadian Science Centre for Human and Animal Health, Canada.
25	Dr. Md. Abdur Razzaque Associate Scientist HDSU, PHSD	Postdoctoral fellowship (sabbatical) training in Demography at Australia National University (ANU), Australia
26	Dr. DM Emdadul Hoque Project Research Manager CHU, PHSD.	Master's Programme in Public Health at the Department of Public Health and Clinical Medicine, Epidemiology and Public Health Sciences, Umea University, Sweden.
27	Dr. Rubina Shaheen Sr. Medical Officer RHU, PHSD	To fulfill the partial requirement for Doctoral programme (sandwich model) in Epidemiology and Public Health at the Umea University, Sweden.
28	Dr. Muntasirur Rahman Medical Officer CHU, PHSD	Master's programme in Epidemiology at the Harvard School of Public Health, Harvard University, USA
29	Dr. Dipak Kumar Mitra Research Investigator CHU, PHSD	Master's programme in Public Health at the Harvard School of Public Health, Harvard University, USA
30	Mr. Md. Ilias Mahmud Senior Research Assistant Nutritional Biochemistry Lab., LSD	Master's Programme in Bio and Food Technology, University of Newfoundland, Canada.
31	Ms. Shehrin Shaila Mahmood Research Officer, SBSU, PHSD	Master's programme in Economics at the University of Waterloo, Canada.
32	Dr. Md. Anisur Rahman Senior Medical Officer Matlab Health Research Centre, PHSD	To fulfill the partial requirement for study at the doctoral programme (sandwich model) in Epidemiology at Uppsala University and Karolinska Institute, Sweden.
33	Dr. Fahmida Tofail Medical Officer, CSD	M.Phil/Doctoral study in Child Development at the Institute of Child Health, University College, London, UK (completed partial requirement)
34	Mr. Faisal Arif Hasan Chowdhury Research Officer RTI/STI Lab, LSD	To attend a training course on Bioinformatics to be held at the International Centre for Genetic Engineering and Biotechnology, India.

Report on Training Courses

Period: 1st April – 30 September 2004

Sl.#	Activity	# of courses	Number of participants and their home countries	
			#	Home countries
1	Emergency Response to Cholera and Shigella Epidemics (25 April – 6 May 2004)	1	10	**Afghanistan-2, Bangladesh-2, Germany-1, Indonesia-2, Japan-1, Kenya-1 & USA-1**
2	International Training Workshop on Management of Severe Malnutrition (10-20 May 2004)	1	19	**Afghanistan-2, Bangladesh-8, Laos-2, Nepal-2, Pakistan-3 & Yemen-2**
3	Global Medicine Course with Students from Sweden (23 May 3 June 2004)	1	21	**Sweden**
4	Introductory Course on Epidemiology and Biostatistics (16 June- 13 July & 15 August – 14 September 2004	2	30	**Bangladeshi**
5	Elective Fellow		33	**Afghanistan-1, Austria-1, Bangladesh-20, Canada-1, Germany-1, Hungary-1, India-1, Thailand-1 & USA-6**
	Fellowship on Poverty and Health		4	**Bangladesh-3 & Pakistan-1**
	Clinical Fellow		8	**Bangladeshi**
	Nursing Fellow		10	**Bangladeshi**
	TOTAL =		135	
	Orientation training		200	**Bangladeshi**
	GRAND TOTAL =		**335**	

Participants by country:

Asia		Africa		Europe			
Afghanistan –	5	Yemen -	2	Germany -	2	Canada -	1
Bangladesh -	81	Kenya -	1	Sweden -	21	USA -	7
Japan -	1		3	Hungary -	1		8
Indonesia -	2			Austria -	1		
Pakistan -	4				25		
Nepal -	2						
Laos -	2						
India -	1						
Thailand -	1						
	99						

Protocol overview

Reporting Period: 1st April – 30th September 2004

Division	Number of protocols Received Approval	Number of protocols under Review Process	Number of protocols Started	Number of protocols Completed	Number of protocols Ongoing	Number of protocols received approval but Awaiting funds
Clinical Sciences Division	3	5	2	2	19	8
Health Systems and Infectious Diseases Division	2	3	3	2	16	4
Laboratory Sciences Division	12	2	4	0	31	12
Public Health Sciences Division	8	3	4	6	34	7
TOTAL	25	13	13	10	100	31

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 interventions and the IMCI project,
3	Develop a package for the prevention of foetal growth restriction	MINIMat and NNP Baseline survey
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.

Nipah Virus Outbreak

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. The outbreak is being highlighted at the American Society of Tropical Medicine, Nov 04.

Zinc for pneumonia.

An important clinical study published in Lancet in May 2004. Follow-up studies have begun to determine the efficacy of zinc when given to children who are treated for pneumonia in an outpatient setting.

Routine use of hypo-osmolar ORS

Based largely on studies carried out at the ICDDRB and elsewhere, WHO is now recommending the universal use of the low osmolar ORS. They also recommended that a phase four study be carried out to assure freedom from hyponatremia in a larger study. This has now been carried out at the ICDDRB with more than 40,000 patients and there was no increased risk of hyponatremia with the use of the lower sodium solution.

Improving indicators for maternal mortality in Matlab.

The rates of maternal mortality have been decreasing in the Matlab area over the last several years and the estimated rates are considerably lower than the national average. Some of the improvement may be due to the community based and facility based strategies for mothers, but this does not explain the lowering of maternal mortality overall.

NNP baseline survey.

The Centre, in cooperation with the NIPORT and IPHN, was requested to carry out a baseline nutrition survey in support of the National Nutrition Project (NNP) to assist with the evaluation of this very large nutrition intervention. The survey is monitoring anthropometric and other nutrition indicators in areas that were included in the earlier BINP, in area that have just begun the NNP, and other comparison areas that are not included in the programme.

ICDDRB in Mozambique

The Centre began a project in Mozambique on cholera and environment, and this year assisted IVI, WHO, and the Ministry of Health with an evaluation of the killed oral cholera vaccine. Two publications from this collaboration describe the unique strains of V. cholerae isolated from this area of Africa which are different from other areas of Africa and similar to mutant strains isolated in Matlab in the mid-1990's.

Update on the 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. Plans are for classes to start in February, 2005 and recruitment is ongoing now. The Centre is developing a course on the use of the laboratory in health programmes. There is still the intention to include the School on one floor of out ICDDRB building as soon as we find the funds for the rest of the building.

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 you should already have received.

Clinical Sciences Division Highlights

Number of publications:	12
Number of articles in press:	5
Number of ongoing protocols:	18
Number of protocols completed:	1

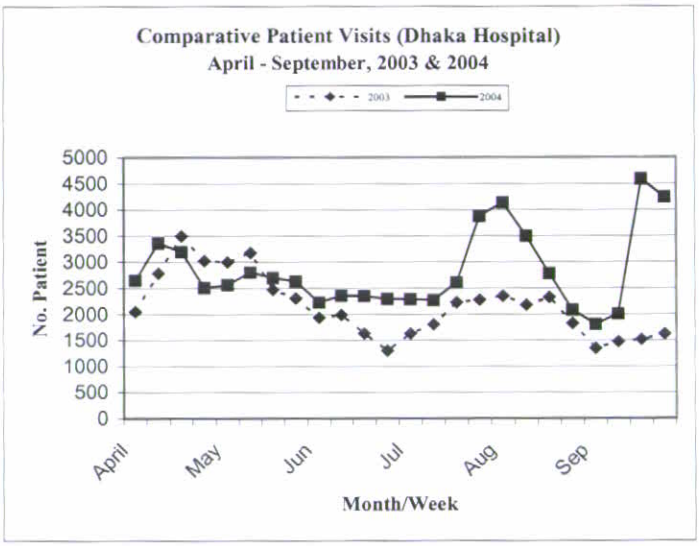
Chart 1. Patient visits at the Dhaka Hospital

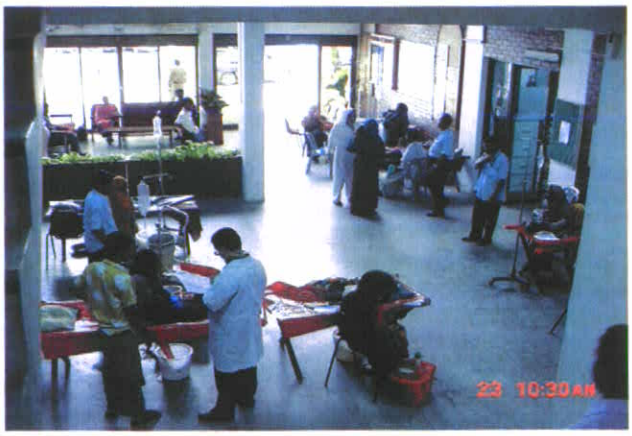
Additional space was needed to handle up to 700 patients daily

Service Activities

In August 2004, the country experienced its biggest floods since 1998, which inundated most parts of the city for weeks, displacing a significant proportion of the city population from their natural residence to temporary shelters down, and water supply system became heavily contaminated with faecal coliforms. At the relief shelters, there were lack of water supply and sanitary latrines, as well as lack of cooking facilities and food to eat. These factors set up the conditions for outbreaks of diarrhoeal diseases, along with other health problems such as skin and respiratory infections.

During the reporting period (April-September 2004), 67,790 patients attended the Dhaka Hospital, which represents a 31% increase in the numbers compared to the same period in 2003 (please see Chart 1). Management of the additional patients required additional resources, including hiring of doctors, nurses, health workers, and sanitary attendants. Provisions were made for cholera cots, chairs, bedside tables, and temporary tents were constructed to accommodate patients and the corridors and the reception area were also used for patient care. The research activities were temporarily shut down, and

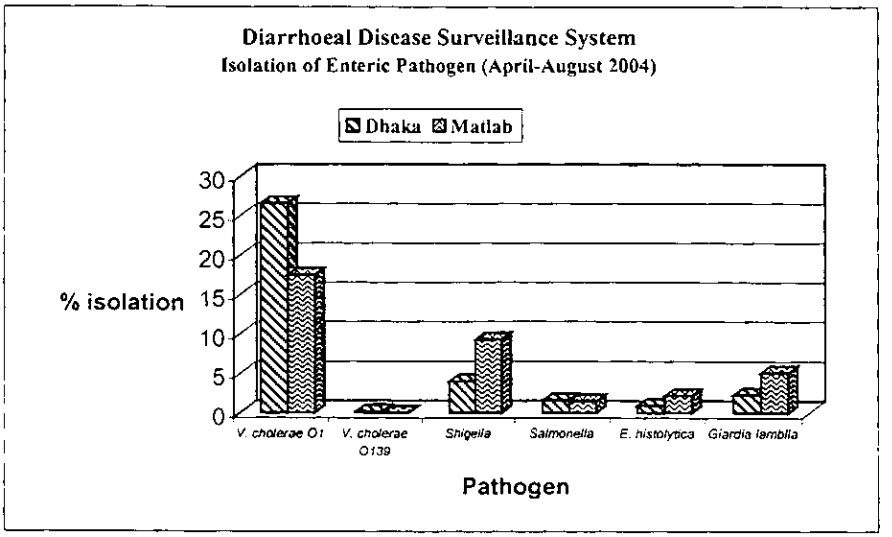




research staff were engaged in the provision of patient care. When the flood situation was improving, heavy showers for days flooded some localities in the Dhaka city, resulting in another outbreak of diarrhoeal diseases and increasing patient visits at the Dhaka Hospital (please see Chart 1), with higher proportion of severely dehydrated patients and increase in the prevalence of cholera patients.

Diarrhoeal Disease Surveillance System

The rates of isolation of various pathogens at the Dhaka and Matlab hospitals are shown in the following figure.



Research

Safety of New Formulation of ORS

A phase-IV trail has just been completed to determine safety of the WHO-and UNICEF-recommended new formulation of ORS (Na^+ 75, K^+ 20, Cl^- 65, $citrate^-$ 10 and glucose 75 mmol/L, and osmolarity of 245 mosmol/L) in a larger population of patients admitted to the rehydration wards of the Dhaka and Matlab hospitals. All patients with uncomplicated watery diarrhoea, and receiving the new formulation of ORS for at least 8 hours, were eligible for analysis. In Dhaka 43,712 and in Matlab 9,588 patients were monitored. In Dhaka 59% and 9% of under-five children had some and severe dehydration respectively, and half of the older children and adults had some dehydration. In Matlab 70% and 25% of the under five children had no sign and some dehydration respectively, and half of the older children and adults had some dehydration. The rate of the occurrence of symptomatic (seizure/altered mentation) hyponatraemia (serum sodium <130 mmol/L) in 21 (0.05%) patients in Dhaka and in 3 (0.03%) of patients in Matlab, were not higher than the rate observed during the previous year (0.09%) when the old formulation of ORS was routinely used. Results of this phase IV trial indicate that the new hypoosmolar ORS, as recommended by WHO and UNICEF, is safe and can be routinely used in the management of acute watery diarrhoea even in a cholera endemic countries.

Zinc Safety Study

ICDDR,B has initiated a large, nationwide project, SUZY, for routine administration of zinc as standard management of diarrhoea in under-five children. As a part of that the Centre has

initiated a phase IV clinical trial in April in a relatively larger population of diarrhoeal patients in the Short Stay Ward of its Dhaka Hospital and its franchising PSKP clinic to determine the rates of adverse events, particularly unusual or excess vomiting. One dispersible zinc sulphate tablet (20 mg elemental zinc) is administered daily for 10 consecutive days to children of either sex, aged 3 months to 5 years. Zinc tablets have been provided to about 19,000 children, and about 10,000 (44%) of them were followed. Vomiting or regurgitation, within an hour of administration of zinc, occurred in 25% of the children; however, the episodes were neither excessive nor severe in nature; no other adverse event was noted. To determine the proportion of vomiting and/or regurgitation attributable to zinc, a randomized, double blind, placebo-controlled clinical trial, nested into the phase-IV trial, will soon begin. Results of these studies will be used in the marketing and implementation of the routine use of zinc therapy in the treatment of acute childhood diarrhea in Bangladesh, and hopefully in other developing countries.

Correlation of vibriocidal antibody titer with protection from Vibrio cholerae infections.

The serum vibriocidal antibody is the only recognized predictor of protection from cholera, but there is a lack of sero-epidemiological data following the emergence of *Vibrio cholerae* O139. A study assessed the association between the vibriocidal antibody titer and protection from cholera in an endemic setting of urban Bangladesh. Although a higher baseline vibriocidal titer correlated with protection from *V. cholerae* O1, infection still developed in some contacts with very high titers. No association between baseline vibriocidal titer and protection from *V. cholerae* O139 infection was found. Results of this study suggest that vibriocidal antibody is an incomplete predictor of protection from V. cholerae infection.

Diarrhoea in elderly

With increasing life expectancy, the proportion of elderly people is also increasing in Bangladesh; however, there is lack of data to characterize diarrhoea in this population. This study identified patients aged over 60 years (4%; n = 478) from all patients (n = 13,782) enrolled into the diarrhoeal disease surveillance system (2% systematic sampling of all patients) of the Dhaka Hospital during 1996-2001. The isolation rates of enteric pathogens from their faecal samples were as follows: *V. cholerae* O1 (20%), ETEC (13%), *Shigella* (11%), *V. cholerae* O139 (10%), *Campylobacter jejuni* (5%), *Salmonella* (3%), EPEC (2%), rotavirus (4%), and *E. histolytica* (2%). The rates of isolation of *V. cholerae* O139 (10% vs. 6%) and *Shigella* (11% vs. 7%) were significantly higher ($p<0.05$ for both comparisons) among the elderly compared to younger patients (15-59 y of age). Significantly higher proportion of them had visible blood in stools (8% vs. 5%), required hospitalization (86% vs. 82%) or referral (1% vs. < 1%) to a health facility. Results indicate the need for early institution of oral or i.v. rehydration therapy, prompt referral, and rapid clinical assessment including the need for antibiotic therapy might be beneficial for the elderly.

Risk factors for death among severely malnourished young children

Implementation of standardized management of severely malnourished children with diarrhoeal disease with or without associated health problems has resulted in impressive reduction (47%) in deaths. Record of all malnourished children who died in 1998 (n=183) and randomly selected 183 children who survived (control) was analysed. In univariate analysis 12 significant risk factors on admission that impacted outcome were identified; however, only two factors, female sex (OR 2.05; 95% CI 1.1-4.0) and positive blood culture (OR 4.6; 95% CI 1.7-12.4) remained significant. Before implementation of the standardized

protocol, only severe malnutrition and non-breastfeeding were significant predictors of deaths.

Bacteraemia in diarrhoeal patients

From laboratory records, patients with positive blood culture from amongst those admitted to the Dhaka Hospital of ICDDR,B between 1994-2003 with diarrhea and associated complications were identified to determine prevalence and outcome of bacteraemia. In total 1,118,637 patients attended the hospital during the study period, 69,653 (7%) of them were admitted to longer stay ward, and blood cultures were performed on 36,353 (52%) of them and the 3512 (9.6%) were positive [enteric pathogen 34% (26% *S. typhi* and 8% non-*Salmonella*); respiratory pathogens 15%; *Enterobacteriaceae* other than enteric pathogen 17%, other aerobic gram-negative bacilli 27 %; *S. aureus* and *S. epidermidis* 6%; and other pathogen 1%). Sepsis was clinically diagnosed in 743 (21%) patients, 643 (18%) of the bacteraemic patients died, and the outcomes of 179 (5%) patients referred to other hospitals were unknown. Risk of death was higher among bacteraemic patients with clinical sepsis than those without sepsis (57% vs.11%, RR-5.8, p=<0.001), and in association with bacteraemia due to respiratory pathogen compared to enteric and gram-negative bacilli (RR= 2.7, p<0.001 and RR =1.5, p=0.0001 respectively).

Child Development

Prof. Frances E. Aboud, a child psychologist from the McGill University, Montreal, Canada has left Bangladesh after spending two year as an adjunct scientist attached to the Child Development Unit of CSD. Her presence at the Centre has not only been useful in bringing newer skills, expertise and research ideas, she also has significantly contributed to assessment of national programmes to support children from birth to the end of elementary school. As a consultant, she assessed the following programmes of PLAN, Bangladesh:

Evaluation of Early Childhood Preschool Programs
Responsive complementary feeding in Bangladesh
Evaluation of the "Shishu Bikash Kendra" component of the Early Childhood Care and Development Program, and
Evaluation of Early Childhood Parenting Programs

After assessing the programmes, she made specific recommendations for their improvement, which would benefit PLAN, Bangladesh and the country.

The Child Development Unit conducted several other studies. In one study assessed the effect of fish oil supplementation to women during their last trimester of pregnancy on mental and psychomotor developments, and behaviour of their infants at 10 months of age. The study did not observe any significant difference in mental development and behaviour ratings of infants born to fish oil-supplemented women; however, the PDI of female babies born with a LBW was significantly better than female babies born to women who received soy oil.

Another study involving 100 infants (mean age of 10.11 months) observed that the mean±SD psychomotor development scores of infants from lower SES was significantly inferior than those from higher SES (96.9±13.8 vs.103.3±11.2; p=0.005), and their MDI and behavior ratings did not differ significantly; however, the difference in PDI did not reach significance (B=6.03, se=3.1, 95%CI:-0.08, 12.1, p= 0.053) in multiple regression.

A study assessed and confirmed the effect of malnutrition on mental, motor and behaviour development of infants. After controlling for confounders, stunted infants had significantly lower scores on PDI (B=5.43,se=2.52,95%CI .43-10.43) and activity (B=1.02, se= 0.32, 95% CI 0.38-1.66), and they also were significantly less happy (B=0.53,se=0.29, 95%CI –0.05-1.11).

Laboratory Science Division Highlights

No. of Publications from (April to September, 2004)	14
No. of Publications in Press	7
No. of Protocols ongoing	32
No. of Protocols completed	2

Important Achievements of the Laboratory Sciences Division:

Peru-15 oral cholera vaccine.

Phase I/II safety and immunogenicity studies of the GCP monitored study on the live oral cholera vaccine Peru 15 has progressed from adults to infants. The vaccine induced little or no side effects in adults or toddlers in whom the study has been unblinded. The study has been completed in 250 participants so far and is in the outpatient phase in the infants now. Low excretion rates of Peru 15 is seen in the vaccinees. The vaccine is remarkably immunogenic. Mucosal and systemic antibody responses in the adults (>75% responding) and the toddlers (84% responding) is very encouraging. Study in the infants is continuing in the outpatient phase and hope to be completed by December 2004.

Tuberculosis specimen bank

Specimens from *M. tuberculosis* infected patients are being collected in the WHO/TDR and USAID funded specimen bank. *M. tuberculosis* strains, sputum, serum, urine and antibody in lymphocyte secretions are being archived.

Production of endogenous antibacterial peptide

Treatment with natural products of digestion stimulates production of endogenous antibiotic (CAP18) in the colon in *Shigella*-infected rabbit model. This results in reduction of bacterial load and eases systems of disease. Plans to move to patients with shigellosis are being initiated.

ETEC cohort study.

A cohort of 321 children have been followed from birth up to 2 years of age in Mirpur which is nearing completion. Studies so far suggest that ETEC is the most common cause of diarrhoea in infants with a first infection seen within 6 days of birth. The incidence of *V. cholerae* is low while that of *H. pylori* is very common, increasing from 9 months of age.

Hyperinfectious cholera Vibrios

Passage through the human gut results in a hyperinfectious state in *V. cholerae* causing it to be more infectious. This phenomenon has been re-modeled in the infant mice and analyses show that the adhesion genes, the type IV pilus gene and *tcpA* are upregulated.

Safe water in Dhaka and Mozambique

A study is in progress to find out the faecal contamination of drinking water in Dhaka city due to flood and development of recommendations for disinfection of contaminated drinking water. Similar study in rural setting is also in progress to find out the contamination of tube wells, which had been inundated during flood. Evaluation of efficacy of disinfectants in tube wells using bleaching powder is in progress. A study is going on in collaboration with the Northumbria University, UK, and the Ministry of Health, Mozambique. In a collaborative study with the Stanford University, California, USA, investigations are being carried out in Matlab HDSS area to determine whether V. cholerae O1 can form biofilm in the aquatic environment to survive during inter-epidemic periods of cholera. In a collaborative study with the Dartmouth Medical College, New Hampshire, USA, an investigation is being carried out to determine temporal dynamics of gene expression and regulation under different environmental conditions.

Shigella resistant to Cipro.

An outbreak of bloody diarrhoea due to infection of ciprofloxacin-resistant *S. dysenteriae* type 1 occurred in the tea estate in northeast Bangladesh in October and November 2003 has been confirmed. Molecular analysis showed differences between the current ciprofloxacin-resistant *S. dysenteriae* type 1 strains isolated in south Asia and those associated with epidemics in 1978, 1984 and 1994.

Real time PCR for diagnosing enteric pathogens

Application of Real time PCR in the diagnosis of *Shigella* and Shiga-toxin producing *E. coli* from diarrhoeal patients has been set up. The Parasitology laboratory also established real-time PCR assay for diagnosis of *E. histolytica*, Giardia and Cryptosporidium. The real-time PCR assay for *E. histolytica* is molecular beacon probe based, Giardia is scorpion probe based and Cryptospordium real-time PCR is with syber green. These real-PCR based assays will be compared with the existing antigen detection tests for these organisms as well as with the rapid diagnostic tests that will be developed at the TechLab as a part of this project.

Field studies on human immunity to amebiasis

This study is continuing in Mirpur. Recently in collaboration with the London School of Hygiene and Tropical Medicine we have genotyped 95 *E. histolytica* isolates from this cohort children and identified 19 genotypes. There were two genotypes significantly associated with invasive disease while one genotype is significantly associated with asymptomatic noninvasive infection. We have also genotyped *E. histolytica* into four groups using melting temperatures in real-time PCR assay. But no association of any of the melting temperatures with invasive disease could be shown.

Antimalarial drug resistance in Bangladesh.

A total of 70 uncomplicated falciparum malaria patients from Charkaria were enrolled into the study out of which 62 subjects (88%) completed the full 42-day follow-up and were treated three days with Quinine and a single dose Fansidar (Q3F). All subjects cleared

parasites within 7 days after initiation of the treatment (no RIII failure was seen). 11 patients (18%) had recrudescence between days 10 and 42.

Clarithromycin resistance in H. pylori

Mechanism of clarithromycin resistance was studied in 12 resistant isolates. The nucleotide sequence of 23S rRNA gene from 12 resistant isolates and 3 susceptible isolate was determined and compared. A novel transition mutation at 2182 associated with clarithromycin resistant was detected. Natural transformation of clarithromycin susceptible isolates with 23S rRNA gene from resistant isolates converted the susceptible isolates to resistant phenotype.

Shigellosis in Bangladesh: species, serotypes and antibiotic resistance

Of the *Shigella* isolates, most patients had *S. flexneri* infection (52.9%) followed by *S. boydii* (22.3%), *S. sonnei* (10.2%), *S. dysenteriae* other than type 1 (9.2%), and non-typable *Shigella* (5.2%). None of the *Shigella* isolates were resistant to ciprofloxacin but one to mecillinam only. *S. flexneri* showed 61.9% resistance to cotrimoxazole, 50.8% to ampicillin , 48.3% to nalidixic acid and 23.8% to amoxicillin plus clavulanic acid (amoksiklav). *S. boydii* showed 45.0% resistance to cotrimoxazole, 26.7% to ampicillin , 35.1% to nalidixic acid, 12.2% to amoksiklav and 3.1% azithrommycin. *S. dysenteriae* other than type 1 showed 56.4% resistance to cotrimoxazole and 16.4% to ampicillin, 20.0% to nalidixic acid and 10.9% to azithromycin. *S. sonnei* showed 95.1% resistance to cotrimoxazole, 77.0% to nalidixic acid and 8.2% to azithromycin while non typeable *Shigella* showed 80.6% resistance to cotrimoxazole, 61.3% to ampicillin, 12.9% to nalidixic acid and 9.7% to amoksiclav. Distribution of S. *flexneri* subserotypes are wide spread in the community, which showed 2a and 3a 26.44% each, followed by 1b (12.54% (Each), Ic and Type 6 9.49% each, 2b (8.47%), Type 4 (3.05%), 4X (1.36%), 4a and Y 1.02% each, 1a and 3b 0.39% each.

Nutritional biochemistry laboratory

Arsenic of more than 10,000 water samples was done by HIVG-AAS and a new method was established for the determination of Arsenic in biological samples like urine, hair and nail by HVG-AAS. Data cleaning and analyses are in progress for the study, "Effectiveness of small fish rich in vitamin A to improve vitamin A status in children living in urban slum.

Major Improvements in Laboratory Sciences Division

- A new **laboratory dedicated for *H. pylori*** was established. The laboratory will be dedicated for molecular pathogenesis of *H. pylori*. The laboratory is equipped with double gas incubator for *H. pylori* culture and gene pulser for DNA transformation.

- The Clinical Laboratory Services started on-line operation from August 1, 2004 using **laboratory information and management software (LIMS)** for paying users, and that for hospital patients, research protocols and staff clinic is on-live trial. Once fully implemented, the overall management of clinical laboratory services will be more speedy and efficient in terms of laboratory data management, laboratory costing and financial management, and scientific analysis of data and quality assurance. The users have appreciated reduction of waiting time and eliminating hand-written reporting.

- **Molecular and serodiagnostic unit** introduced new cancer markers (CA19-9, CA 125, CA 15-3), detection of *H. pylori* IgG, Hepatitis B viral load, Hepatitis C virus detection and Hepatitis C viral load as routine tests. Molecular typing of pathogenic *Escherichia coli* from stool culture has been set up. In addition to DNA Engine Thermal Cycler, Agarose

Gel Electrophoresis system, PCR Work Station, Micro-centrifuge one analyzer with chemiluminescence technique will be added to the unit to increase its capability.

- The services of **Clinical Microbiology Laboratory** improved and became more efficient due to availability of services of Dr. Dilruba Ahmed, PhD (Microbiology, New Zealand) and Dr. Liton T. D'Costa, MBBS, MSc (Biotechnology, Australia). In addition, automated blood culture system has shortened the reporting timing of the positive cases and benefiting the patients. Microbiological data available from the past two decades has been organized and ready for computerization.

- The services of **Clinical Hematology laboratory** improved, more efficient and increased capability because of automated equipment like coagulation assay analyzer, ESR analyzer, blood sample mixing machine and more computers.

- The services of **clinical biochemistry laboratory** became more efficient due to connection of Hitachi 902 to LAN system. One Immunochemistry analyzer has been ordered to facilitate more tests/assays on hormone, drug assays and rescheduling of tests to increase the output and reduce turn around time.

- Computerization of the **Matlab laboratory** made it efficient in organizing laboratory data and its management. Laboratory data of the past two decades has been organized and partly computerized for retrospective analysis for trends of diarrhoeal diseases in rural Matlab. Storage capability of isolated microbial strains has increased. New autoclave machine has increased its sterilizing capability.

- A **new laboratory in Chakaria** Community Health Project of Public Health Sciences Division launched in March 2004 to cater to the need of laboratory diagnostic support to its studies. The laboratory diagnostic facility is also available to the outpatients paying users, who used to run to Chittagong or distant places to avail the diagnostic support for patient care activities. Routine hematological tests including detection of malaria, biochemical tests including serum electrolytes, liver renal function, pregnancy test, fecal and urine analysis are available. Required equipment and staff were hired and trained in Dhaka laboratory. Quality assurance is being monitored from Dhaka, in addition to its built-in internal quality assurance scheme.

- As a part of LSD's Fire Control and Protection Scheme, an Electrical Consultancy Firm was engaged who had done marking of MCBs & Phase cables, posted danger sign in all SDBs and updated drawing of whole electric wiring as well as replaced all defective circuit bakers and made suggestion for future improvement.

- Officials of Bangladesh Atomic Energy Commission (BAEC) inspected LSD facilities for using radioisotope in health research activities. Being satisfied BAEC issued License for LSD to use radioisotope in health research purpose. As required, LSD procured a Radiation Dose Rate Meter at a cost of Tk.60,000 from BAEC for regular monitoring of radiation dose at the working lab and storing area to ensure safe operation.

HEALTH SYSTEMS AND INFECTIOUS DISEASES DIVISION

Number of publications	9
Number of publications in press	11
Number of on-going protocols	30
Number of completed protocols	11

Important achievements of the Health Systems & Infectious Diseases Division (HSID): Organized by Programs and Units

Programme on Infectious Diseases and Vaccine Sciences/ Infectious Diseases Unit

Nipah virus investigations.

In a series of four outbreak investigations, ICDDR,B in collaboration with the Government of Bangladesh, the US Centers for Disease Control and Prevention and the World Health Organization identified Nipah virus infection in Bangladesh for the first time, and described new aspects of its epidemiology. In the four outbreaks investigated to date, 90 cases were identified, 66 (73%) died. Fruit bats (*Pteropus giganteus)* (shown in the photo) appear to be the principal reservoir for the virus; 2 *P. giganteus* bats, but no other species of bats, birds or domestic animals were Nipah antibody positive. The most recent outbreak in Faridpur in February 2004, was different from the previous outbreaks in that 6 patients had acute respiratory distress syndrome, and close contact with a case of Nipah encephalitis was a strong risk factor for developing Nipah encephalitis. A follow-up study to evaluate the long term sequelae of Nipah virus infection is planned for the coming year.

Health and Science Bulletin

The HSB offers brief presentations of recently completed research at the Centre followed by a comment section that focuses on the practical implication of the work. In addition, updated surveillance of a growing list of conditions is included in each issue. These now include antibiotic resistance patterns of diarrheal pathogens, *Mycobacterium tuberculosis*, and *Neisseria gonorrhoeae* from various surveillance sites, and the proportion of diarrheal isolates from the ICDDRB hospital that are V. cholerae 01, V. cholerae 0139, and *Shigella*. The HSB is distributed to more than 8,000 public health policy makers, scientists, doctors and other health care providers, non-governmental organizations, and the media in Bangladesh and in the south Asian region. The seventh edition was published in Oct., 2004. A recent survey of readers concluded that it was widely appreciated. Of note, 80% of readers

read the Bangla version. Recently, the HSB has become regularly cited in newspaper articles in Bangladesh, further extending the implications of ICDDRB research.

Pneumonia epidemiology and prevention.

The impact of a conjugate Hib vaccine (Tetract Hib) on pneumonia and meningitis morbidity in Bangladeshi children< 2 years has been estimated, based upon a birth cohort of approximately 50,000 children residing in 3 out of 10 zones of Dhaka city. Using incident case-control methodology during the study period from June 2000- October 2003 approximately 75,000 doses of Hib conjugate vaccine were distributed through 31 centres offering child vaccinations in the area. About 40% of the total vaccine doses given in the study during the study period were Hib-DPT, the rest was DPT only. When analyzed using the community controls, Hib vaccine offered 92% protection against confirmed Hib meningitis, a 50% protection against purulent meningitis and 34% protection against pneumonia among children who received at least two doses of the vaccine. These data demonstrate that the burden of Hib is considerable in Bangladesh, and provides the basis for informed policy decisions on initiation of Hib vaccination in Bangladesh.

Burden of Streptococcus pneumoniae in Bangladesh.

PIDVS is heading up a program to evaluate the burden of *Streptococcus pneumoniae* in Bangladesh. In 2004 a network of hospitals established blood and cerebrospinal fluid culture surveillance for *S. pneumoniae*. In the first 3 months, 8 isolates of *S. pneumoniae* were identified. Six of the eight isolates were resistant to cotrimoxazole, the first line agent in treatment of acute respiratory tract infection. Complementary community based surveillance has also been established at an urban field site in Dhaka. .

Enteric Diseases

Prospective surveillance for diarrhea in Kamalapur has demonstrated a large burden of disease from *Shigella* with a high proportion of dysentery. Ongoing surveillance of *Shigella* has been notable for an increased proportion of isolates resistant to multiple anti-microbials. During late November 2003, a 3-year old resident of a tea production estate in Sylhet division was hospitalized at the ICDDR,B (Dhaka) with bloody diarrhoea, rectal prolapse, and peripheral oedema. Fluoroquinolone-resistant Sd1 was isolated from stool. On 11 December 2003, an investigative team from ICDDR,B visited the tea estate. Four residents were identified with an ongoing illness, which included bloody diarrhoea. A rectal swab from one patient, who had not yet received antimicrobial drugs, yielded Sd1 resistant to ampicillin, co-trimoxazole, nalidixic acid, tetracycline, ciprofloxacin, norfloxacin, and ofloxacin, and susceptible to azithromycin, pivmecillinam, and ceftriaxone. Two community-based care providers, who delivered treatment services for families on the same tea estate, reported treating about 50 out-patients with bloody diarrhoea between early October and mid-December 2003. Four patients, including 2 young adults and 2 children <5 old, were reported to have died after having developed symptoms of bloody diarrhoea. The findings of this investigation suggest that there is ongoing transmission of a multi-drug resistant clone of Sd1 in northeastern Bangladesh.

In community based surveillance of children with fever in the Kamalapur urban surveillance site, *Salmonella typhi* is the organism most commonly isolated from blood. The overall incidence of typhoid fever was 3.9 episodes/1000 person-years. The incidence among children less than 5 years old was 18.7 episodes/1000 person-years, placing Bangladesh amongst countries with the highest incidence of typhoid fever. In a follow-up study of risk factors for typhoid fever in Kamalapur, drinking unboiled water at home (adjusted odds ratio

[AOR] 12.1, 95% CI 2.2 - 65.6;) and water from the primary source having a bad odor during the 14 days prior to the patient's illness onset (AOR 7.4; 95% CI 2.1-25.4) were strongly associated with *S. typhi* infection. Using a latrine for defecation was significantly protective (AOR 0.1; 95% CI 0.01-0.9; p<.05). This study confirms that the most basic of public health interventions, safer drinking water and sanitation, are likely to have major impact on the burden of typhoid fever in the South Asian megacities.

Cholera outbreaks in developing countries often occur in areas with limited laboratory facilities and financial resources. In order to confirm cholera outbreaks in a timely fashion, a sensitive diagnostic test that can be performed by low-skilled personnel is needed. In collaboration, staff from CDC and ICDDR,B: The Centre for Health and Population Research 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 50th symptomatic patient at a diarrhea treatment center 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. A preliminary analysis of the data shows that the IP dipstick had the highest sensitivity (93%), irrespective of skill level.

Vector-borne disease prevention and control

A multidisciplinary team was formed, consisting of epidemiologists, immunologists, entomologists, clinicians, and behavioral scientists to study visceral leishmaniasis. Community surveys were conducted in winter 2002 and 2003, which have confirmed intense ongoing transmission. Risk factors for disease include proximity to previous cases of visceral leishmaniasis and age between 3 and 45 years. Consistent bed net use was protective. The case-fatality rate over the study period was 10%, 7% in males compared to 15% for females.

Health & Family Planning Systems

Health Systems and Economics Unit

The broad research agenda of the unit is concerned with access to health care, utilization, coverage and health outcomes; measurement of these through information systems, surveillance and surveys; and with the organization, management and financing of service delivery. The work of the unit includes a significant amount of health economics research focusing on issues of poverty and health (equity), cost-effectiveness of different interventions, cost of illness and demand side financing. During 2004, the unit completed eight projects and currently has nine projects at different stages of implementation. The work of the Programme has focused primarily on the scaling up of zinc as a treatment for childhood diarrhea. Three studies have been completed, 3 are being carried out and one is under development.

Use of ESP services in the transition to a static clinic system: 1998-2002.

This study has provided the only reliable evidence on the use of services and coverage in a period of major change in the Government service delivery system, 1998-2002. An ICDDR,B Working Paper is now in print following dissemination of the results. Data from the HSID surveillance areas (Abhoynagar and Mirsarai) were used to compare quarterly trends in selected indicators for wards that had a new community clinic operationalised and those that did not. In general, it was found that women had made the major change in health seeking behaviour required. The level of key indicators (eg. CPR; ANC and EPI coverage) was maintained or improved despite the major supply-side changes in some wards. In 2003, the

current Government reverted to the old domicilary/satellite clinic system. However, the study results are timely to inform the World Bank appraisal mission in November 2004 and negotiations over financial support for the current sectoral program from 2005-08.

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). A paper was published in the July 2004 issue of *Health Policy and Planning*. The data indicate high and equitable coverage of selected child and reproductive health services and a reduction of about 50% in neonatal mortality from 1999-2002, among the poorest one-third and others. The work has led to further research on neonatal deaths (see ongoing research) and validation of recording. Preliminary results confirm that neonatal mortality is below 25 per 1000 live births in 12 areas where the NGOs have worked since at least 1996.

Identifying and addressing unmet needs in PHC clinics: use of a screening tool.

This study evaluated use of a screening tool in Government and NGO clinics and an ICDDR,B Working Paper is now in print. It was found that 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. As the results from the NGO clinics were particularly encouraging, discussions were held with the NGO programme managers who expressed interest in scaling up use of the tool.

Evaluation of a six-month pilot to introduce urban community health volunteers

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 August 2003, which provided baseline indicators on service use and coverage in intervention and comparison areas. The follow-up survey completed in April 2004 identified significant depot activity, including providing information, referral and supply of commodities. A review of clinic service statistics indicated that use of ESP services at the NGO clinics had increased considerably.

Exit survey for assessment of quality of care, clinical laboratory services.

To assess the quality of ICDDR,B laboratory services in terms of user satisfaction, an exit survey was conducted with 206 users during April-May, 2004. The findings were presented in a meeting of the Centre management in July 2004 and used as a basis for decisions about ways of improving the laboratory services.

Review of the reproductive health status of poor women in Bangladesh.

This was part of a five-country study funded by the World Bank. It included extensive literature review, quantitative analyses of data on reproductive health status, and a district level field survey to assess the quality of reproductive health services in Bangladesh. The survey identified factors hindering service quality and suggested possible interventions to improve service delivery.

Acceptance of Zinc Dispersible Tablets and Adherence to Zinc Treatment Instructions.

This study was carried out in 4 rural and urban sub-districts. The tablets were reported by mothers of children with diarrhea to be as good as or accepted better than other medications. Fifty-five percent of children received the zinc for the prescribed 10 days and 98% prepared

the formulation correctly. It is concluded the planned marketing of zinc tablets will need to place particular emphasis on the 10 day treatment schedule, but that taste should not be a problem.

Baseline National Coverage Survey for treatment of Childhood Diarrhea.

Conducted in all 6 Divisions of Bangladesh, Dhaka, and Chittagong, this survey serves as a baseline from which to monitor changes in treatment practices with the introduction of zinc. Of note, the parents of 61% of the over 6,000 cases of under-five childhood diarrhea identified sought services froma provider. 97% of these used the private sector, with 3% split between MOHFW facilities and NGOs.

Scaling Up Zinc for Young Children (SUZY) Project:

In addition to the on-going research activities, over the past 6 month the following has been achieved:

- MOUs between Nutriset (zinc importer) and Social Marketing Company (SMC), SMC and Bitopi (local advertising agency)
- Selection of brand name (Baby Zinc) and packaging design
- Final registration of zinc (in October)
- Development of a revised business plan
- Publication of second edition of SUZY news

Surveillance & Data Resources Unit/DSS Field Sites Unit

Levels, trends and determinants of unintended births in rural Bangladesh: evidence from the ICDDR,B FHRP areas

This study was executed by staff of the unit in collaboration with researchers from the United States and funded by USAID. It seeks to understand the factors leading to pregnancies in families who do not intend to have any more children. The ICDDRB field areas are unique in the developing world since we have information about the future intent of families along with actual pregnancies that follow from these families. The goal of this project is to assist families avoid unintended pregnancy as well as to assure that all children, whether intended or not, are well cared for. Completed in June, the dissemination seminar is foreseen for November. A follow-up to this protocol was developed and submitted to NIH in June. The planned start date is April 2005 and the duration 4 years.

Health Systems and Infectious Diseases Surveillance System – Report, 2000-2001.

An analysis of the surveillance data from 2000 and 2001 has been published both in printed and in electronic form. Future reports will be produced more quickly now that software has been developed to integrate the data coming from the field in a timely manner.

Emergency Flood Relief in Kamalapur

This year's monsoon season witnessed flooding of a level not seen in the past 15 years. The worst affected areas in the country included the older, more southerly areas of Dhaka, which houses the Centre's urban site Kamalapur. The surveillance area covers 4 Km2, and is home to approximately 200,000 people.

As soon as the flooding started in the site, the Centre director and a number of staff visited to take stock of the situation. What followed was a systematic needs assessment of the

community, not only those who participate in the Centre's research activities, but all community members.

First, field research assistants (FRAs) were sent into the community to find out how many families had been displaced to camps, how many remained in flooded homes, what was the status of the water in the community, and whether people had access to food and medicine. The FRAs visited 40% of the households throughout the community and systematically gathered data. The field staff also collected water from all the public taps and sent it to the Centre's environmental health lab for testing. What was found was that 6% of the population had been displaced to camps and were in active need of food, 50% of the those remaining in their homes had standing water in and around the house, everyone had access to some food, but it was not optimal and 8% were in active need of medical attention. The water testing revealed that, as the waters receded, 95% of all municipal water taps were heavily contaminated. In addition to this, the Centre met with and coordinated its activities with local elected and other leaders, NGOs and community groups to develop a unified approach.

The Centre then took a three-pronged approach to addressing these issues. The first focus was on water. Several approaches to end-use water purification were evaluated, but alum potash, a locally available product familiar to the community, was adopted. A simple message was developed around this strategy for distribution throughout the community, and alum potash was provided free of cost to over 30,000 households. Second, 5 satellite clinics were established, in partnership with local NGOs, schools and community groups, to provide emergency services. At the peak of the flood, these clinics, together with the main clinic, served between 1,000 to 1,500 people per day. Third, after an initial food distribution to 1,650 families in the flood camps, 8,000 food packets provided by the World Food Programme were distributed from the field office over a five day period, servicing over 34,000 needy and vulnerable people who were screened and then brought to the clinic in small groups to avoid crowding. The process was orderly, experiencing no civil disturbances.

The Programme will publish an outline of the methodology it used to address this flood for future reference at the Centre and wider dissemination.

Family Health Research Project

The FHRP, a large project funded by USAID, is hosted in the HSID Division but projects are carried out in all Divisions. Its mandate is to carry out operations research that will strengthen the primary health care programmes, especially the Essential Services Package, of Bangladesh. The project works closely with other USAID funded projects in carrying out its mission. The studies spanned many disciplines and subject areas to include research into the introduction and evaluation of new tools to promote healthcare delivery and management, effectiveness of community-based strategies, risks of HIV/AIDS and sexually transmitted diseases and ways to identify and protect. These covered the areas of population sciences, emergency obstetric care, neonatal care, general health, family planning, and HIV/AIDS.

Research

- New concept papers developed : 30
- Studies ongoing : 12
- Studies completed : 08
- Studies in pipeline : 02

Reports Published

- Surveillance System Report 2000-2001

- Programmatic and non-programmatic determinants of low immunization coverage in Bangladesh
- Costs of the Community-based Protocolized Management of Severely Malnourished Children at Selected NGO-run Clinics

Dissemination of Research Protocols

- Community-based protocols Management of Severe Child Malnutrition: Cost and Cost Effectiveness Analyses of PSKP Services
- Programmatic and non-programmatic determinants of low immunization coverage
- Plateauing of Bangladesh Fertility Decline
- Introduction of new hypo-osmolar ORS to routine use
- Evaluation of a six-month pilot to introduce Depot-holders in three types of urban area
- The acceptability, effectiveness and cost of strategies designed to improve access to basic obstetric care in rural Bangladesh

Collaboration with Government and NGO's through FHRP

FHRP maintains close collaboration with different government departments of MOHFW, national and international NGOs, and development agencies working in health field. In the April-September 2004 period the collaborations taken place with the Ministry of Health and Family Welfare, NIPORT, Institute of Child and Mother Health (ICMH), Mother and Child Health Institute (MCHI), National Nutrition Project (NNP), National Tuberculosis Control Program, DMCH, Upazila Health Complex, WHO, BRAC, CONCERN Bangladesh, NSDP, etc. This collaboration is necessary for consultation with concerned Line Directors, Program Managers and other Stakeholders to identify the needs and priorities. This also facilitate translating research findings into programmes for replication by the NGOs and respective Government agencies involved in Health, Nutrition, and Population (HNP) sector.

Supervision and management of surveillance sites

The project partially supports three demographic and epidemiological surveillance sites: one at Abhoynagar in Jessore district, another one at Mirsarai in Chittagong district, and other one in the Dhaka metropolitan area. The surveillance data that are being collected through these three field sites are providing information on use and practice of health, economic, societal changes within these communities over a longitudinal period of time. This has huge importance and value as the data are being used as resources to different researches carrying out by the researchers within and outside the Centre. An attempt will be made to review significance of current surveillance data collection procedure, tools, and strategy to make an informed decision on current funding pattern to continue and/or expanding it in future stages.

Targeted Research

Over the reporting period, 8 research protocols completed and 6 dissemination seminars to share the key research findings organized. Currently, 12 Research Protocols are ongoing with the funding from USAID. The protocols are shown on the following table.

Name of the protocol	**Principal Investigator**
The Community-based component of the evaluation of the health and economic impact of the IMCI Strategy in Bangladesh: Development and evaluation of a community-based intervention	Dr. Shams El Areefin
Community-based interventions to reduce neonatal mortality in Bangladesh.	Dr. Shams El Areefin
The effectiveness and utility of a green banana diet in the home management of acute and persistent children diarrhoea.	Dr. G. H. Rabbani
Management of tuberculosis by private practitioners and health seeking behaviour of symptomatic adults/TB suspects.	Dr. Shahed Hossain
Vulnerability to HIV/AIDS of migration-affected families	Dr. Rasheda Khanam
Field evaluation of simple rapid tests in the diagnosis of syphilis	Dr. Motiur Rahman
Investigation of the Nipah Virus Outbreak in the Faridpur District: An in-depth examination of beliefs and practices associated with the disease.	Dr. Lauren Blum
Levels, trends, and determinants of unwanted births in rural Bangladesh	Dr. Carel Ven Mels
Reinitiating fertility decline by meeting the needs of high parity couples with long-term family planning methods in Bangladesh.	Dr. Abbas Bhuiyan
Community-based intervention to reduce childhood drowning in Bangladesh.	Dr. Lauren Blum
Feasibility, acceptability and program effectiveness of misoprostol in preventing post-partum haemorrhage (PPH) in rural Bangladesh	Dr. M A Quaiyum
Essential Laboratory Services: A baseline assessment of existing laboratory services in urban and rural Primary Health Care (PHC) in Bangladesh.	Dr. Motiur Rahman

Public Health Sciences Division

Number of publications (Nov03 -Sept04)	22
Number of publications in press	11
Number of on-going protocols	33
Number of completed protocols	8

Matlab Hospital

During April-September 2004, a total of 32,481 patients were treated at Matlab

Number of diarrhoea patients:	
Diarrhea Treatment Centre	8819
MCH-FP:	
Child health	3525
Reproductive Health	3617
Deliveries	291
Clinical Services at Sub Centres:	
Outdoor services(ARI and Common illnesses)	6224
Reproductive health (ANC/PNC+ Common illness)	9499
Deliveries	170
Male clinic patients	

Child Health Unit

Projahnmo-I: Community based intervention to reduce neonatal mortality in Bangladesh: Sylhet

Almost all recently delivered women in the study area (6600) had contact with project trained Community Health Workers during pregnancy (Fig. 1). Results from a household survey of recently delivered women carried out about 7 months post-implementation show (i) improved knowledge of maternal and neonatal danger signs and where to go for these danger signs; (ii) increased rates of positive health practices (e.g. use of Clean Delivery Kits for delivery, delayed bathing of the new born for three days, early drying and wrapping of the baby). CHW's presence during deliveries is starting to improve, rising from 5 - 6% in Sep '03 to 18% in April '04 (Fig. 2).

Fig.: 1: **Coverage of pregnancy (BNCP) and neonatal care visits by CHWs (estimates for neonatal care visits restricted to deliveries occurring at home only)**

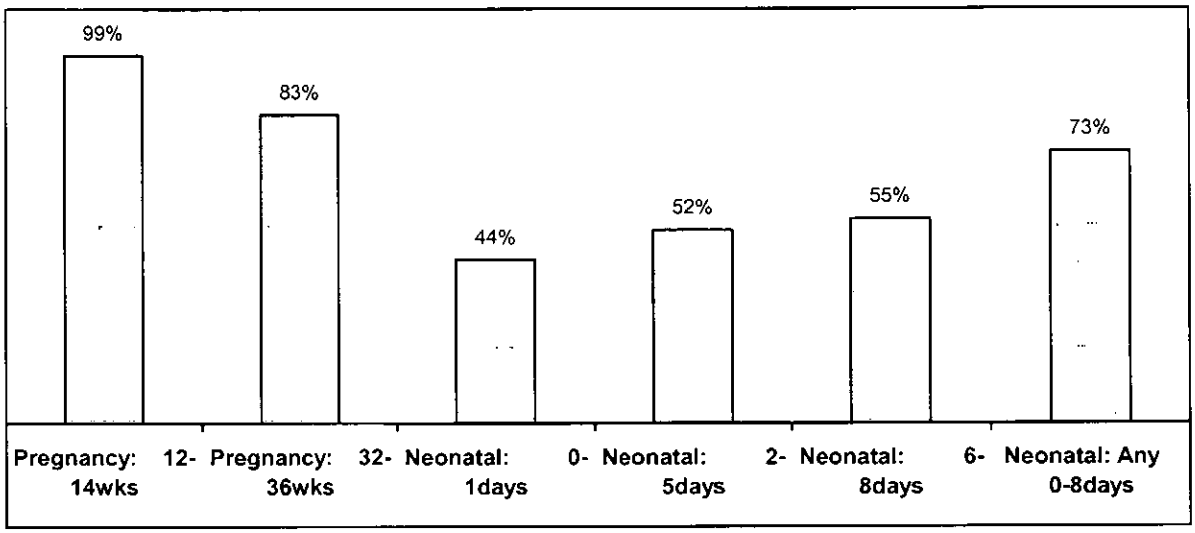
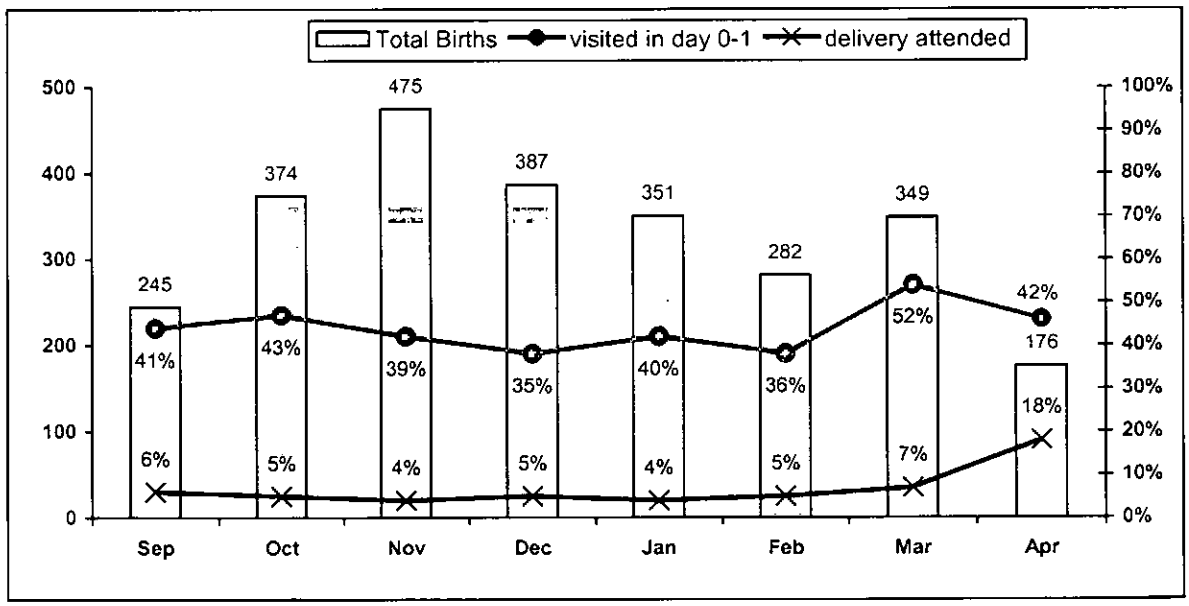


Fig. 2 CHW presence during deliveries taking place at home and within days 0-1 by calendar month



Tuberculosis study

A TB surveillance system was set up in Matlab (106,000 population) with trained field workers interviewing all persons > 15 years to detect suspected TB (by cough >21 days) and sputum (acid-fast bacilli[AFB]). The population-based prevalence rate of smear-positive TB cases was 97/100,000 among persons aged ≥15 years. There was male predominance of

cough and isolation of AFB ($p<0.05$). The prevalence of tuberculosis was high in some clusters (relative risk = 5.53, 95% CI: 3.19, 9.59).

Rotavirus vaccine trials

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 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. The vaccine was found to be safe among infants aged 6-14 weeks of age. However, because of poor immunogenicity of the formulation used, another phase II study will be needed prior to initiation of the efficacy study, planned for Matlab in 2005.

MINIMat Phase 1: Combined interventions to promote maternal and infant health– a study in Matlab.

Starting in October 2001 and ending enrollment in October 2003, a total of 4436 pregnant women were included in MINIMat Phase-I. As of June 2004 a total of 5665 births and 3422 birth weights had been measured. For all live births, both mother and children are followed monthly for the first year and then every 3 months up to 24 months. Maternal and child morbidity and anthropometric measurements are taken and child development assessed. Primary outcomes are low birth weight and maternal hemoglobin status.

MINIMat, Phase II.

From November 2003 we have started MINIMat Phase II whereby MINIMat mothers with live births are enrolled with the aim of following them up to their next child birth. In this phase, maternal blood and urine are collected to see the Hb level and arsenic level in urine. As of 27 September, 55 women have been enrolled.

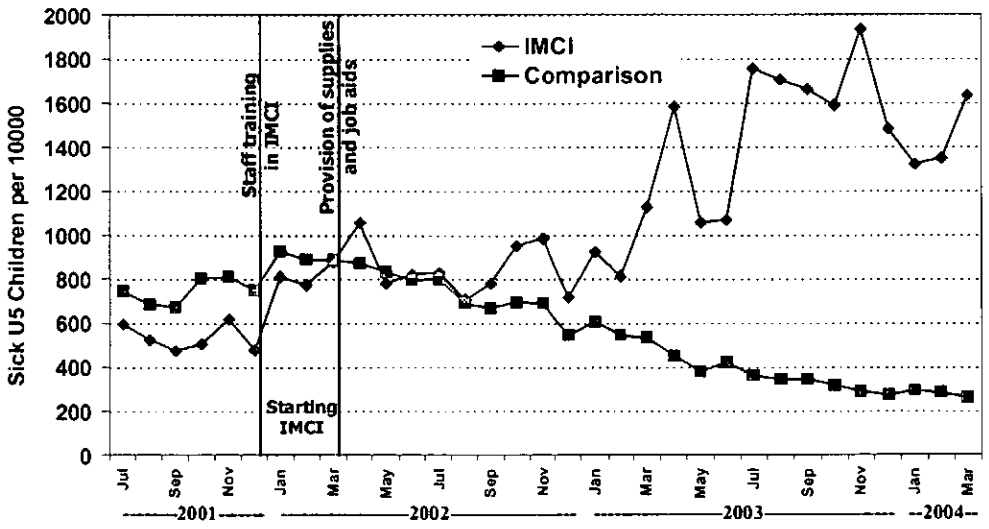
IMCI: An evaluation of the health impact of Integrated Management of Childhood Illness (IMCI), Matlab, Bangladesh - a randomized experimental study

The Community-IMCI activities aim to intensify community-based interventions to increase the proportion of sick children who are brought to an appropriate provider, early in the illness episode. These interventions include ward-level community meetings with community leaders, mosque-based male group meetings through trained religious leaders (Imam), mothers group meetings and household counseling visits through community-based health workers, and village doctors trained to promote referral of severe cases and to improve prescribing patterns in general as well as to avoid harmful/bad practices. Mini-theaters are conducted in all intervention areas to disseminate the key messages in an innovative, attractive and locally appropriate way aimed at improving family and community practices. Two local theatre groups have been developed and trained by a BCC organisation to perform mini theater.

A health facility survey (2003) shows significantly better care in IMCI facilities than in comparison facilities by clinical assessments and by management of presenting illnesses

while the quality of care in comparison facilities did not improve. Attendance for child health care at IMCI facilities also increased dramatically after the introduction of IMCI from 0.6 sick- child visits/child/year in the last half of 2001 to 1.9 sick-child visits/child/year 21 months after IMCI implementation, while attendance at comparison facilities declined (Fig3).

Figure 3: Sick under 5 utilization of 1st level facilities in IMCI intervention and comparison areas per 10,000 children



Reproductive Health Unit

Unmet Obstetrics Need (UON) project :

The incidence of life-threatening obstetric complications, Absolute Maternal Indications (AMIs) which require surgery (Major Obstetric Interventions) plus maternal deaths has been found to be 1% through validation in Matlab. This benchmark of 1% is now used in 7 districts to calculate the expected number of mothers with such life-threatening complications who are not being managed in EOC facilities (Unmet Obstetric Need). The districts were selected in consultation with the Ministry of Health (DGHS) and UNICEF. They include Mymensingh and Tangail in Dhaka, Noakhali in Chittagong, Jessore in Khulna, Patuakhali in Barisal, MoulviBazar in Sylhet and Bogra in Rajshahi Division, and are considered among the best performing districts in the country.

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

Between 1987-2001, use of trained attendants increased from 5% to 26% in the Matlab intervention (>1 km) areas. Distance and cost appear to be the most important barriers to the use of basic obstetric services. For both home- and facility- based strategies, the least poor were about 2 times more likely to use the services compared with the most poor despite free obstetric services. The findings suggest there is no difference in effectiveness on maternal and perinatal outcomes between home and facility-based obstetric care services.

The final dissemination of the project entitled "Acceptability, effectiveness and cost of strategies designed to improve access to basic obstetric care in rural Bangladesh", was held on September 16th.

Social & Behavioural Science Unit

Socio-cultural and behavioural component for dysentery study

Due to the symbolic significance of blood loss and the fact that there is much uncertainty regarding treatment, bloody dysentery is perceived to be extremely serious. Causal interpretations most commonly relate to humoral theories, and remedies involve the consumption of "cooling" foods that will reduce the heat associated with dysentery. Despite many misconceptions about vaccines and the fact that this approach contradicts etiological explanations, the perceived severity of the bloody dysentery makes vaccines attractive compared to other preventative measures in this case.

With less severe problems, the introduction of a vaccine without an understanding of the perceptions of illness and demand for vaccines in their social and cultural context could lead to low rates of acceptance. When launching a vaccination programme, approaches should, thus attempt to bridge biomedical and socio-behavioural perspectives by taking into account cultural constructs, perceived social risks and consequences of the illness, and the social circumstances of the target population.

Women's health and domestic violence against women

The level of physical violence against women by husbands is high in both urban (40%) and rural (42%) areas. Factors positively associated with violence are the dowry or other demands in marriage, and history of physical abuse of husband's mother by his father, while better couple communication mitigates the violence.

Women experiencing violence have poorer physical and mental health outcomes compared to the women in non-violent relationships. Most abused women (66%) were silent about their experience. The main reasons behind this silence are high acceptance of violence, stigma, and fear of greater harm. 60% of urban and 51% of rural abused women never received any help from others. Only 2% ever sought help from institutional sources, from where support was not forthcoming. Women approached these sources only when they could not endure anymore or the violence became life threatening or children were under risk.

Action research into positive and negative deviance in child nutrition in rural Bangladesh

Use of pre-lacteals and colostrums feeding are commonly practiced among both positive and negative deviant children. Complementary foods are introduced too early and almost all of the children irrespective of their positive or negative deviance status receive them at around the age of three months. The two groups differ, however, in other aspects of feeding. Positive deviants have greater quantity, quality and variety of foods and the frequency of feeding is increased. The feeding of positive deviant children is well paced and better supervised compared to the negative deviants. These findings highlight the necessity of strengthening interventions for exclusive breastfeeding but also highlight the importance of focusing on the other aspects of feeding that make a difference.

Health & Demographic Surveillance Unit

MCH interventions and causes of infant mortality in rural Bangladesh, 1988-2001:

Using data from the Matlab Health and Demographic surveillance area between 1988-2001, the study examined changes in mortality of late neonates and post-neonates (7 days-11 months) due to diarrhoea and pneumonia in ICDDR,B (intervention area) and government areas, a rural area of Bangladesh. In 1988-91 all-cause infant mortality rate was 49 in the Government area and the rate was 28% lower in ICDDR,B areas. By 1997-2001, the mortality rate had declined by more than 33% in both areas. Diarrhoea mortality declined around 50% in both areas whereas pneumonia mortality declined 17% in the ICDDR,B area and 14% in Government area in the same period. The greater decline in diarrhoea mortality resulted in pneumonia becoming the number one killer of late neonates and post-neonates in the ICDDRB area.

Factors associated with death among the elderly in Matlab, Bangladesh:

Results of a study of the socioeconomic differentials in, and causes of death of the elderly (60+) people in Matlab from 1993 to 1998, show that the risk of dying is much lower among the married elderly than widows / widowers. Elderly who were not staying with children experienced a significantly higher risk of dying, than those staying with children. Survival is higher among elderly who are literate, having land and living in households with a drinking water facility, than those who are illiterate, have no land, and stay in household with no drinking water facility. Differentials by gender in cause-specific mortality rate are minimal. Death due to most causes decreased with increasing educational level, except for cardio-vascular and malignant diseases.

The effects of birth spacing on infant and child mortality, pregnancy outcomes, and maternal morbidity and mortality in Matlab, Bangladesh:

The effects of short intervals on mortality are strongest in the earliest part of infancy and decline as the child becomes older. For both the early and late neonatal periods, inter-outcome intervals shorter than 15 months are the most pernicious. During the late neonatal period, the effects of short intervals are smaller than they are in the first week of life, but they are still statistically significant for intervals of less than three years compared to those that are longer. After the first month of life, intervals of less than 18 months are associated with high post-neonatal mortality, and after the first year of life, intervals of 18-35 months are the most detrimental.

A woman with inter-pregnancy intervals of less than six months (less than 15 months for inter-birth interval) has around a 30 percent greater chance (statistically insignificant) of maternal mortality than a woman with an inter-pregnancy interval of 27-50 months, while maternal mortality is two times higher for an inter-pregnancy intervals of 75 months or longer intervals.

Determinants and consequences of late abortion in a rural area of Bangladesh

Using birth history data from Matlab, ICDDR,B during 1998-2000, the study examines factors associated with first and second trimester abortions separately and also morbidity and mortality of women who aborted pregnancy during 28 weeks of gestation. Both bivariate and multivariate analysis and the ratio of abortions were carried out. Results of the analysis shows that education, mobility and decision making power of the women have significant positive relationship with first trimester abortion while women's age and education have significant positive relationship with second trimester aborting. It is interesting to note that in case of

first trimester abortion, women's age has a significant positive relationship when it first entered in the model. However, when women's mobility factor was added into the model, the effect of age became insignificant. This did not happen in case of second trimester abortion.

In case of morbidity, it shows that reporting morbidity pattern was slightly different between the two types of abortion. In term of trends during the 1998-2000, the study documented that both types of abortion are increasing over the years in both areas. This rise in abortion in both areas might be related with unintended pregnancy and lack of efficient supply logistics. Lower ratio of both types of abortion in the treatment area indicates that the presence of family planning intervention in the treatment area substantially reduced induced abortion.

Verbal autopsy and causes of death in Matlab HDSS

In Bangladesh, population-based data on cause of death of reasonable quality, particularly of adults and elderly is very limited. HDSS verbal autopsy, based on simple open-ended questions, has been inadequate to classify a high proportion of adult and elderly deaths. To generate population-based data on causes of death, and to estimate burden of disease with reasonable accuracy, HDSS has trained a "death survey" team and introduced structured verbal autopsy questionnaires (for neonates, post-neonates and children, and adults and elderly) modifying the WHO/INDEPTH model for local adaptation and adding supervision by public health physician in 2003. The community health research workers detect deaths, and the trained death survey team interview the family members of the deceased with the verbal autopsy questionnaires. Each questionnaire is reviewed and assigned a 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 is underway.

INDEPTH-Network has organized a workshop to harmonize the analysis of cause of death data from INDEPTH sites. This workshop has highlighted the importance of harmonization of data collection, coding and analysis of cause of death data. INDEPTH-Network is organizing a workshop for verbal autopsy coders in December 2004 on standardization of the methods to be used in coding deaths in INDEPTH sites and on sharing their experiences in the use of the standardized INDEPTH verbal autopsy questionnaire. The workshops contribute to skill development, improvement in data quality and comparability of the data across the sites.

Matlab Hospital Management System

During 2004 Matlab patient registration, clinical examination, diagnosis and treatment have been computerized to get instant reports, and for retrieval of a patient's prior clinical and microbiological records. Large numbers of patients are admitted to Matlab hospital every year with the majority coming from out of the HDSS study area. The newly developed client/server- based Hospital Management System allows us to trace them over time.

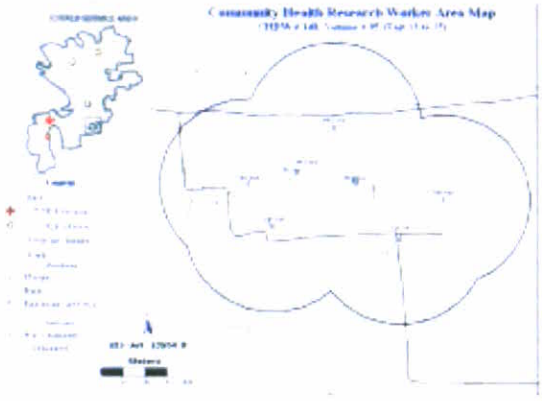
Key features of the system are:

- Graphic and text reports can be generated at any point in time, enabling the decision-maker to see different patterns.
- Historical information of patients can be retrieved (previous cause of admission, management, etc.).
- Patient's historical laboratory information can be displayed, which will be important to see the patterns of organism isolation (previous pathogen isolation, sensitivity, etc.).

- Patient's ID (HDSS residence/Outside residence) can be retrieved easily with the help of a new algorithm, even when a patient cannot recall his/her ID number.

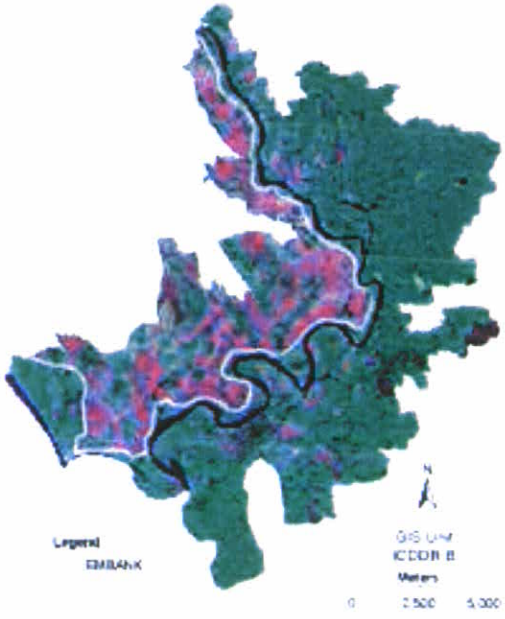
GIS activities

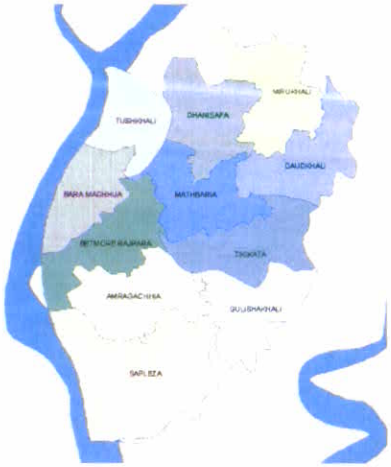
Currently being added to the spatial database for the HDSS study area are the locations of tubewells, ditches, ponds, health facilities, educational institutes etc. Spatial data collection, processing and spatial analysis are still ongoing for some of the projects like IMCI, arsenic studies and MINIMat. The map shows how new CHRW working areas were defined in the ICDDR,B areas (indicating bari locations, with some other structures).



Due to development of new software and satellite imaging, there is increased scope to expand GIS activities in different fields. The GIS unit currently generates thematic maps, creates spatial variables, and is doing spatial analysis with geo-referenced data. Spatial analysis can generate surfaces to see the spatial and temporal relationships. Any kind of spatial information can be extracted from high-resolution imagery. Population distribution and clustering of the population and disease patterns can be visualized using GIS tools. A Landsat TM image shows the difference of vegetation within the embankment and outside of embankment in Matlab study area. We have a high resolution QuickBird satellite image of Matlab area.

Satellite Image of Matlab Study Area





Spatial data like household location, water bodies, location of health facilities will be collected at Mathbaria and Bakergonj upazila to fulfills the requirements of the project "Epidemiology and Ecology of *V. Cholerae* in Bangladesh" that started from April, 2004. The objective of the study is to select five neighboring unions from the Upazila hospital from where most patients come and identify the contaminated ponds, ditches and spatial clustering of the cholera patient. Any ecological effect of the clustering and other spatial relationships will be investigated.

Arsenic

A large surveillance study correlating arsenic exposure and health and reproductive outcomes is nearing completion. The population of Matlab was surveyed to determine the numbers of cases of aresenicosis along with measurement of arsenic concentrations in the tube wells of Matlab. A dissemination seminar to release the findings of this study is planned for late 2004.

Flocculent technology for arsenic

The flocculent-disinfectant intervention significantly reduces arsenic levels in tubewell water and, to a lesser extent, urinary arsenic in women who consume treated water. Following initiation of treatment with flocculent disinfectant, arsenic concentrations in drinking water decreased by an overall mean of 138 μg/L (85%, $p<0.0001$); 88% met the Bangladesh standard of <50 μg/L. Also, 96% of the pond water samples met the WHO bacterial potability guideline. Samples showed distinctly improved clarity which would enhance acceptability. This strategy has a potential role to provide drinking water with improved quality and safety to communities in rural areas.

CURRICULUM VITAE
OF
Dr. Marjorie Koblinsky

EDUCATION

1978 Certificate of Community Medicine and Health, Liverpool School of Tropical Medicine
- Public health at community level focused on mothers and children

1976 Institute of Development Studies, Sussex, UK
- Study program on public health in developing countries

1968-1973 Doctor of Philosophy, Columbia University, Graduate Faculties, New York, Biochemistry
- Dissertation: Mechanism of action of steroid hormones

1963-1967 Bachelor of Science, Simmons College, Boston, Massachusetts
- Chemistry (with High Distinction)

PROFESSIONAL EXPERIENCE

2002-present Johns Hopkins University, Bloomberg School of Public Health, Dept of Population and Family Health Sciences, Sr. Scientist
Initiative for Maternal Mortality Programme Assessment (IMMPACT)
Coordinator, North American Consortium

As Sr Scientist with JHU, I direct the work with IMMPACT, a seven-year global initiative to determine effective and cost-effective strategies to reduce maternal mortality and severe morbidity, and their implications for equity and sustainability. To help generate this new knowledge and ensure its use by policy makers and program managers, IMMPACT is enhancing the methods for measuring maternal mortality and other relevant health outcomes and processes and strengthen capacity for evidence-based decision-making and rigorous evaluation. Applied research activities are conducted through a collaborative network of country and technical partners, with a focus on eight developing countries.

2000-2002 Save the Children Federation, Washington, DC
Project Director, NGO Networks for Health

NGO Networks was a USAID cooperative agreement with Save the Children for $48 million over five years to improve services and practices for reproductive health through networks of PVOs and local NGOs. A consortium of five PVOs, including CARE, Save the Children, Plan International, ADRA, and PATH, NGO Networks implemented 15 projects in 11 countries through the local offices of the PVOs. As Project Director, I

provided the technical guidance for the project (starting in its third year), and managed its implementation with between 8 and 20 staff.

1989-2000 John Snow, Inc., Arlington, Virginia
Project Director, MotherCare

Over the 12 years of its operation, MotherCare worked in 22 countries, implementing over 40 projects funded by a series of USAID contracts totaling nearly $50 million. Ending in 2000, it produced over 100 articles, 11 training manuals, and 29 issues of the newsletter and policy briefs, and paved the way for safe motherhood programming in many countries. As Project Director, I provided the technical leadership and managed up to 50 staff at any one time in the head office and three field offices.

1986-1989 Ford Foundation, New York, Urban Poverty Program
Program Officer, Reproductive Health

1983-1986 International Centre for Diarrhoeal Disease Research, Bangladesh
Scientist, Community Services Research Working Group
Project Director, MCH-FP Extension Project (1984-1986)

1981-1982 Johns Hopkins University, Baltimore, Maryland
Instructor, Department of Ophthalmology
Program Manager, Vitamin A Deficiency, International Center for Epidemiological and Preventive Ophthalmology

1977-1980 International Development Research Centre (IDRC), Asia Regional Office, Singapore
Program Officer, Health Sciences Research

1973-1976 Ford Foundation, New York, New York
Project Specialist, Population
Assistant Director, Review of Reproductive Sciences and Contraceptive Development, Population Division

PROFESSIONAL AFFILIATIONS

1997-present Associate, Department of International Health, Johns Hopkins University, School of Hygiene and Public Health

1999-2002 Honorary Senior Lectureship in the Department of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, University of London

JOURNAL ARTICLES

Koblinsky M, L Sibley, N. Kureshy. Increasing use of skilled birthing or emergency care for maternal survival: challenges for Safe Motherhood. (Submitted 2004)

Sibley L, Sipe T and M Koblinsky. Does training of traditional birth attendants improve referral of obstetric complications: A review of the evidence. (Submitted 2004)

Sibley L, Sipe T and M Koblinsky. Does training of traditional birth attendants increase use of antenatal care services: A review of the evidence. J Midwifery Womens Health Jul-Aug 2004; 49(4):298-305.

Koblinsky M and OMR Campbell. Factors affecting maternal mortality reduction: Learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica and Zimbabwe. (Submitted 2003)

Ronsmans C, Achadi E, Supratiko G, Zazri A, McDermott J and Koblinsky M (2001). Evaluation of a comprehensive home-based midwifery programme in South Kalimantan, Indonesia. Trop Med and International Health. 6(10): 799-810.

Ronsmans C, Campbell OMR, McDermott J and Koblinsky M (2002). Questioning the indicators of need for obstetric care. WHO Bull 80: 317-324

Koblinsky M, Campbell O, Heichelheim J (1999)..Organizing delivery care for safe motherhood Bulletin of the World Health Organization. 77(5): 399-406.

Kwast, B.E. and Koblinsky, M.A. (1995). Starting Maternity Care Programmes in Developing Countries to Reduce Maternal Mortality. Contemp. Rev. Obstet. Gynaecol., 7: 220-225

Koblinsky, M.A.(1995). Beyond Maternal Mortality: Magnitude, Interrelationship, and Consequences of Women's Health, Pregnancy-related Complications and Nutritional Status on Pregnancy Outcomes. International Journal of Gynecology & Obstetrics 48 (Suppl): S21-S32

Alisjahbana A., Williams C, Dharmayanti R, Hermawan D, Kwast BE, and Koblinsky M(1995). An Integrated Village Maternity Service to Improve Referral Patterns in a Rural Area in West-Java. International Journal of Gynecology & Obstetrics 48 (Suppl):S83-S94

Campbell O, Koblinsky M, Taylor P(1995). Off to a Rapid Start: Appraising Maternal Mortality and Services. International Journal of Gynecology & Obstetrics 48 (Suppl):S33-S52 .

Koblinsky MA, Tinker A. and Daly P (1994). Programming for Safe Motherhood: a guide to action. Health Policy and Planning 9(3): 252-266

Fauveau V, Mamdani M., Koblinsky M, and Steinglass R (1992). Maternal Tetanus: Magnitude, Epidemiology and Control of a Neglected Cause of Maternal Mortality. International Journal of Gynecology and Obstetrics 40:3-12.

Koblinsky, M.A., Griffey Brechin, S.J., Clark, S.D., Yousaf Hasan, M.(1989). Helping Managers to Manage: Work Schedules of Field Workers in Rural Bangladesh. Studies in Family Planning 20(4):225-234

Simmons, R., Koblinsky, M.A., and Phillips, J.F.(1986). Client Relations in South Asia: Programmatic and Societal Determinants. Studies in Family Planning 17(6): 257-268

Koblinsky, M.A., Huque, Z., Baqee, L. Island, T., Rahman, A., and Ali, S. (March 1985). Operational Research in the Public Sector. Implementation and Priorities. Diarrhoeal Dialogue 29:4-5

Stanton, B., Clemens, J., Koblinsky, M., Khair, T.(1985) Developing World The Urban Volunteer Programme in Dhaka: A Community-based Primary Health Care and Research Initiative. Tropical and Geographical Medicine 37:183-187.

Feachem, R.G. and Koblinsky, M. (1984). Interventions for the Control of Diarrhoeal Diseases among Young Children: Promotion of Breast Feeding. Bulletin of the World Health Organization 62 (2): 271-91

Feachem, R.G. and Koblinsky, M. (1983). Interventions for the Control of Diarrhoeal Diseases among Young Children: Measles Immunization. Bulletin of the World Health Organization 61(4): 641-652

Harkavy, O., Jaffe, F., Koblinsky, M. and Segal, S. (1976). Funding of contraceptive research. Proc R Soc Lon B 1195: 37-55

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Koblinsky, M., Beato, M., Kalimi, M., and Feigelson, P.(1972). Glucocorticoid-binding proteins of rat liver cytosol: Physical characterization and properties of the binding proteins. Biol Chem 247: 7897-790

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Koblinsky, M. Para salvar la vida. La Paz, Bolivia: Stampa (1996).

Turman, T., AbouZahr, C., Koblinsky, M. (eds). International Journal of Gynecology & Obstetrics: Reproductive Health: The MotherCare Experience 48: Supplement (1995).

Koblinsky, M., Timyan, J., and Gay, J., (eds). Women's Health: A Global Perspective. Boulder, Co: Westview Press (1992).

Greep, R.O. and Koblinsky, M., (eds). Frontiers in Human Reproduction and Fertility Control. Cambridge: MIT Press (1977).

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Koblinsky M. Indonesia Case Study, 1990-1999. In In Factors Affecting Maternal Mortality Reduction: Lessons from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, and Zimbabwe. Washington, DC: World Bank (2003)

Koblinsky MA (as part of IOM Committee). Systems of Care for Mothers and Neonates. In Improving Birth Outcomes in Developing Countries. Stoll B and Lucas A (Co-Chairs). Washington DC: Institute of Medicine (2003)

Koblinsky, M.A. (as part of the NAS Committee). Healthy Pregnancy and Childbearing. In Reproductive Health in Developing Countries. Haaga, J., Tsui, A., and Wasserheit. (eds). Washington, DC: National Academy Press (1997).

Koblinsky, M.A., Community Health Workers. In Reaching India's Poor: Non-governmental approaches to Community Health. Pachauri, S. (ed.), New Delhi: Sage Publications. P389-416 (1994).

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Koblinsky M, Conroy C, Kureshy N, Stanton M, and Jessop S. Issues in Programming for Safe Motherhood. Washingon DC: John Snow Inc/MotherCare (2000)

Reed, H, Koblinsky, M, and Mosley, H. (Eds). The Consequences of Reproductive Morbidity, Maternal Morbidity and Maternal Mortality, Washington, DC: National Academy Press (1999)

Campbell O, Fillippi , Koblinsky M, Marshall T, Mortimer J, Pittrof R, Ronsmans C, and Williams L. Lessons Learnt: A decade of measuring the impact of safe motherhood programmes. London: London School of Hygiene and Tropical Medicine (1997)

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Koblinsky, M.A., Timyan, J., and Gay, J. "Women's Health at the Crossroads" Excerpts from The Health of Women: A Global Perspective. Koblinsky, M.A., Timyan, J., and Gay, J. (eds). Partnership for Safe Motherhood paper (1992).

Measham, D.M. with Koblinsky, M. Maternal Mortality: Levels, Trends, and Determinants, Working Paper 10, Arlington, Virginia: MotherCare (1991).

NEWSLETTERS (Editor, Commentator, Author):

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MotherCare, John Snow, Inc. August 1999. "Scaling-up MotherCare". MotherCare Matters, Vol 8. No. 2

MotherCare, John Snow, Inc. May 1999. "Safe Motherhood Indicators--Lessons Learned in Measuring Progress". MotherCare Matters, Vol. 8, No.1

MotherCare, John Snow, Inc. October 1997. "Learning and Action in the First Decade: The MotherCare Experience". MotherCare Matters, Vol. 6, No. 4

MotherCare, John Snow, Inc. August/September 1997. "Methodological Issues in Perinatal Mortality Research". MotherCare Matters, Vol. 6, No. 3

MotherCare, John Snow, Inc. March/April 1997. "A Tribute to Jose Luis Bobadilla". MotherCare Matters, Vol. 6, No. 2

MotherCare, John Snow, Inc. August 1996. "Improving Obstetrical and Neonatal Management: Lessons from Guatemala". MotherCare Matters, Vol. 5, No. 4

MotherCare, John Snow, Inc. December 1995. "Young Adults—Is Age a Risk Factor?" MotherCare Matters, Vol. 5, No. 2/3

MotherCare, John Snow, Inc. February/March 1995. "On the Pathway to Maternal Health - Results From Indonesia". MotherCare Matters Vol 5, No. 1

MotherCare, John Snow, Inc. June 1994. "Healthy Pregnancy, Safe Delivery - The MotherCare Experience". MotherCare Matters Vol 4, No 2

MotherCare, John Snow, Inc. April 1994. "Anaemia and Women's Health". MotherCare Matters Vol 4, No 1

MotherCare, John Snow, Inc. April/May 1993. "Anaemia and Pregnancy". MotherCare Matters Vol 3, No 1/2

MotherCare, John Snow, Inc. October 1992. "Defining and Measuring Morbidity: a first step toward action". MotherCare Matters Vol 2, No 4

MotherCare, John Snow, Inc. May/June 1992. "How can maternal mortality be reduced?". MotherCare Matters Vol 2, No 2/3

MotherCare, John Snow, Inc. October/November 1991. "Is perinatal mortality a useful indicator of maternal mortality?". MotherCare Matters Vol 2, No 1

MotherCare, John Snow, Inc. March 1991. "Reducing Perinatal Mortality: identifying and modifying risk factors". MotherCare Matters Vol 1, No 4

MotherCare, John Snow, Inc. September/December 1990. "Perinatal Mortality: the uncounted millions". MotherCare Matters Vol 1, No 2/3

MotherCare, John Snow, Inc. June 1990. "Overview - Maternal Health". MotherCare Matters Vol 1, No 1

AWARDS

1998 MotherCare Project-Recipient of 1998 World Health Day Award, American Association of World Health
1993 Recipient of the International Health Award, NCIH

MEMBERSHIP

Advisory Board Member

Global Outreach Department, American College of Nurse-Midwives
SAFE Project, University of Aberdeen
Saving Newborn Lives, Save the Children

Committee Member

Committee on Reproductive Health, National Academy of Sciences 1994-1997
Committee on Birth Outcomes, Institute of Medicine 1999-2002

Stephen P. Luby

Programme on Infectious Diseases & Vaccine Sciences
ICDDR,B Centre for Health and Population Research
Mohakhali, Dhaka 1212, Bangladesh

work phone 880 2 9881761
home phone 880 2 885 5583
fax 880 2 882 3963
email sluby@icddrb.org

Educational Background

Creighton University 1981
Bachelor of Arts, *summa cum laude* (philosophy)

University of Texas--Southwestern Medical School at Dallas
MD 1986

University of Rochester--Strong Memorial Hospital
Internship and residency in Internal Medicine.

Centers for Disease Control -- Epidemic Intelligence Service 1990
Completed Preventive Medicine Residency 1993

Professional Background

ICDDR,B Centre for Health and Population Research
Head, Programme on Infectious Diseases and Vaccine Sciences, 8/04 - current

Centers for Disease Control and Prevention
Medical Epidemiologist, Foodborne & Diarrheal Diseases Branch, 12/98 – 7/04
Major responsibilities

1. Direct the activities of the Cooperative Research and Development Agreement between the Procter and Gamble Company and Centers for Disease Control, Foodborne and Diarrheal Diseases
2. Direct a research program on typhoid fever epidemiology
3. Primary supervisor of 2 – 4 Epidemic Intelligence Service Officers 8/01 – 7/04
4. Principle investigator of international research projects with an average ongoing total employment of over 60 persons

Aga Khan University, Karachi, Pakistan
Assistant Professor, Epidemiology, Community Health Sciences Department, 10/93 - 10/98

Centers for Disease Control and Prevention, Atlanta, Georgia
Preventive Medicine Resident, Malaria Branch, 7/92 - 9/93

Centers for Disease Control, Atlanta, Georgia
Epidemic Intelligence Service officer, Division of Field Epidemiology
stationed at South Carolina Department of Health and Environmental Control 7/90 - 6/92

Languages

English - native language, speak and write fluently

Spanish - Can work professionally in Spanish speaking countries including negotiation of projects, protocols, and implementation details with Spanish speaking colleagues, scientific presentations, and routine correspondence

French - basic conversational, reading, and writing skills

Urdu - basic conversational skill

Bangla – just starting

Certifications and Awards

Diplomate, National Board of Medical Examiners, 1987, #332215

Diplomate, American Board of Internal Medicine, 1989, #127955

Georgia Composite State Board of Medical Examiners, 1992, #035937

Outstanding Teaching Award, Department of Community Health Sciences, Aga Khan University, 1996

HIV/AIDS Prevention Shield, for contributions to prevention of HIV/AIDS in Sindh, Pakistan, Government of Sindh, 2001

Senior author on Alexander D. Langmuir Prize Manuscript, Center for Disease Control, 2001. (Brooks JT, Rowe SY, Shillam P, Heltzel DM, Kamm K, Hannah EL, Hunter SB, Puhr ND, Slutsker L, Hoekstra, RM, Luby SP. *Salmonella* Typhimurium infections transmitted by chlorine-pretreated clover sprout seeds.)

Senior author on Nakano Award Manuscript, National Centers for Infectious Diseases, Centers for Disease Control, 2004 (Reller ME, Mendoza CE, Lopez MB, Alvarez M, Hoeskstra RM, Olson CA, Baier KG, Keswick BH, Luby SP. A randomized controlled trial of household based flocculant-disinfectant drinking water treatment for diarrhea prevention in rural Guatemala. *Journal of the American Society of Tropical Medicine & Hygiene.* 2003; 69:411-419.)

Grants

Have secured a total of $3.5 million in research funds including:

- $2.7 million dollars as lead investigator on externally funded research
- $750,000 as co-investigator on externally funded research

Bibliography

Published 79 peer reviewed scientific manuscripts including:

- 20 as first author
- 23 as second author
- 24 as senior author

8 additional manuscripts in press

Selected Publications:

Luby S, Kazembe P, Redd S, Ziba C, Nwanyanwu O, Hightower A, Franco C, Chitsulo L, Wirima J, Olivar M. Clinical signs for the diagnosis of anemia in African children, *Bulletin of the World Health Organization.* 1995 73:477-482.

Marsh D, Husein K, Lobo M, Ali Shah M, Luby S. Verbal autopsy in Karachi slums: comparing single and multiple cause of child deaths. *Health Policy and Planning,* 1995 10(4) 395-403.

Redd S, Kazembe P, Luby S, Nwanyanwu O, Hightower A, Ziba C, Wirima J, Chitsulo L, Franco C, Olivar M. Clinical algorithm for the treatment of *Plasmodium falciparum* malaria in children. *Lancet.* 1996 347:223-227.

Marsh D, Hashim R, Hassany F, Islam N, Kara A, Kamal K, Mubin T, Mirza O, Rizvi N, Jalisi F, Janoo J, Hussain N, Iqbal Z, Irfanullah A, Khan A, Khan R, Pirzada F, Hussain A, Ansari G, Siddiqui A, Luby S. Front-line management of pulmonary tuberculosis: an analysis of TB diagnosis and treatment practices in urban Sindh, Pakistan. *Tubercle and Lung Disease.* 1996 77:86-92.

Luby S, Hassan I, Jahangir N, Rizvi N, Farooqi M, Ubaid S, Sadruddin S. Road traffic injuries in Karachi: the disproportionate role of buses and trucks. *Southeast Asian Journal of Tropical Medicine and Public Health.* 1997, 28(2):395-398.

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Luby S, Syed A, Atiullah N, Faizan K, Fisher-Hoch S. The limited effectiveness of home drinking water purification efforts in Karachi, Pakistan. *International Journal of Infectious Diseases.* 2000 Jan; 4(1):3-7.

Luby S, Khanani R, Zia M, Ali M, Vellani Z, Qureshi AH, Khan AJ, Mujeeb SA, Shah SA, Fisher-Hoch S. An evaluation of blood bank practices in Karachi, Pakistan and the government's response. *Health Policy and Planning.* 2000 Jun; 15(2):217-222.

Luby S, Agboatwalla M, Raza A, Sobel J, Mintz ED, Baier K, Hoekstra RM, Rahbar MH, Hassan R, Qureshi SM, Gangarosa EJ. Microbiologic effectiveness of hand washing with soap in an urban squatter settlement, Karachi, Pakistan. *Epidemiology and Infection.* 2001 Oct;127(2):237-44.

Luby S, Agboatwalla M, Razà A, Sobel J, Mintz E, Baier K, Rahbar M, Qureshi S, Hassan R, Ghouri F, Hoekstra R, Gangarosa E. A low-cost intervention for cleaner drinking water in Karachi, Pakistan. *International Journal of Infectious Diseases.* 2001; 5(3):144-150.

Luby S, Zaidi N, Rehman S, Northrup R. Improving private practitioner sick-child case management in two urban communities in Pakistan. *Tropical Medicine & International Health.* 2002 March;7(3):210-219.

Luby S, Agboatwalla M, Schnell B, Hoekstra RM, Rahbar MH, Keswick B. The effect of antibacterial soap on impetigo incidence, Karachi Pakistan. *Journal of the American Society of Tropical Medicine & Hygiene.* 2002; 67(4):430-435.

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ICDDR,B: Centre for Health and Population Research

External Review of the Clinical Sciences Division (CSD)

Review Team:

Prof. Claudio F. Lanata (Chair)
Senior Researcher
Instituto de Investigación Nutricional, Lima, Peru.

Prof. A. K. Azad Khan
Dhaka, Bangladesh

Mr. Abdul-Muyeed Chowdhury
Executive Director,
BRAC, Dhaka, Bangladesh

Prof. William B. Greenough, III
Johns Hopkins Geriatrics Center, Baltimore, MD, USA.

Dr. Dilip Mahalanabis
Director
Society for Applied Studies – SAS, Kolkata, India.

Dr. Ahmed Al-Kabir
Country Director
Unity for Helping Partners – UFHP, John Snow International, Dhaka, Bangladesh.

October 28-30, 2003

Review Process

The external review of the Clinical Sciences Division (CSD) of ICDDR,B: Centre for Health and Population Research was organized by the Centre, as agreed with the Board of Trustees (BoT). The review was scheduled just prior to the November 2003 meeting of the BoT, with the scheduled described in Annex 1 of this report.

The Centre's Director welcomed the review team noting its importance given that an external review of CSD was long overdue, and that important decisions were expected to be taken by Dr. M.A. Salam, recently appointed as the Head of the Division, where the recommendations of the review team would serve as an important input. Dr. Sack asked the review team to consider the activities of the CSD in the areas of research and training, and in the services provided by the Dhaka Hospital, including its financial aspects. In reviewing these activities, the recently published strategic plan of the Centre should be taken into consideration. He requested the review team to also consider seven questions he considered important to be covered by the review, as indicated in his letter to the review team (Annex 2).

After an initial meeting with Dr. Salam, to discuss the agenda of the review, a quick tour of the Hospital, known as Dhaka Hospital or Cholera Hospital, was made, including its various inpatient facilities, kitchen and laundry, followed by visits to the Physiology Laboratory, the Special Procedure Clinic (the old "Traveller's Clinic"), the Progati Samaj Kallyan Protisthan (PSKP) Clinic, the Child Development Unit (CDU), and the Nutrition Unit. During the visit, several aspects of the clinical services provided were noted and discussed with Dr. Salam.

Dr. Salam then presented the divisional activities, in the presence of CSD staff and the Centre's Associate Directors. Dr. Salam's presentation was a summary of a very extensive report that was provided ahead of the review to each members of the review team (Annex 3). He also presented the major recommendations of the previous CSD review conducted in 1995, noting that many of the problems identified during the review still persist. Presenting the clinical services provided by the division, it was noted that several other units and programmes of the Centre provide clinical care to patients- activities not included in the CSD, and therefore, not monitored by their staff. The most relevant among them was the Matlab Hospital, operated by another division of the Centre. The reviewers' team commented that the current structure may not be ideal, since it lacks in coordination and utilization of resources, as well as possible existence of more than one standard of care within the Centre. The Hospital in Dhaka provides care for around 100,000 patients, with an estimated 15,000 to 20,000 deaths averted each year. A significant proportion of these patients (about 40%) are currently being transferred to the PSKP Clinic after initial assessment upon arrival by the triage nurse, due to their milder nature of diarrhoea. It was noted that even though this constitutes a significant reduction in the demand for care in the Dhaka Hospital, its operation costs is maintained at the same level, and thus the cost per patient treated in the hospital has increased. The PSKP Clinic was reported to provide good clinical care, as well as education and other services to patients; however, this effective

model of provision of primary care to diarrhoeal patients has not being extended to the other six clinics that PSKP has in the Dhaka city, were they provide an Essential Services Package with the fund support of USAID.

The hospital operates under several constrains, mainly the lack of an adequate number of staff, small space for the number of patients admitted, leading to overcrowding; inadequate hand washing facilities for patients, relatives and staff; no radiologist; and older equipments that have not being replaced lately such as X-ray machines and laundry facilities. An old study of hospital infections showed a significant rate of hospital-acquired infections at the hospital. Such a study was not repeated. An audit of medical records of patients who died in the hospital was used in the past to identify problems that could be solved, but it has not currently done. The managerial style to run the hospital was mainly through participation of the heads of three units. No group discussion and problem solving methods were used. With the exception of the number of patients treated and the number of deaths, there is no other regular data collection system in place to monitor the quality of care provided to the patients.

On the second day of the review, a more detail presentation of the many research activities of the CSD were presented to the review team. These research activities were undertaken both with project funds as well as core funds, although there were complains that some of the studies (mostly the physiology ones) were not given priority by the management in the past. The financial constraints of the division did not allow opening of new areas of research, even though some progress have been made in the area of tuberculosis and acute lower respiratory diseases (ALRI) research. The preliminary results of an "Exit Interview" study conducted by members of another division (HSID) were presented and discussed.

On the last day of the review, a site visit to the Kamalapur Field Clinic was done, where several aspects of the field works done in the area was presented and discussed. Members of the review team then had individual meetings with invited members of the CSD to find out their own views on the main problems facing the CSD; one group met with nurses and other service staff; another group met with the doctors doing their fellowship at the CSD; and the third group was available to any member of the CSD who wanted to meet privately with the review team.

A preliminary report of the review team was then prepared and presented to Dr. Salam for initial comments, then to Dr. Sack, and finally, as part of the BoT meeting, to the full Board in a session where the Director, Associate Directors and Unit Heads were also present.

Key Findings

The review of the CSD included several aspects of the research, training and services provided by the Division, although, due to lack of time, the team could not review all activities performed. It is important also to mention that Dr. Salam's role as Associate Director and Head of the CSD was recent, without sufficient time to introduce new changes in the way the Division is operating. The following were the main findings highlighted in the review.

Research Activities

The team felt that that the research activities of CSD were outstanding, with several lines of research either opening new grounds and/or moving to the field for wide implementation. Several examples were provided in which an idea tested initially in the Physiology Laboratory later underwent clinical studies in humans confirming the initial results, and then moving towards wider implementation in the field. These characteristics of the research conducted at the CSD were considered unique, which should be preserved and strengthened.

The following were considered the most important review findings of specific research activities presented:

Physiology Laboratory

The research conducted in this laboratory, under the leadership of Dr. GH Rabbani, was outstanding. Many of the reviewers considered the type of research conducted as unique in the world, breaking new grounds in the area of diarrhoeal diseases, such as the works with polyphenols and with green bananas, increasing short chain fatty acids in the gut, with significant improvement of diarrhoeal diseases in animal models and humans. It was also important to note the work with antioxidants in arsenic toxicity. It was felt, however, that.this laboratory has not expanded its work to cover other research areas outlined in the Centre's Strategic Planning such as in ALRI or tropical diseases, which should be done in the future.

Breast Feeding Counseling Unit

The work of this unit, which started in the Hospital as a research activity, has being expanded to document impressive results in the promotion of exclusive breastfeeding in the field, including its impact on morbidity. The review team considered that the work of this unit in the hospital should now be part of the regular hospital services to the patients, involving all of its nurses, to make it sustainable. The review team also considered it of high priority to expand the activities of the unit promoting the intervention for wider dissemination and implementation in Bangladesh including at GoB health facilities. These activities should be able to be supported by many donors.

Complementary Feeding Study

Dr. M. Islam presented the design and initial results of the complementary feeding study. This study is developing interventions to increase the energy density of complementary foods. It was still in its developmental phase. Given its importance for nutrition interventions in Bangladesh, the study should be supported to develop interventions that could be widely promoted and practiced. The review team

recommended to consider recipes prepared with the cheapest sources of protein and energy (which could be determined by computer programs), according to the market value of different food products in each region, and to include interventions that could be implemented at the primary health care.

Child Development Unit (CDU)

Dr. Jena Hamadani presented the comprehensive research portfolio of the Child Development Unit, with several tools developed to measure child development and to study them in relation to malnutrition, micronutrients status and intervention, and arsenic toxicity. The studies were very well received by the review team. The statistically negative correlation between child development and zinc supplementation was considered to be of relatively minor biological magnitude, which should be replicated in other studies before any major conclusion could be taken. It was felt that many of the tests being applied have been used very infrequently in developing countries, and it would be important to validate results of the studies to demonstrate its value and applicability in poor countries with different cultural backgrounds. It was also noted that many of the studies assumed that the results of the test applied would be easily interpreted by policy makers, which may not be the case. It was recommended that studies cross-validating the developmental tests with study outputs that would be easily understood by policy makers e.g. like school performance or later job experiences, would help proper interpretations of the importance of the indicators being developed by the policy makers.

Improved ORS

Dr. PK Bardhan presented very important studies where liposomes where used as a novel delivery mechanism to facilitate absorption of electrolytes in the gut, with a very small osmolar value. Tapioca was used instead of glucose, to improve the cost of the solution being developed. The results presented were very promising, justifying its evaluation in clinical trials. Dr. NH Alam later presented the large phase IV study evaluating the acceptability and efficacy of the low-osmolar ORS solution currently recommended by WHO.

Research with enteric enterophathogens

Limited work was done currently on specific enteropathogens. The work with *Helicobacter pylori* presented by Dr. SA Sarker was a good example of how they should be continued.

ALRI Studies

Dr. H Ashraf presented a day care-based study on the clinical management of children with moderate or severe ALRI (pneumonia cases defined with WHO definition) who were referred to the hospital for admission but could not be admitted due to shortage of beds. The review team was pleased that clinical studies

on ALRI were starting, and recommended that such works be continued. Basic physiologic studies on ALRI (pneumonia and broncheospastic airways diseases) were also recommended.

Tuberculosis Studies

Dr. T. Ahmed presented a study on childhood tuberculosis, in which several diagnostic procedures were used. It was expected that such studies could help identify a study design that could be used in further epidemiological studies of tuberculosis in children and subsequently in evaluating new tuberculosis vaccine candidates. The studies were in its initial stages, however, CSD were congratulated for these studies. It was recommended that the new diagnostic test using lymphocytes secreted antimicrobial antibodies developed at the Laboratory Sciences Division should be included in the package of diagnostic tests being evaluated.

Hospital Surveillance Program

The reviewers considered that this long lasting surveillance program has produced important results in the detection of new diarrhoeal diseases outbreaks as well as in monitoring the occurrence of epidemics and shifting in the incidence of enteropathogens monitored along with monitoring of the antimicrobial susceptibility of important enteric bacterial pathogens. The review team recommended preservation of these studies.

Zinc supplementation studies

Dr. SK Roy reviewed several clinical studies conducted by CSD for evaluation of Zn supplementation in the management of diarrhoeal diseases including cholera and persistent diarrhoea. The studies were considered to be of very high quality as well as important for the Centre's research portfolio in the area of micronutrient research.

Despite important research conducted by CSD, it was apparent to the review team that a miss-match existed between the research themes currently covered by the CSD and the research outlined in the Centre's strategic planning. It was recommended that additional funding be located to expand or initiate studies on ALRI, including basic physiology studies; tuberculosis; tropical diseases such Dengue; and studies in perinatology and maternal health.

Clinical Services

The clinical services provided at the hospital were an important activity of the CSD. The review team highlighted several aspects of the services provided:

- The hospital is providing services to a large number of patients each year, which seems to have become stable over the latest years, even though Dhaka population keeps

increasing. This would imply that the rate of hospital attentions per population may be decreasing, due either to more hospitals delivering similar care, improved primary health care, or changes in the epidemiology of severe diarrhoeal diseases. It was recommended that the number of hospital visits should be expressed both in absolute numbers as well as a population-based rate.

- The review team considered that the franchising experience of the hospital was very successful, displacing a significant proportion of patients outside of the hospital without compromising the quality of care. The benefit of this has not been well documented. It was suggested that the consequent reductions in the patient load at the hospital should have freed hospital staff to provide more closer observation and better attention to sicker patients, for instance.
- A unique characteristic of the hospital was that there was no significant waiting time for an initial evaluation and proper attention. This was considered a very important characteristic of the system, which should be preserved.
- The number of staff-to-patients ratio was considered very low. This should be studied to find out an ideal ratio and/or search for other options to solve this problem such as the use of students or hospital volunteers that could increase the number of service provider without increasing hospital expenditures. The division needs to develop a system of volunteers /students to help in its clinical services.
- Doctors currently visit admitted patients during rounds, twice per day. Accepting the universal principle that any patient admitted to a hospital should be seen by a doctor as soon as possible, the current system limits the scope of a doctor's assessment of a patient until the next scheduled round. Even though doctors are available on call, they see patients between rounds only if the nurses call for their services. The review team suggested that the issue be studied to identify the potential consequences to patients, and also to examine alternatives to assure an initial medical assessment of patients as soon as possible after their admission to the hospital.
- Even though junior doctors are periodically provided with technical updates, no such programme exist for nurses and other professional staff in the Division, faltering their professional development.
- Current management does not have provisions for broad participation by all categories of staff in the decision-making processes and problem solving activities. There also is a lack of an open forum for self-assessment and problem solving approaches.
- Nurses and other staff need to be active participants, teaming with doctors and management, to improve quality of care and services overall. The whole concept of teams as a working strategy of the division needs to be built.
- Excellent initial study on quality of care and patient's satisfaction, with key preliminary results:
    - No waiting time
    - No major problem of extra payments
    - Current registration fee well accepted
    - General willingness to pay for food and lodging
    - General willingness to pay for medications
    - Very short time for provider-patient interaction
    - Attention given mostly for medical aspects of care; very little time given for reassurance/counseling and mother's/family support/education.

  - Privacy not perceived as a major concern of patients, although it is a real problem. Provision for privacy needs to be created.
  - No good explanation is provided to the patients as to why are they referred to the PSKP Clinic.
  - The study did not include evaluation of workers' satisfaction.
  - The study did not include how units and teams of the hospital interact to improve quality of care or variables that may be considered to improve and support team building.
- The majority of patients came from known clusters in Dhaka. These sites should be evaluated as potential starting points to place new franchising clinics, as a strategy to decrease attendance to the hospital.
- Even though the quality of care was considered "good" there were many aspects that needed improvement. Protocols should be clearly defined and adherence to them should be monitored.
- There is a need to identify data needed for decision-making. This could include development of a clinical record that fully or partially could be entered into a computer database. Other mechanisms to generate data should include simple and rapid systems, such as "quick and dirty studies" aimed to seek response to key questions generated during quality improvement exercises.
- Serious financial problems to run the hospital exist, which needs a strategic solution. Funds given to ICDDR,B earmarked for the hospital as well as other source(s) of existing funds supporting the hospital need to be identified. A business plan to generate income from services with potentials should be developed, which should be identified with the help of consultants and market research studies. Several services already providing such services, such as the diagnostic unit and paid immunization services, could be expanded to generate additional income for the Division.
- There is a need to develop a cost-center concept, and ways to cover cost of services provided by the division.

Training Services

The CSD is providing several types of training. This however, does not play a prominent role in the division activities. The presentation of the CSD did not include a section presenting those activities fully, and the review team did not have the capacity to go over them in detail. However, some important aspects were identified:

- Training activities are not done in a structured system. Activities are organized independently of each other, responding to emerging needs, without a program to describe them and to potentiate them.
- The CSD is under-utilizing its training opportunities and their potential. Many of them could generate income. These activities have not been structured/ organized taking a business-like approach.
- There was no market-oriented strategies to promote training activities in Bangladesh and in the region. There are no studies to evaluate their value for the trainees, and how they could be improved to increase their potential.

- There is no a strategic planning on improving training at the CSD and at ICDDR,B. This should be developed, linked with the overall Centre's strategic planning, which should include liaison of the Centre with other organizations to potentiate them and allow them to have an academic value.

Recommendations

After reviewing all these activities of the CSD, the review team met in private and agreed on the following recommendations that were presented to the Division and the Centre for their consideration:

Management

It is important that the management of the Division should be improved. The following areas were highlighted:

- Develop annual work plan, with broad participation, covering research, service and training activities. This should provide the basis for increased support for the division by all members and Centre's programmes.
- Continue encouraging staff to develop their own research projects with proper funding.
- Abolish the current time divide between service and research. Allocate individual's time according to his/her expertise, and division's need and resource availability.
- Establish a system of a joint appointment between different divisions of the Centre.

Research Component

The overall research productivity of the CSD was considered to be excellent. In response to the Centre's strategic planning, the Division should consider:

- Recruiting an international scientist, expert in respiratory diseases, to expand research on ALRI, as an initial step.
- Later, creation of new areas of clinical research such as research on tropical diseases, neonatology and maternal health.
- Expansion of new research areas should not be done solely within the division; these could and should be done in collaboration with other institutions and/organizations, particularly those already funded by major donors (ADB, USAID, World Bank, etc).

Service Component

The current characteristics of the services provided by the CSD were considered not ideal. The Centre and the CSD should discuss ways to improve the services. In doing so, the following recommendations should be considered:

- Hire a separate hospital administration, under the Division's Associate Director.
- Develop a well-documented cost structure. All users of the clinical services within the Centre (e.g. research projects) should pay for it.
- Establish a fee for food and lodging as well as for medications. The level of these fees needs to be defined by the division and the Centre. Future levying of fees

require further studies to decide when they should be implemented. The vision is that in future all major services provided should be charged for, with a safety net to deal with individuals unable to pay, charging those costs to a donor or core support fund.

- Develop a well thought strategic plan to solve the financial problems of the hospital. The following recommendations should be considered:
    - All users of the CSD facilities should pay for them (projects, training, etc).
    - The real costs of these services should be incorporated in all new research projects that will use the CSD services.
    - Other divisions should be encouraged to use the CSD services as much as possible, avoiding duplication.
    - The GoB support should be earmarked for patients care.
    - Expansion of income-generating activities of the division through a well developed business plan with appropriate marketing strategies.
    - The development of the Centre's new building, should include space that could be used to generate income for CSD, such as modern diagnostic facilities, training centers, and independent pay hospital.
    - Under the current organization, the hospital is run within the Centre's administrative, financing and human resource structure. This may not necessarily be the best for the hospital to be competitive in the market. As part of a research organization, it may not attract donors from charitable organizations. The Centre should explore an alternative organization that will make the hospital attractive to such types of donors.
    - It was considered important that the Centre's uses the Hospital Endowment Fund in a transparent manner, consistent with the wishes of the donors, providing regular report to them on the benefits obtained by their donations.
    - The possibility to identify an individual to be in charge of bringing funds for the service component of the CSD should be considered.
    - Consider including patents or licensing fees for the products developed at the CSD in the future, which could generate funds to support CSD's works..
- Expand the franchising model with a network of primary and secondary care clinics, working in a separate organization from the current ICDDR,B Human Resources structure, which could be through existing NGOs or other alternatives, but with the ICDDR,B identity. The purpose of this system would be to diminish the need for patients, particularly those with uncomplicated illnesses, to come straight to the Dhaka Hospital, as well as to avoid deaths during transportation. This could be done in steps, starting in areas where most hospital users come from, to be expanded later throughout the country, if found successful. These peripheral clinics, some of them with a 24 h facility, should be self-sufficient and should generate a fee (that could be donor generated) to pay back to ICDDR,B for their technical input and supervision. These clinics /organizations, should also facilitate conduction of research studies. Incentives should be build in these franchising system, to help staffing issues, as well as to develop a career program (for instance, individuals from these organizations should be given priority for openings at the Centre).
- Savings that could be generated by these new finance and franchising strategies, should be used to open new research/clinical services.

Training Component

The Centre should recognize the values and potentials of current and future training activities provided by the CSD. These should be structured and expanded. The following recommendations were highlighted:

- The Centre needs to develop a strategic plan and a well-defined business plan for training, as a whole as well as those done within the CSD. These activities should be considered as a business unit for generating income.
- The Centre should explore doing these activities in partnership with existing training institutions in Bangladesh.
- It will be important to identify a leader, with appropriate training and experience, to lead these activities. This person should have the capacity to bring funds and implement marketing approaches.
- It was recognized that currently there are no career structures for the CSD staff. These should be developed, which should include training for nurses (midwives) and junior doctors.
- Training activities should also be considered as a strategy to improve the manpower of the hospital. Trainees should be involved in service activities, as part of their structured training, to improve the capacity of the Centre's services activities.
- In developing and expanding these training activities, the Centre should consider the inclusion of research to evaluate training programs including their value for trainees years after their training, in their works/practices. Results of these studies should be used to improve and adapt training activities. These types of studies should be supported by specific funds, which could include endowment funds.

Annex 1
Final Agenda for the Review

Annex 2
Dr. Sack's letter to the review team

Annex 3
Division Report

RESPONSE TO REPORT OF THE EXTERNAL REVIEW OF THE CLINICAL SCIENCES DIVISION (CSD) (OCTOBER 28-30, 2003)

INTRODUCTION

Following resolution of the Board of Trustees (BoT) meeting in June 2003, the External Review of the Clinical Sciences Division (CSD) was held during October 28-30, 2003, just prior to the November 2003 meeting of the BoT.

After the review, the team submitted a draft report during the November 2003 meeting of the BoT, and subsequently their final report. Formal response of the division to the report has been scheduled during the November 2004 meeting of the BoT.

Before making a response, the Clinical Sciences Division would like to express thanks to the Board for taking the decisions for external review, which was long over due. The division remains grateful to the members of the review team for their efforts in making an excellent review over a very limited period of time. The division finds the recommendations as well as the general comments of the review team as very appropriate and constructive, and believes that they would be of immense help in guiding the division and its activities over the next many years.

As mentioned above, the external review report has two sections. The first section describes the background and processes of the review, observations by the team and key findings, and the reviewers' general comments on the structures and activities of the division. The second section highlights their specific recommendations covering all major activities of the division. The divisional response to the report has also been organized under two sections. In the first section an efforts has been made to respond to each of the recommendations of the review team. The division considered the first section of the report and general comments of the team as also invaluable, and thus made efforts to respond to them in the second section.

SECTION-1: RECOMMENDATIONS

After reviewing all these activities of the CSD, the review team met in private and agreed on the following recommendations that were presented to the Division and the Centre for their consideration:

A. MANAGEMENT

It is important that the management of the Division should be improved. The following areas were highlighted:

1. **Develop their own annual work plan, with broad participation, covering research, service and training activities. This should provide the basis for increase support for the Division by all members and Centre's programs.**

   Response: CSD is developing its annual plan for 2005, specifically for hospital and patient care activities, which would be completed before the November 2004 meeting of the BoT. The success of planned research would depend mostly on availability of the required fund support. The division would continue with its current training activities, however, would develop them into more structured ones including development of course curriculum and establishment of appraisal systems. Efforts would be made for implementation/consolidation of some newer training areas such as child development, breastfeeding counseling and management of severe malnutrition.

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

   Response: This remains the Centre's as well as CSD's policy, which would be continued as suggested. It may be mentioned that, there usually are two types of opportunities for securing fund support for research projects- one works at individual level (the division/Centre might play a supportive role), mostly through collaboration with other institution(s) or through establishment of personal linkages with potential sponsors (e.g. testing of pharmaceutical products). The second involves competing for funds available at the Centre. CSD scientists will explore both types of opportunities, and to address decreasing funding opportunities for clinical research on diarrhoeal diseases, would explore newer research areas within Centre's Strategic Plan. Nutrition and ALRI research are given higher priority within the division. ALRI being the second most common problem encountered at the hospital, this moves up in priority, however, the division would require skills (either develop or import) as well as a supportive infrastructure for ALRI works. The Centre is developing collaborations with the University of Basle to improve skills in this area.

   Potential newer areas of research include health system research, especially related to urban health. Additionally, developing other clinical skills could be important for carrying out HIV-AIDS research in future.

   A potential conflict would arise between the needs to maintain the clinical services and initiating new clinical activities in these new fields by the same group of people. There thus would be a necessity to establish and maintain a balance, between different activities of the division.

3. **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: This is a very important suggestion, and its implementation is essential to improve efficiency and t usage of time of the CSD scientific staff, particularly for other important activities e.g. patient care and training. This has been discussed on several occasions among the CSD scientific staff and there has been a consensus on the need for this change. The Division would define research involvements of each of its staff on a yearly basis. It may be mentioned that the Division is in the process of reorganization its patient care activities, which would require time commitments from its staff to undertake various assigned responsibilities. Adjusting for time requirements for these two broad activities, time available to the staff for patient care would be determined.

4. **Establish a system of a joint appointment between different Centre's Divisions**

   Response: Coordination between Divisions occurs through the programmes and it is possible for scientists to work together across Divisions without having a formal "joint appointment." A joint appointment is difficult to workout, might not improve collaboration, and might confuse lines of responsibility.

B. RESEARCH COMPONENT

The overall research productivity of the CSD was considered to be excellent. In response to the Centre's strategic planning, the Division should consider:

1. **Recruit an international scientist, expert in respiratory diseases, to expand research on ALRI, as an initial step.**

   Response: The Division is in the process of developing a programme on ARI studies, in collaboration with interested scientists of other Divisions. The objective would be to identify research issues with a particular focus on basic studies in the line of reviewers' suggestion and Centre's Strategic Plan. The group would define the resources requirements for addressing identified research issues, and examine mechanism(s) for their acquisition. Additionally, they would identify the need for physical facilities and equipments/instruments, and possible fund support for such activities. The full proposal would then be presented to the CD for discussion and finalization including exploring/identifying funds. The division hopes to make progress by the end of 2004, and one step toward the development of an ALRI research agenda would be through collaboration with the University of Basle. It may be mentioned that the Centre Executive Director, during his recent trip, had discussion with scientists of Basle University, and we are hopeful that it would finally workout.

2. **Later, new areas of clinical research should be created, like research on tropical diseases, neonatology and maternal health.**

   Response: CSD considers establishment of ARI research as its first priority, but would also initiate discussions with the Child Health Programme to identify research topics of public health importance, in the line of Centre's Strategic Plan, and identify

those relevant for CSD to address. However, it seems unlikely the CSD will develop a full clinical research programme on neonatal health. This is a very highly technical area that is very reliant on high tech equipment, and this type of research would not seem to fit our mission. Similarly, the Division is unlikely to develop clinical research in projects in obstetrics. Public health aspects are being developed in both neonatal and maternity care, but this is not so appropriate for the CSD.

3. **Expansion of new research areas should not be done solely within the Division. These could and should be done in collaboration with other institutions and/organizations, particularly those already funded by major donors (ADB, USAID, World Bank, etc).**

   Response: Many new research areas were opened and expanded within CSD in which other institutions/organizations had great interests on, with or without fund support/sharing of costs. For example, the Exclusive Breast Feeding initiatives involved active collaboration with the WHO and UNICEF, the Child Development activities involved collaborations with or without fund support from the UNICEF and ADB as well as the University of Dhaka, and complementary feeding issues are being addressed in collaboration with UCDavis.

C. SERVICE COMPONENT

The current characteristics of the services provided by the CSD were considered not ideal. The Centre and the CSD should discuss ways to improve the. In doing so, the following recommendations should be considered:

1. **To hire a separate hospital administration, under the Division's Associate Director.**

   Response: This would be addressed in the organogram of the Division that would provide a structure to support divisional activities, ensure delegation of responsibilities, establish administrative hierarchy and accountability, improve efficiency, and develop a career structure for the staff. Taking into account the valuable suggestions of the reviewers, patient care activities have been reorganized within the organogram that emphasizes a team approach of management. CSD invested a considerable time for discussion at several staff meetings to suggest a new organogram that has provisions for a head of the clinical services, and hospital head/administrator. This has been discussed with Director, HR and the job descriptions of the two above-mentioned posts are being developed, following which the proposal would be taken to the Executive Director and for discussion at the CD.

2. **Develop a well-documented cost structure. All users of the clinical services within the Centre (like research studies) should pay for it.**

   Response: Cost structures do exist in the Centre, and the hospital (patient care areas) has several cost centers. However, there remains scope to improve transparency of costing. CSD would like to attach this to its planned changes in its patient care activities, which is expected to facilitate performing exact costing for each of its functional units. The Finance Department would actively help and participate in this process.

3. **Establish a fee for food and lodging as well as for medications. The level of these fees needs to be defined by the Division and the Centre. Future fees require further studies to decide when they should be implemented. The vision is that in the future all major services provided should be charged for, with a safety net to deal with individuals unable to pay, charging those costs to a donor or core support fund.**

   Response: In discussions with the CD, there is a general agreement to increase the general registration fees, initially to Taka 40.00, and establish pay beds in the short stay ward and general ward as the first step. The issue of introduction of charging for food and cost was discussed at the CD. Its implementation would involve costs for collection of the fees, and estimated that there would only be a marginal financial benefit to the Centre. CD reached the consensus opinion to negotiate with and encourage the Government of Bangladesh instead to cover for such costs through increasing their contribution to the Centre.

4. **Develop a well thought strategic plan to solve the financial problems of the hospital. The following recommendations should be considered:**

   (i) **All users of the CSD facilities should pay for them (projects, training, etc)**

   Response: The CD recognized the need to address this issue, and agreed to address this in reviewing research proposals at the Research Review Committee, in which directors of all scientific Divisions are members. Additionally, they would carefully review the proposals, before approving their submission to the RRC, to ensure that appropriate budgetary provisions are made for covering costs of all services rendered by CSD facilities

   (ii) **The real costs of these services should be incorporated in all new research projects that will use the CSD services.**

   Response: Please see the response in the above paragraph.

   (iii) **Other Divisions should be encouraged to use the CSD services as much as possible, avoiding duplication.**

   Response: The CD agreed to encourage their staff to avail CSD services, wherever appropriate, and make efforts to ensure that this is actually practiced within respective Divisions on a routine basis. This would also be overseen while reviewing research protocols at the RRC.

   (iv) **The GoB support should be earmarked for patients care.**

   Response: The Government of Bangladesh provides un-earmarked core support to the Centre, currently amounting to US$425,000/year (total operating cost of the Dhaka hospital is around US$1.6-2.0 million). The CD, after discussing the pros and cons, agreed to earmark this grant to support costs of the hospital. This could also help reduce the indirect costs of the Centre, which the donors would find to their benefit.

(v) **Expand income-generating activities of the Division through a well-developed business plan with appropriate marketing strategies.**

Response: Centre is in the process of developing its Business Plan and Sustainability Plans for all of its service activities, including those within the CSD. Augmenting income generation is an associated activity, which would include those available and to be built within CSD.

(vi) **The development of the Centre's new building, should include areas that could be use to generate income to the CSD, like modern diagnostic facilities, training centers, independent pay hospital, etc.**

Response: The recently developed Master Plan of the Centre has provision for adding floors to the existing hospital building for increasing patient care space, including creation/expansion of pay wards as well as provision of adequate space for diagnostic facilities. The additional space to be created would also be used to host the BRAC-ICDDR,B collaborative James Grant School of Public Health.

(vii) **Under the current organization, the Hospital is run within the Centre's administrative, financing and human resource structure. This may not necessarily be the best for the Hospital to be competitive in the market. As part of a research organization, it may not attract donors from charitable organizations. The Centre should explore an alternative organization that will make the hospital attractive to these types of donors.**

Response: CD discussed this issue at length and resolved that it may not be the best to develop two different human resources structures within the Centre, without careful review of the possible consequences. A consulting firm (Price Waterhouse Coopers) is currently examining the alternative of establishing an ICDDR,B-operated NGO under its Business Plan, along with examination of other activity areas e.g. diagnostic laboratories.

(viii) **It was considered important that the Centre's use of the Hospital Endowment Fund should be in a transparent manner, consistent with the wishes of the donors, providing regular report to them on the benefits obtained by their donations.**

Response: For the last many years the Centre is using a portion of the HEF proceeds (US$200,000) to meet costs of the patient care activities of Dhaka Hospital. This is done to meet the expectations and respects the wishes of the donors who contributed to the fund. This is done in a transparent way, although the details of the expenditures are not captured in the reporting. With reorganization of the hospital and implementation of the new cost centers, it would be possible to precisely reflect actual costs of various functional areas of the hospital, and using "Suchona" it would also be possible to provide detailed breakdown on the use of the HEF proceeds. This amount, along with the GoB contribution (US$425,000) (totaling US$625,000) would meet about 40% of the total cost of the Dhaka hospital, and as mentioned earlier could help reduce Centre's overhead costs.

(ix) **The possibility to have an individual identified that could be in charge of bringing funds for the service component of the CSD should be considered.**

Response: CD discussed this issue and considered it appropriate to address under Centre's Business Plan, which is being developed.

(x) **Consider including patents or licensing fees for the products developed at the CSD in the future, which could generate funds to support the CSD work.**

Response: Despite a late start of "patenting" of products, the Centre has decided to implement it for the all products/tests it develops. CSD, however, would be unlikely to have great potential to develop such products, with the exception of development of perhaps some "training" materials in collaboration with Centre's Training and Education Unit (TEU).

5. **Expand the franchising model with a network of primary and secondary care clinics, working in a separate organization from the current ICDDR,B Human Resources structure, which could be through existing NGOs or other alternatives, but with the ICDDR,B identity. The purpose of this system would be to diminish the need for patients, particularly those with uncomplicated illnesses, to come straight to the Dhaka hospital, as well as to avoid deaths during transportation. This could be done in steps, starting in areas where most hospital users are coming from, to be expanded later throughout the country, if found successful. These peripheral clinics, some of them with a 24 h facility, should be self-sufficient and should generate a fee (that could be donor generated) to pay back to ICDDR,B for their technical input and supervision. These clinics /organizations, should also facilitate conduction of research studies. Incentives should be build in these franchising system, to help staffing issues, as well as to develop a career program (for instance, individuals from these organizations should be given priority for openings at the Centre).**

   Response: This has been discussed in a later section (point 2 under the section of Review and General Comments).

6. **Savings that could be generated by these new finance and franchising strategies, should be used to open new research/clinical services.**

   Response: The CD, after discussion reached a general consensus to use the income earnings of its diagnostic facilities (about US$70,000/year) to support patient care activities.

D. TRAINING COMPONENT

The Centre should recognize the value and potential of current and future training activities provided by the CSD. These should be structured and expanded. The following recommendations were highlighted:

1. **The Centre needs to develop a strategic plan and a well-defined business plan for training, as a whole as well as those done within the CSD. These activities should be considered as a business unit, to generate income.**

   Response: This would be addressed under Centre's Business Plan, currently being examined by an external consulting firm (Price Waterhouse Coppers). CSD would work closely with TEU (ISD) in developing such courses/training materials. This issue would be discussed during the "External Review" of the Information Sciences Division, scheduled for mid-2005.

2. **The Centre should explore doing these activities in partnership with existing training institutions in Bangladesh.**

   Response: The Clinical Fellowship Programme of CSD has been developed in collaboration with the Bangladesh College of Physicians and Surgeons (BCPS), and the University of Dhaka (DU). Both BCPS and DU recognized the training received by the fellows for further studies in Paediatrics and Internal Medicine. The Centre would also collaborate with BRAC in establishing and in the operations of the James Grant School of Public Health. This issue would be further discussed during the External Review of ISD.

3. **It will be important to identify a leader, with appropriate training and experience, to lead these activities. This person should have the capacity to bring funds and implement marketing approaches.**

   Response: Please refer to the above paragraph.

4. **It was recognized that currently there are no career structures for the CSD staff. These should be developed, which should include training for nurses (midwives) and junior doctors.**

   Response: For scientific staff, there already is a career structure (Scientific Ranking Policy), which has been recently updated, with provisions for scores coming from good clinical and public health works that improved the scopes of the clinicians including those working in the CSD. The Centre has recently created "Job Families', following which there are career structures for most categories of staff of the Centre. Currently, there is no structure for the trainees; however, it has been consistently observed that most of the trainees are benefited from their exposure to the Centre in any of the following ways: (i) being at advantageous position in getting employment at the Centre and within Bangladesh, and (ii) also in getting opportunities for higher studies/training both within and outside the country.

5. **Training activities should also be considered as a strategy to improve the manpower of the Hospital. Trainees should be involved in service activities, as part of their structured experience, to improve the capacity of the Centre's services activities.**

   Response: Training programme for the doctors and nurses was initiated in late eighties and early nineties respectively with the objectives to benefit the trainees as well as the hospital/Centre. The fellowship programme for the doctors had been very useful to both the fellows and the Centre. The programme had not been that successful to the nurses although they gain confidence in dealing with diarrhoeal patients with wider spectrum of illnesses, and also a few get employed at the Centre, usually under research projects. The Centre is also benefited (providing stipend much less than the salaries of a staff nurses, and the ability to hire trained nurses during emergency situations of unusually higher patient visits at the Centre). Sanitary attendants and health workers are the two other largest groups of staff in the hospital, but establishment of a training programme for such staff may not be possible.

   This issue would be further discussed during External Review of the ISD.

6. **In developing and expanding these training activities, the Centre should consider the inclusion of research, to evaluate their training programs, including their value for trainees several years after they were trained, in their practices. Results of these studies should be used to improve and adapt training activities. These types of studies should be supported by specific funds, which could include endowment funds.**

Response: This issue would be further discussed during External review of the ISD.

SECTION -II : GENERAL COMMENTS

1. **"it was noted that several other units and programmes of the Centre provide clinical care to patients, activities not included in the CSD and therefore not monitored by their staff. The most relevant unit was the Matlab Hospital, in charge of other Centre's Division. It was commented by the review team that this structure may not be ideal, by its lack of coordination and utilization of resources, as well as possible the existence of more than one standard of care within the Centre"**

   Response: Historically, the Dhaka Hospital was established in 1962 to facilitate clinical research on cholera; subsequently research on other diarrhoeal diseases and nutrition were added to the agenda. The development of the hospital, from the time of its inception reflects the direction of research focus of the Centre over the period. Similarly, the Matlab hospital was established to facilitate community research, and its development followed that of the Centre's research directions at this field site. There are similarities and dissimilarities between two hospitals. For example, the Dhaka Hospital lacks in MCH-FP and Obstetric units, although case management of diarrhoeal diseases are important activity of both of these hospitals. Like wise, other primary care facilities have been developed at the Kamalapur and Mirpur Field sites. Because the objectives, and the set ups of these service facilities are different it might be difficult to merge them under one service component of the Centre. Additionally, the mechanisms of fund support of these service units are also different, and thus sharing of resources would be unlikely. We, however, appreciate the comments on the standards of care, and CD strongly felt for application of the same standards of care as it relates to common services e.g. management of diarrhoeal diseases, ARI, and severe malnutrition. The Dhaka hospital is in the process of developing its own standard of care, and Matlab hospital staff would be involved in the process. Once developed, they would be shared with other potential user units and CD, and with CD's approval they would serve as Centre's standards.

2. **The PSKP Clinic was reported to provide good clinical care, as well as education and other services to patients; however, this model of attention has not being extended to the other six clinics that they have in Dhaka, were they provide an Essential Services Package with the support of USAID.**

   Response: Drs. Shahadat Hossain and Hasan Ashraf have had discussion with PSKP management on the issue of possible extension of the model to other ESP clinics operated by the same NGO. However, inadequate physical facilities and funds were the main obstacles. It may also be mentioned that USAID, who provided the fund support for establishment of the ESP clinics, would stop their support to the programme in 2007. CSD would, however, continue dialogue with PSKP and/or other NGOs operating ESP clinics in Dhaka city to explore the possibility of extending the franchising programme. .

3. **The Hospital runs under several constrains, mainly:**

   (i) **the lack of an adequate number of staff,**

   Response: The workforce need was reassessed following the External Review, and the findings were similar to that or an earlier assessment in 1998- there indeed are shortage of staff in almost all categories. CD discussed this issue,

and reached the consensus to redo the assessment after restructuring the patient care services.

(ii) **small space for the number of patients attended which leads to crowding,**

Response: This has been addressed in an earlier section (Point 4 (vi) under section C. SERVICE)

(iii) **not many hand washing facilities for patients, relatives and staff,**

Response: The wards are under renovation, and the issue would be addressed in redesigning the wards in which professional architect/interior designer would be involved.

(iv) **no radiologists and old equipments that have not being replaced lately, like the X ray machines and laundry facilities,**

Response: These issues have been discussed with CSD staff as well as at CD. First, the X-ray machine is very basic and thus a modern machine would be required if this was to generate income. Second, addressing the issue would also need either employing a competent radiologist (full or part time). The Centre has very recently decided to address the issue of acquisition of necessary capital equipment/ instrument from 2005. At the time of making budgets for 2005, all Divisions would be asked to provide a list of essential equipment/ instrument. After compiling the information, CD would review the list and prioritize items, taking into consideration fund availability and its Business Plan.

The laundry machines have been procured long time ago, and although two washing machines were donated pot-1998 floods, they too are about 5 years old, and the drying machine in use was procured over two decades ago!

Response: Please see the above response.

(v) **An old study of hospital infections showed a significant rate of hospital-acquired infections in patients. This study has not been repeated,**

Response: Dr. Jason B. Harris, an ID Fellow from MGH, Boston has recently performed a chart review (for a three-month period) to assess the magnitude of this problem at the longer stay ward (short stay was not included since the average stay was too short to identify cases of nosocomial infections), and determined a rate of nosocomial infections of 9%. CSD has planned to take the advantage of Dr. Jason's expertise in performing such review in training a few CSD staff to perform similar studies on a regular basis during his next trip to the Centre. Additionally, the patient care providers at the hospital would be sensitized, through discussions and didactic sessions, to identify cases of nosocomial/ suspect nosocomial infections, under the supervision of the Infection Control Officer (ICO). CSD would very shortly introduce 'hand rub' in place of hand washing by all staff engaged in direct patient care, in an effort to reduce hospital acquired infections Review of the changes before and after introduction of "hand rub" would allow us to determine the efficacy of the hand rub in reducing hospital acquired infections as well as the proportion of

such infections contributed by hospital staff. CSD would seek help and expertise of LSD (currently a clinical microbiologist is a member of the Hospital Infection Control Committee) in establishing an effective infection control programme at the hospital.

(vi) **An audit of medical records of patients who died in the hospital was used in the past to identify problems that could be solved but it has not been done lately,**

Response: It seems that the reviewers were perhaps indicating the 'autopsy' study that was done as a research protocol in the eighties. Currently, each of the deaths is reviewed at the morning sessions 365 day/year, although separate discussion, as done in many other places (often called 'death review') is not held. CSD has decided to incorporate 'death review', to be conducted periodically (e.g. every 3 months), within its Medical Audit and analyze data to monitor the trend and in improving patient care practices (and in modifying treatment guidelines).

Medical Audit is continuing, although there are ample scopes to improve auditing, particularly strengthening the components of assessment of patients' satisfaction and quality of cares components.

Response: CSD would seek help of the HSID that conducted the 'exit interview' in 2003, for periodic assessments and to transfer the skills to CSD staff for making this a regular in-house activity of the Division.

(vii) **The managerial style to run the hospital was mainly with participation of head of units; however, no group discussion and problem solving methods were used. Outside counting the number of attentions provided by each unit and the number of deaths, no other regular data system was in place in the hospital to monitor the quality of care provided,**

Response: The current system was introduced considering that it is often difficult to perform meaningful discussions involving a large group of people. Instead, an advisory committee was formed with the heads of the three clinical units and the Chief Physician to discuss issues of importance (all divisional activities). The unit heads were expected to communicate the discussions with the members of respective units; however, the system did not work well. Following External Review, the issue was discussed with all categories of staff. It has been decided that this would be attached to the reorganization of the patient care services, which would include implementation of a system of broader participation in the decision making by all categories of staff. Assessment of quality of care and work for its improvement are both important; however, it would require establishment of standards against which to compare the quality. CSD would, by the end of 2005, complete the reorganization including setting of standards (setting of standard would involve participation of the Matlab hospital, and review and approval by CD.

(viii) **The research activities (those presented by the CSD staff) were done both with project funds as well as core funds, although there were complains that some of the studies (mostly the physiology ones) not always were given priority by management in the past. The financial constrains of the**

Division did not allow opening new areas of research, even though some progress was made in the area of tuberculosis and acute lower respiratory diseases (ALRI).

Response: Most of the Centre's research activities are supported by project funds. Centre often receives funds e.g. USAID fund for targeted health systems research, and DFID grant for addressing issues of poverty and health. All scientists of the Centre are eligible to submit proposals and compete for such funds. Basically there is no "core" fund for research, except for small amounts allocated to the Divisions, called "Project Development Fund (PDF)" to support pilot and small-scale studies. Although there had been debates earlier as to whether the Centre should get involved in basic research, for the last several years the Centre has been promoting such studies. The issue, however, is getting fund to support such studies. That such studies ate still possible including securing funds are illustrated by several basic studies conducted in the Clinical Sciences Division and the Laboratory Sciences Division in the recent years. Collaboration with laboratories is very helpful in conducting basic research, however.

4. **It was also felt, however, that this (physiology) laboratory has not expanded its work to cover other research areas outlined in the Centre's Strategic Planning, like in ALRI or tropical diseases, which should be done in the future**

   Response: The issue has been discussed among the CSD scientists, and there is a consensus that research, particularly basic research on ARI should be the initial focus for the Division. Establishment of an effective ALRI research interest group, through participation of scientists across Divisions, is in the formative stage (please see an earlier section). The group would discuss and define the works that have been already done, the works in progress, and those needed to be done to address the need of the country, in the line of Centre's Strategic Plan. The group would also decide what resources are required to address identified research issues such as space, laboratory facilities, instruments/equipment, skills and fund. A comprehensive proposal would then be presented to CD.

5. **The work of this (Breast Feeding) unit, which started in the Hospital, has being expanded to document impressive results in the promotion of exclusive breast feeding in the field, including its impact on morbidity. The review team considered that the work of this unit in the hospital should now be part of the regular hospital management of patients, in charge off all nurses in the hospital, to make it sustainable. The review team also considered of high priority that the unit should expand its activities promoting the intervention developed for wide dissemination in Bangladesh, including GoB health facilities. These activities should be able to be supported by many donors**

   Response: This has already been added to the routine services of the hospital. CSD staff are continuing his efforts for its wider implementation in Bangladesh.

6. **Complementary Feeding: It was recommended to consider recipes prepared with the cheapest sources of protein and energy (which could be determined by computer programs), according to the market value of different food products in each region, and to include interventions that could be implemented at the primary health care**

Response: Following this recommendation, CSD has already working to develop such recipes.

7. **Child Development Unit: It was felt that many of the tests being applied have been used very infrequently in developing countries, and was important to do validation studies to demonstrate its value and applicability in poor countries with different cultural backgrounds It was also notice that many of the studies assumed that the results of the test applied would be easily interpreted by policy makers, which may not be the case. It was recommended that studies cross-validating the developmental tests with study outputs that would be easily understand by policy makers, like school performance, or later job experiences, would help proper interpretations of the importance of the indicators being developed.**

   Response: CDU has been established only a few years ago, and it is still is in its infancy while its members are being trained. Thus, the current focus of the unit is to strengthen its skills and capacity. Once that is done, the unit would first like to work with national institutions/organizations, and at a later suitable time consider extension of its works to other countries. There already is a plan to evaluate WFP's school feeding programme, and to assess its impact on school performance. Dr. Jena Hamadani, Head of the Unit, has been requested to make a response to this comment.

8. **Limited work was done currently on specific enteropathogens. The work with *Helicobacter pylori* presented by Dr. SA Sarker was a good example how they should be continued.**

   Response: In collaboration with LSD scientists, CSD would develop a research programmes on *H. pylori.*

9. **The review team was pleased that clinical studies on ALRI were starting, and recommended that this work should be continued. Basic physiologic studies on ALRI (pneumonia and broncheospastic airways diseases) were also recommended.**

   Response: This issue has been discussed in an earlier section. The findings of Dr. Ashraf's study (the study is un-blinded) are very encouraging. CSD considers it better to organize a workshop involving health NGOs, GoB, and donor agencies to share the findings of the study, when completed. A very important suggestion came from Centre's Executive Director regarding establishment of 24-hour emergency treatment facilities within a few selected ESP clinics to provide care to patients with dehydrating diarrhoea, ALRI, fever, and convulsions. Based on the results of the ongoing study available till date, Dr. Ashraf has also developed a concept paper to examine the feasibility of provision of care to all children with ALRI, irrespective of severity, as well as to look into antimicrobial options for management of such children; this has been submitted for considering FHRP fund support.

10. **It was recommended that the new diagnostic test using lymphocytes secreted antimicrobial antibodies developed at the Clinical Science Division should be included in the package of diagnostic tests being evaluated.**

Response: The new diagnostic test has actually been developed in the Laboratory Sciences Division. CSD is continuing to work in childhood tuberculosis, and collaborating with NGO's in developing research proposals.

11. **Despite these important research results, it was apparent to the review team that a mismatch existed between the research themes currently covered by the CSD and the research outlined in the Centre's strategic planning. It was recommended that additional funding be located to expand or initiate studies on ALRI, including basic physiology studies; tuberculosis, tropical diseases such Dengue; studies in perinatology and maternal health.**

    Response: This has also been addressed in an earlier section. The general feeling among the CSD staff is to take a phasic approach, starting with ALRI, and then use that experience in addressing other newer areas of research.

12. **It was recommended that the number of hospital attentions should be expressed both in absolute numbers as well as a population-based rate.**

    Response: In future, CSD would periodically report changes in the number of patient visit in absolute numbers as well as proportion of the population base as available from Bangladesh Demographic and Health Surveys.

13. **The benefit of this has not been well documented. It was suggested that the reduction on the patient's load should have free hospital staff to dedicate more attention to sicker patients, for instance.**

    Response: The comment is well taken, and CSD would make a response to inform how did the franchising benefit the hospital?

14. **The number of staff to patients' ratio was considered very low. This should be studied to find out an ideal ratio and/or search for other options to solve this problem, like the use of students, or hospital volunteers that could improve the number of number of staff without increasing the hospital expenditures. The Division needs to develop a system of volunteers /students to help its clinical services.**

    Response: This has been addressed in an earlier section. CSD has repeated its workforce assessment and the findings have been the same as observed in an earlier assessment in 1998- there is shortage of staff of almost all categories. The workforce assessment has been submitted to HR for review, before sharing with the ED and the CD. The issue of examining the possibility of getting services from volunteers has been discussed within the Division on several occasions, and finally at the CD. The general feeling is that it may not be possible to develop and maintain such a system in Bangladesh context.

15. **It was suggested that this issue should be studied, to identify the potential consequences to patients as well as alternatives to assure an initial medical assessment of patients as soon as admitted to the Hospital.**

    Response: CSD would address this issue along with reorganizing its patient care activities.

16. **Even though technical updates were given to junior doctors, not such activities were regularly programmed for nurses and other professional staff in the Division, faltering their professional development.**

Response: Currently there are regular in-house training programmes for updating knowledge and skills of nurses. However, the programme has not been a great success due to the fact that all duty nurses cannot be pulled out from duties for theoretical sessions, and that the nurses who are not on duty are unwilling to attend! The Division is considering other options e.g. training while performing their normal duties; however, feels that such programmes would be very time consuming (to cover all nurses). The nurses would be consulted, and discussions would be held to get their suggestion and support for establishment of an effective programme. Taking a phasic approach, CSD would consider establishment of similar programmes for other hospital staff.

17. **Current management does not allow broad participation of staff in decision-making processes and problem solving activities. No open forums for self-assessment and problem solving approaches.**

Response: CSD members have agreed to establish new management style that would ensure participation of staff of all levels. This would be linked to reorganization of the patient care activities.

18. **Nurses and other staff need to be active participants in teams with doctors and management to improve quality of care and services overall. The whole concept of teams as a working strategy of the Division needs to be built.**

Response: Please see the response above (point17).

19. **Excellent initial study on quality of care and patient's satisfaction, with key preliminary results:**
    - (i) **No waiting time**
    - (ii) **No major problem of extra payments**
    - (iii) **Current registration fee well accepted**
    - (iv) **General willingness to pay for food and lodging**
    - (v) **General willingness to pay for medications**
    - (vi) **Very short time for provider-patient interaction**

      Response: This would be addressed along with reorganization of the patient care services.

    - (vii) **Attention given mostly for medical aspects of care. Very little time given for reassurance/counseling and mother's/family support/education**

      Response: This would be addressed along with reorganization of the patient care services.

    - (viii) **Privacy not a major concern of patients, although it is a real problem. Provision for privacy needs to be given.**

Response: CSD is already in the process of addressing this in modifying the hospital layout. Privacy has been established for adult females, although not fully due to lack of space within the short stay ward, and the layout of the general ward would be developed soon that would have separation of adult males and females, as well as creation of separate toilets for males and females. The concern is that establishment of such facilities would require space and displace more patients to the shed.

(ix) **No good explanation why patients were referred to the PSKP Clinic**

Response: According to agreement, PSKP were expected to provide a staff to interact with the patients/attendants of minors being referred to the Clinic and explain to them the reason for their referral, in addition to explanation provided by triage nurse. CSD has initiated dialogues with PSKP management to assign a staff at the triage, and if that fails, it would find an efficient alternative to address this issue on its own.

(x) **The study did not include an evaluation of worker's satisfaction.**

Response: This would be addressed along with implementation of new management system that would ensure participation of staff of all categories as well as address this issue.

(xi) **The study did not include how units and teams of the hospital interact to improve quality of care or variables that may be considered to increase and support team building.**

Response: A system would be developed within the new management system under development.

20. **The majority of patients came from known clusters in Dhaka. These sites should be evaluated as potential starting points to place new franchising clinics, as a strategy to decrease attendance to the Hospital.**

Response: This has been addressed earlier.

21. **Even though the quality of care was considered "good" there were many aspects that needed improvement. Protocols should be clearly defined and monitored for compliance.**

Response: This too would be a part of the new team to be formed. Each team would be responsible for developing case-management protocols (standards), an effort that had been initiated years ago but was not completed, and those would be shared among all staff before being finalized and implemented. Additionally, standards of care would be defined for each functional unit of the hospital along with mechanisms for monitoring application of the standards. Once developed, the protocols would be circulated to all Divisions for comments and suggestions before their finalization.

22. **There is a need to identify data needed for decision-making. This could include the development of a clinical record that fully or partially could be entered into a computer database. Other mechanisms to generate data should include simple and**

rapid systems, like "quick and dirty studies" aimed to respond key questions generated during quality improvement exercises.

Response: CSD is in the process of establishing a Data Archival Cell that would include data generated from the surveillance system, medical records, and research protocols. We plan to start from an area with potentials for generating lesser amount of data (e.g. special care unit and research ward) and with experience extend that to other units. The Division is currently examining a computer soft ware that has been developed by a Centre staff (under HDSS) and installed at the Matlab hospital, for its customization for the Dhaka hospital.

23. **Serious financial problems to run the hospital exist, which needs a strategic solution. Funds given to ICDDR,B earmarked for the hospital should be identified, as well as other sources of existing funds that are supporting the hospital A business plan to generate income from those services that could have that potential should be developed, including with the help of consultants and market research studies. There several services already providing those services could be expanded to generate additional income for the Division, like the diagnostic unit and immunization clinic.**

Response: The CD have agreed to allocation of the GoB contribution (US$425,000), proceeds of HEF (US$200,000), and income earnings (US$70,000) from Centre's Diagnostic labs to meet the operations cost of the Dhaka hospital. Additionally, the Centre is also working to develop its Business Plan, and market survey component has already been done. One of the aims of the business plan would be to expand the diagnostic facilities within CSD including radiology, ECG, and ultrasonography. Efforts would also be taken to recruit a histopathologist, who would perhaps be located within LSD. There also is a plan to generate more income at Special Procedure Clinic through addition of pay consultation in the areas of CSD's competence, performing higher numbers of endoscopic examinations, and adding newer vaccines.

24. **There is a need to develop a cost-center concept, and ways to cover cost of services provided by the Division.**

Response: Cost centers are in existence since inception of the hospital; however, there are scopes to improve them to reflect unit costs better and the Centre is working in that line.

TRAINING SERVICES

25. **The CSD is providing several types of training. This however, does not play a prominent role in the Division activities. The presentation of the CSD did not include a section presenting those activities fully and the review team did not have the capacity to go over them in detail. However, some important aspects were identified:**

Response: It is true that the involvement of CSD in training activities have not been adequately reflected in the presentations during the review due to an oversight.

26. Training activities are not done in a structured system. Activities are organized independently of each other, responding to emerging needs, without a program to describe them and to potentiate them.

Response: CSD is involved in a number of structured training activities e.g. international course on case management of diarrhoeal diseases (previously national courses as well), management of PEM, and epidemiology courses. The Training and Education Unit (TEU) organize these courses. The topics and practical sessions to be covered for training of clinical and nurse fellows have been developed; however, that lacked in assessment of the programmes. Elective training of foreign medical students is not structured. The Division is currently working to develop structured training programmes including development of curricula for these training activities along with establishment of a system to assess the impact of the training, which would be completed by 2004.

It is also true that there has not been effective marketing strategy to promote such training and particularly to generate income. The CD felt that this issue should be taken up during External Review of Centre's Information Sciences Division scheduled for mid-2005.

For the last several years, CSD have been providing training to the students of the College of Home Economics, Dhaka, and very recently, training on Child Development has also been initiated for students of the Dhaka University. These are to be taken as Centre's contribution to national institutions.

27. The CSD is under-utilizing its training opportunities and their potential. Many of them could be income generating. These activities have not been structured under a business-like approach.

Response: CSD is currently involved in courses organized by TEU on: (i) case management of diarrhoeal diseases for international participants, (ii) emergency response to cholera and shigellosis, (iii) case management of severe malnutrition, and (iv) epidemiology course for national participants. With the exception of the epidemiology courses, such training courses are organised with fund support of identified donors. The epidemiology courses are mostly for nationals and Centre staff and although the participants pay fees, they are largely considered as contribution of the Centre to the national institutions or individuals. CSD also provides orientation and training opportunities to foreign medical students, and until now the students are not charged for their training at the Centre. Recently, a course on Child Development has also been organized for students of the Dhaka University. Further, CSD provides training to a large number of students from the College of Home Economics; however, these too are free of costs. Although there are potentials, the scope for generation of income might not be great, and these are to be seen as Centre's mandated activities to support national institutions. Case management course had been and remains the major training activity of the Division. However, such courses are not currently organized since that role has been taken over by the National Diarrhoeal Disease Control Programme (NCDDP).

These issues would also be taken up during External Review of the Information Sciences Division scheduled for 2005.

28. **There were no market-oriented strategies to promote these training activities in Bangladesh and in the region.**

Response: These issues would be taken up during External Review of the Information Sciences Division scheduled for 2005, and also in the development of Centre's Business Plan.

29. **There are no studies to evaluate their value for the trainees and how they could be improved to increase their potential**.

Response: Although formal study to know if and to what extent the trainees are benefited have not been done, TEU maintains a list of the course participants and communicate with them to know if and how did they apply the knowledge and skills acquired during the training. This issue would be taken up during External Review of the Information Sciences Division scheduled for 2005.

30. **There is no a strategic planning how to improve training at the CSD and at ICDDR,B. This should be developed, linked with the overall Centre's strategic planning, which should include liaison of the Centre with other organizations to potentiate them and allow them to have an academic value.**

Response: The Centre would collaborate with BRAC in the establishment of the James Grant School of Public Health, and CSD would be involved in its courses and training programmes. This issue would also be taken up during External Review of the Information Sciences Division scheduled for 2005.

ICDDR,B
CENTRE
FOR HEALTH AND
POPULATION RESEARCH

The Fund Development Committee

The Fund Development Committee was established and convened for the first time at the full Board meeting in November 2003. The Committee, chaired by Dr Kul Gautham of UNICEF, met to discuss the Centre's fundraising activities. The discussion focused on the role of the Board of Trustees in the Centre's fund development strategy. There was consensus among the Committee members that the Trustees could assume an ambassadorial role by identifying potential donors and engaging them on the Centre's behalf. In the event that these individuals, groups or organisations were interested in making a financial contribution to the Centre, then the actual 'ask' would be made by the Centre's directorate and fundraising staff. This suggestion was then approved by the full Board at their closing meeting. The Trustees requested factsheets and presentation materials to assist them in their role as ambassadors for the Centre. The concept of 100% Board giving was not universally approved; Trustees cited inability, disinclination, conflict-of-interest and existing commitments among their reasons.

The By-laws of the Fund Development Committee (FDC) must now be revised to accommodate these discussions, as was requested by the Board in the resolutions from that meeting.

However, at the retreat in November, the subject of fundraising will form an integral part of the Board's deliberations. The Executive Director, Dr David Sack, approved the decision to postpone the revision of the FDC By-laws until after the discussions in November as they will impact the revisions.

However, some agenda items will remain the same at the presentation of the FDC during the Board Meeting. These are:

- A presentation on the role of the ER&ID office in resource mobilization
- A decision on the role of the Board in fund development, following discussions at the retreat and incorporating Ms de Kuyper's suggestions
- The nature of the presentation materials required by the board to equip them for this purpose
- The significance of the Centre's brand in fund development (this includes discussion of the name change strategy, progress on which has been impeded by the departure of Ms Julia Ackley who was spearheading the process)

We look forward to discussions on the above at the Board retreat and meeting.

National Liaison Committee

During 2003, the Centre's Board of Trustees decided that it would include a National Liaison Committee among other subcommittees on the Board.[1] The functions of the committee, as stipulated in the Bylaws are as follows:

- Review the collaborations between the Centre and national institutions and make recommendations to the Full Board on how collaborative arrangements can better address issues of the country's needs and priorities.

- Review any plans for future health systems research activities that involves both the Centre and national institutions. In doing so, the Committee will make recommendations to the Full Board for endorsement of any proposed plan that: focuses on the country's health research needs and priorities, and engages national institutions in research opportunities, capacity building, laboratory strengthening or health services.

- Make recommendations to the Full Board for changes in any proposed plan that may enhance opportunities for better cooperation and collaboration at all levels.

- Provide oversight on the activities of the Centre's Programme Committee. In consultation with the Programme Committee, ensure that the Centre is supportive of and avoids actions prejudicial to the interest of research in similar fields carried out by local NGOs, national research institutes and other national organizations in Bangladesh.

Since there is limited time at the Board meetings to accomplish all these functions, there is need for clarification of the intent of these Bylaws and a mechanism for reporting on the progress of the relationship between the Centre and the national governmental and non-governmental institutions. Clearly, by setting up this committee, the Board felt that they need to monitor the activities of the Center in terms of its cooperation with national institutions so that the Centre can be supportive and not inhibit research at these other institutions.

The Centre scientists clearly feel that they are being supportive. However, we currently do not have any objective measure of this interaction. Some indicators would be useful for the committee to track the progress toward being supportive. The Forum 8 and the Ministerial Meeting in Mexico City may highlight some of these ideas, and I expect that the report to the Board will use some of the concepts from Mexico. If the Board can agree generally on the set of indicators and format for reporting, the management can use these in future reports to the Board.

Suchona will help us to track certain "liaison protocols and activities" in a more precise and efficient manner. These reports have not yet been created, but once developed, they can be reproduced easily in the future. Other indicators will require additional information gathering, so will not be so easily quantified. Still others may best be explained through example, since they are not easily quantified.

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[1] The other committees being Programme Committee, Finance Committee, HR Committee, and Fund Development Committee.

I believe we need to avoid the notion that the relationship between the ICDDRB and the national institutions is a one-way street, and that somehow the Centre is always teaching the other institutions the "correct methods." Clearly, the Centre is unique and has much expertise and skills to contribute, but we also are learning from national institutes constantly. Thus, the indicators must examine both aspects of our relationships with national institutions.

Some potential indicators might include:

1. Listing of research protocols that are carried out jointly with national governmental and non-governmental institutions. This information on research protocols can come from Suchona.

2. Listing of non-research activities carried out jointly with national governmental and non-governmental institutions. In addition to protocols, many activities are conducted jointly, such as surveillance, outbreak investigations, consultations, etc.

3. Listing of publications that are published jointly with Bangladeshi scientists from institutions. The publications would reflect scientific output of the joint collaborations.

4. Advisory groups and technical interest groups in which staff from national institutions advise the Centre on new protocols. Several of the protocols have the benefit of input from technical advisory groups. The technical interest groups are routine with FHRP protocols and are being formed with other protocols as well.

5. Protocols or activities in which the governmental organization or NGO requests the Centre to carry out the work. This indicator would illustrate the extent the Centre is able to respond to the ideas and needs of local institutions. Requests from national control programmes are especially relevant, e.g. operations research in support of the national tuberculosis programme or the IMCI.

6. Training programmes for national professionals outside the Centre. In addition to the training courses and fellowships, this might include special orientation / sensitization seminars (e.g. civil surgeons seminar on shigella and the up-coming one on zinc and the training workshop with Bangladesh Pediatric Society on zinc as a treatment.

7. Service that the Centre carries out in support of the needs of the people of the nation. The hospital activities is the most obvious type of service, but there are others as well.

8. Quantification of the financial impact of the protocols and activities above. This might include the funds that are channeled through the Centre to the other institution by way of subcontracts and might also include projects that are possible through the improved capacity development through previous cooperation with the Centre. (The latter might be more important.)

9. Issue specific collaborations dealing with national health policy and/or programs. This might include specific policy issues and or scale up activities that are undertaken jointly with the MOHFW e.g. MOHFW Zinc planning & implementation committee + advisory committee.

The most Centre's most important impact within the country may also be the most difficult to document; that is, the role the Centre plays in highlighting the importance of evidence-based decision making. It is our hope that the presence of the Centre in Bangladesh and its role as a good partner with the government, increases the value of data on which policy makers can make decisions. This data need not necessarily come from the Centre, indeed much of it comes from other institutions or from other countries. Together with these other institutions, an academic discourse occurs here that is obvious to visitors to Bangladesh. Some examples include the use of the data from the Demographic Health Surveys, and the importance that is given to evaluation of government programme (e.g. NNP).

A final consideration regarding the National Liaison Committee; the Bylaws appear to be very "management oriented" rather than "governing oriented" and the Board may want to revise the Bylaws to make them more appropriate for a Board of Trustees.

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

Centre Name Change Strategy

At the November 2003 Board of Trustees Meeting it was determined by the Board to readdress the name of the organization. The Board suggested that ERID conduct an informal survey and report its findings. The possibility of hiring a public relations firm to assist with the process was also brought up. However, it was decided that before this route was taken, the Centre should conduct its own exercises to assist the process.

An internal committee has been formed to guide the name change process. This committee is comprised of staff approved by the Centre Directorate. The Committee met once prior to the departure of Ms Julia Ackley, who was spearheading the name change process. At the meeting, it was decided to distribute an email to external and internal audiences to assess the climate for a name change and to gather potential candidate names.

Due to understaffing in the ER&ID office following the departure of Ms Ackley, this activity has yet to be undertaken.

However, the success of the Centre's brand identity will directly impact its ability to mobilise resources and may thus be considered at the November retreat and meeting as part of the discussions on resource mobilisation. It is important to have a name that will resonate with a wide variety of audiences – scientists, donors, and general international and Bangladeshi populations - as all of these groups are critical to the Centre as it seeks to promote its work both here and abroad and to secure funding. The latter is a key concern of the Centre and the Centre's current and potential donors are a large and powerful interest group. For this reason, it may be appropriate to reconsider the involvement of an external advisory body or consultant in the name change process and to solicit the opinion of the Board's consultant, Ms Mary de Kuyper.

Following the recruitment of a new officer to undertake grant management activities for ER&ID, the office is now in a position to resume activities relating to the name change and hope to agree a strategy and timeframe for these at the November 2004 Board retreat and meeting.

4/BT/NOV 2004

HUMAN RESOURCES COMMITTEE

BOARD OF TRUSTEES MEETING
November 2004

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

HUMAN RESOURCES COMMITTEE MEETING

HUMAN RESOURCES COMMITTEE MEETING
Sunday, 28 November 2004

Agenda

1. Approval of agenda
2. Approval of the minutes of June 2004 meeting
3. Response to resolutions of June 2004 meeting
4. Staffing:
   - 4.1 Staffing status
   - 4.2 Status of recruitment of International Professional Staff
     - a. Deputy Executive Director, D2, Executive Director's Division
   - 4.3 Information on new International Professional Staff
     - a. Director, D1, Public Health Sciences Division
   - 4.4 Renewal of contracts
     - a. Director, Finance, P5, Executive Director's Division
     - b. Operations Research Scientist, P4, Health Systems and Infectious Diseases Division
     - c. Health Economist, P4, Health Systems and Infectious Diseases Division
   - 4.5 Status of Seconded Staff Contracts
     - a. Director, Health Systems & Infectious Diseased Division, D1
     - b. Scientist, P4, Health Systems & Infectious Diseased Division
   - 4.6 Renewal Contract of Adjunct Scientist
     - a. Prof. Frances E. Aboud
     - b. Prof. Yoshifumi Takeda
   - 4.7 List of established International Professional Posts
5. Promotion of Bangladeshi Scientists to International Professional Levels
6. Review of 6 years' rule for International Professional Staff
7. Human Resources Agenda update
8. Gender Policy – Annual Report
9. Staff salaries
   - 9.1 National Officer & General Services Categories
   - 9.2 International Professional Category
10. Any other business

Minutes
Human Resources Committee Meting
Friday, 11 June 2004

The Human Resources (HR) Committee of the Board of Trustees (BoT) held its meeting on 11 June 2004 at 2.00 pm in the Sasakawa Training Lecture Room.

Present:

Dr. Ricardo Uauy Dagach (Chair, BoT)
Dr. Claudio Lanata (Chair, HR Committee)
Prof. AK Azad Khan (Chair, Finance Committee)
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Prof. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:

Dr. Kul Gautam (Chair, Fund Development Committee)

Invited: Centre Directorate

Minutes: Ms Loretta Saldanha

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

Dr. Lanata thanked Ms. A Walton and Mr. A Neogi for the briefing provided on "Suchona" and HR, Finance staff and all those who have worked long hours to achieve the results that have been demonstrated to-date.

1. Approval of the Agenda

The agenda was approved.

2. Approval of the Minutes of the November 2003 meeting

The Minutes were approved. Reviewing the resolutions

18: Dr. Lanata said that this will be discussed in detail in the context of the "six-year rule" at the November BoT meeting.

19: It was reported that specific criteria exists. There is only one career path and that is the scientific path.

Dr. Lanata invited Ms. Ann Walton, Director, HR to present the HR agenda.

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.

The HR staff participated in a 2-day retreat which provided an opportunity to work together outside the office environment, to develop a department mission statement and to incorporate some of the training needs identified. The department is now operating under a new framework and is in the transition process from being a "policing" department to one of support to the organization.

Agenda 3.1: Staffing Status

There were 57 additions and 29 separations during the reporting period. The total number of Centre fixed-term staff belonging to all categories thus increased by 28. Information on staffing status was provided by job family, by funding (restricted/unrestricted), and by division, HR has taken an indepth look at the gender balance issue and presented results by gender ratio for the Centre/by Division, by job family and grade. In response to a comment that a better term be used for staff paid from unrestricted funds, it was reported that this would require an analysis of time allocation.

In response to a comment that the Board has in the past given strict instructions not to increase fixed-term staff, but if people are working full-time for years on end the Centre needs to convert these staff to fixed term to enable them to receive benefits. It was clarified that this may have been done due to shortage of funds – if the Centre has funds the Board does not have a problem with staff increases, however the Centre should have a mechanism when the budget shrinks. It was reported that the Centre does have a mechanism. Out of 2000 staff there is only a risk for 300 have contracts without end dates staff and these staff are nearing retirement.

Agenda 3.2aa,b,c: Status of Recruitment of International Professional Staff,
3.3a: Completion of Tenure in International Professional Post;
3.4a,b,c:.Renewal of Contracts,
3.5a Status of Secondaed Staff Contracts,
were discussed in a closed session of the Board and relevant resolutions drafted (attached).

Agenda 4: Human Resources Agenda Update

Although the HR Department has been mandated to implement the HR Agenda, 19 HR staff 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 HR has recruited 281 individuals, processed 727 contracts and 895 daily wagers. This has limited but not made impossible to advance with the HR agenda, which was presented below.

Human Resources Information System

Summarizing the information presented, Ms Walton concluded that to facilitate Centre wide implementation and acceptance of Navision. HR and Finance trained all Principal Investigators as well as all units in using Navision. In addition, HR trained the staff members with very little or no computer skills in using the system for viewing "self-information" and pay slip as well as leave applications. 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.

Gender Equality

Providing a summary of the activities to-date Ms Walton said that a Gender audit started in April 2004. Key organization structures, procedures, policies and practices are being reviewed to identify whether and how they discriminate against women or man 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 indicators of possible phasing. A two-page summary was presented. The first annual work plan will be presented in November.

The Board recommended that based on the ongoing review an update of activities be presented at the November BoT meeting.

Performance Review System

It was reported that the development of the performance management training module and the behavioural competencies will be completed during the coming months. The roll out of the new performance review system can only be considered once the system has been stable for several months and users are comfortable operating in the new environment.

It was suggested that the Centre develop a pilot programme first and wait for Suchona to be stable. Ms. Walton reported that a tool for performance evaluation does exist but this needs to be refined. In response to the Board's comment that the it is necessary for the performance review system to be in place if the Board is planning on discussing the 6-year rule in November, it was clarified that a framework needs to be identified – tool development is the easy part but culture training is the hard part; a commitment from the CD is necessary to pilot the revised system and that the Centre needs to look at the performance evaluation cycle instead of making it a once a year event.

The Board recommended that the Centre pilot the revised system with international professional staff by November 2004.

Dr. Lanata thanked Ms Walton for presenting the HR agendas and indicated the Board's satisfaction with the progress made on the HR agenda particularly with the implementation of the gender equality policy.
The meeting concluded at 3.30 pm.

Human Resources Committee
Resolutions

Res/6/BT/June 04

The Board confirmed the appointment of Dr. Marjorie Koblinsky as Director, Public Health Sciences Division, effective 1 September 2004 for an initial period of 3 years.

RES/7/BT/June 04

The Board agreed that the Centre continue the search for candidates for the post of Deputy Executive Director

RES/8/BT/June 04

The Board agreed to abolish the post of Director, Policy & Planning.

RES/9/BT/June 04

The Board resolved that the current employment contract of Dr. Gopinath Balakrish Nair with the Centre be extended up to April 08, 2006 to complete 6 (six) years as a fixed term international professional staff, under the same terms and conditions.

RES/10/BT/June 04

The Board resolved that it is in the best interest of the Centre to extend Dr. Kim Streatfield's contract for an additional 18 months on completion of six years service effective 17 July 2004, under the same terms and conditions.

RES/11/BTJune 04

The Board is pleased with progress made on the HR agenda particularly with the implementation of the gender equality policy.

RES/12/BT/June 04

The Board resolves that the current secondment agreement of Dr. Charles Larson between McGill University and ICDDR,B be extended for an additional 3 years effective 1 July 2005.

RES/13/BT/ June 04

The Board wishes to place on record their appreciation for Dr. Breiman's contribution to the Centre as Director, HSID and Head, Infectious Diseases and Vaccine Programme(PIDVS).

RES/14/BT/June 04

The Board approves the appointment of Dr Charles Larson as Director, Health Sciences and Infectious Diseases Division, effective 13 June 2004 for an initial period of three years.

RES/15/BT/June 04

The Board noted the plans for the implementation of the performance review system and encouraged the Centre to pilot the revised system with international professional staff by November 2004. → Nov. 2005

RES/16/BT/June 04

The Board wishes to place on record its sincere appreciation for the tireless efforts of the Finance and Human Resources Staff as well as all those who have worked long hours on the "Suchona" project, alongside their routine responsibilities, to achieve the results that have been demonstrated to-date. The Board is confident that once this system is stable the Centre will have achieved another important "milestone".

Response to resolutions

RES/7/BT/June 04

A report on the status of this recruitment will be presented during the Human Resources Committee meeting of the Board.

RES/15/BT/June 04

Human Resources was unable to pilot a revised performance review system with International Professional Staff due to the on-going demands regarding the implementation of Suchona and the departure of the Senior Manager, Human Resources during this period.

4.1 Staffing Status

There were 83 additions and 47 separations during this reporting period (April 01, 2004 – September 30, 2004). The total number of Centre fixed-term staff belonging to all categories thus increased by 36 as shown in Table 1.

Table 1

STAFFING OVERVIEW
April 2004 – September 2004

Separations/Additions of Staff

Functional Areas	Unrestricted Funds		Restricted Funds		**Total**		**Net Change**
	Sep.	Add.	Sep.	Add.	**Sep.**	**Add.**	
Administrative	--	1	(1)	2	**(1)**	**3**	**2**
Clinical	(1)	1	(2)	13	**(3)**	**14**	**11**
Computing	(1)	1	(2)	6	**(3)**	**7**	**4**
Finance/Procurement	--	--	--	--	--	--	--
Human Resources	(1)	--	--	--	**(1)**	--	**(1)**
Information Services	(1)	--	--	--	**(1)**	--	**(1)**
International	(1)	--	--	--	**(1)**	--	**(1)**
Laboratory	(1)	2	(2)	2	**(3)**	**4**	**1**
Maintenance	(1)	3	--	--	**(1)**	**3**	**2**
Research/Technical	(2)	4	(26)	37	**28**	**41**	**13**
Scientific	--	1	(3)	3	**(3)**	**4**	**1**
Support Services	(2)	3	--	3	**(2)**	**6**	**4**
Training	--	--	--	1	--	**1**	**1**
	(11)	16	(36)	67	**(47)**	**83**	**36**

Net additions : 36

Table-2
BOT/HR/NOV/2004

ICDDR,B
STAFFING STATUS

as of September 30, 2004

RF – Restricted Funds
UF – Unrestricted Funds

Fixed-Term Staff	September 2003			March 2004			September 2004		
	RF	UF	Total	RF	UF	Total	RF	UF	Total
Administrative	29	65	**94**	31	67	**98**	32	68	**100**
Clinical	31	102	**133**	31	101	**132**	42	101	**143**
Computing	40	38	**78**	41	39	**80**	45	39	**84**
Finance/Procurement	1	22	**23**	1	22	**23**	1	22	**23**
Human Resources	0	6	**6**	0	8	**8**	0	7	**7**
Information Services	5	8	**13**	6	8	**14**	6	7	**13**
International	2	16	**18**	2	17	**19**	2	16	**18**
Laboratory	7	36	**43**	9	37	**46**	9	38	**47**
Maintenance	1	21	**22**	1	21	**22**	1	23	**24**
Research/Technical Support	231	214	**445**	243	213	**456**	254	215	**469**
Scientific	20	40	**60**	22	39	**61**	22	40	**62**
Support Services	36	207	**243**	38	210	**248**	40	212	**252**
Training	2	2	**4**	2	2	**4**	3	2	**5**
Subtotal	**405**	**777**	**1182**	**427**	**784**	**1211**	**457**	**790**	**1247**
Other contract types									
Seconded	5	5	**10**	3	6	**9**	3	6	**9**
Short-Term	2	3	**6**	3	3	**6**	3	2	**5**
Contractual Service Agreement	238	28	**266**	303	31	**334**	429	33	**462**
Primary Health Care Provider	20	0	**20**	20	0	**20**	14	0	**14**
Health Worker	37	50	**87**	38	50	**88**	38	50	**88**
Fellow	5	21	**26**	5	25	**30**	6	20	**26**
Daily Wager	*	*	*	144	18	**162**	84	109	**193**
Subtotal	**307**	**107**	**414**	**516**	**133**	**649**	**577**	**220**	**797**
GRAND TOTAL	**712**	**884**	**1596**	**943**	**917**	**1860**	**1034**	**1010**	**2044**
%							**51**	**49**	**100**

* Not available from the previous HRIS system

Table-3
BOT/HR/NOV/2004

STAFFING STATUS
By Division

as of September 30, 2004

Sl. No.	Location	International Professional			National		Total
		Fixed-Term	Short-Term	Seconded	Fixed-Term	Others	
1.	Executive Director's Division	4	2	1	141	36	184
2.	Public Health Sciences Division	5	1	3	467	330	806
3.	Clinical Sciences Division	2	-	-	199	212	413
4.	Laboratory Sciences Division	4	-	-	190	93	287
5.	Health Systems and Infectious Diseases Division	2	1	5	203	102	313
6.	Information Sciences Division	1	1	-	29	10	41
	Total	**18**	**5**	**9**	**1229**	**783**	**2044**

Table-4
BOT/HR/NOV/2004

STAFFING STATUS BY GENDER AND DIVISION
as of September 30, 2004

Employment Types / Contract Types	CSD		LSD		PHSD		HSID		EDD		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	2	2	1	0	9	4	13
Short-Term	0	0	0	0	0	1	0	1	0	2	1	0	1	4	5
Seconded	0	0	0	0	2	1	4	1	1	0	0	0	7	2	9
Fellow	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1
Subtotal	1	0	1	0	5	3	5	3	3	4	3	0	18	10	28
Bangladeshi Int'l	1	0	2	1	1	0	0	0	0	0	0	0	4	1	5
National															
Fixed-Term	111	88	158	32	227	240	91	112	127	14	26	3	740	489	1229
CSA	23	20	41	19	67	219	18	26	11	15	3	0	163	299	462
PHCP	0	0	0	0	4	10	0	0	0	0	0	0	4	10	14
Health Worker	2	68	0	3	0	3	0	8	0	4	0	0	2	86	88
Fellow	7	12	0	0	1	0	0	0	0	0	1	4	9	16	25
Daily Wagers	34	46	24	6	9	17	13	37	4	2	1	0	85	108	193
Subtotal	177	234	223	60	308	489	122	183	142	35	31	7	1003	1008	2011
GRAND TOTAL	179	234	226	61	314	492	127	186	145	39	34	7	1025	1019	2044
%	43	57	79	21	39	61	41	59	79	21	83	17	50	50	100

Table-5
BOT/HR/NOV/2004

LIST OF INTERNATIONAL PROFESSIONAL STAFF
as of September 30, 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	30.06.2007 *
6.	MERCER, Mr. Alec	UK	Operations Research Scientist, HSID	P4	29.09.2002	28.09.2005
7.	NAIR, Dr. Gopinath Balakrish	India	Director, LSD	D1	09.04.2000	12.12.2004
8.	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/NOV/2004

FIXED-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
9.	QADRI, Dr. Firdausi	Bangladesh	Senior Scientist, LSD	P4	01.07.2002	30.06.2005 *
10.	RABBANI, Dr. Golam Hassan	Bangladesh	Scientist, CSD	P4	01.07.2002	30.06.2005 *
11.	SALAM, Dr. M. Abdus	Bangladesh	Director, CSD	D1	01.07.2003	30.06.2006
12.	SALDANHA, Ms. Loretta	India	Executive Assistant to Executive Director	P1	10.04.2003	09.04.2006
13.	STREATFIELD, Dr. Peter K.	Australia	Head, Health & Demographic Surveillance Unit, PHSD	P5	18.07.1999	17.07.2005
14.	THORPE, Mr. Peter	UK	Director, ISD	P5	01.08.2001	31.07.2007
15.	VARGHESE, Dr. Beena	Indian/USA	Health Economist	P4	10.10.2002	09.10.2005
16.	WALTON, Ms. Ann G.	Canada	Director, Human Resources	P5	04.03.2003	03.03.2006
17.	YUNUS, Dr. Mohammad	Bangladesh	Senior Scientist and Head, MHRC	P4	01.01.2004	31.12.2006 *
18.	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/NOV/2004

LIST OF INTERNATIONAL PROFESSIONAL STAFF
as of September 30, 2004

SHORT-TERM

Sl. No.	Name	Country	Job Title	Pay Level	Contract Start Date	Contract End Date
1.	ALAM, Dr. A. N.	Bangladesh	Head, Training & Education Dept.	P4	01.05.1996	31.01.2005
2.	BROOKS, Ms. Vanessa J.	USA	Grants Administrator, ED	P4	01.10.1997	31.12.2004
3.	GURLEY, Ms. Emily Suzanne	USA	Programme Officer	--	01.10.2003	30.09.2004
4.	HUGHART, Ms. Nancy F.	USA	Co-ordinator, CHNRI Secretariat	--	06.06.2004	05.12.2004
5.	LEMON, Ms. Hannah R.	UK	Senior Associate, ER&ID	--	14.05.2003	13.12.2004

Table-7
BOT/HR/NOV/2004

LIST OF SECONDED STAFF
as of September 30, 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.	BROOKS, Dr. W. Abdullah	USA	Scientist, HSID	P4	01.07.2001	30.06.2005	JHU
3.	KOBLINSKY, Dr. Marjorie A.	USA	Director, PHSD	D1	01.09.2004	31.08.2007	JHU
4.	LARSON, Dr. Charles P.	Canada	Senior Operations Research Scientist, HSID	P5	01.05.2002	30.04.2005	McGill
5.	LUBY, Dr. Stephen	USA	Head, PIDVS	P4	08.08.2004	07.08.2006	CDC
6.	MELS, Mr. Carel T. van	Netherlands	Demographer, HSID	P4	29.12.1999	31.12.2005	NIDI
7.	SACK, Dr. David A.	USA	Executive Director, ICDDR,B	ADG	01.10.1999	30.09.2005	JHU
8.	SERAJI, Dr. Habibur Rahman	Bangladesh	Scientist	--	09.11.2001	30.06.2005	JHU
9.	WAGATSUMA, Dr. Yukiko	Japan	Scientist, HSID	P4	17.01.2000	16.01.2006	JHU

CDC : Centre for Disease Control
McGill : McGill University
JHU : Johns Hopkins University
NIDI : Netherlands Interdisciplinary Demographic Institute

Table-8
BOT/HR/NOV/2004

LIST OF ADJUNCT SCIENTIST
as of September 30, 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

4.2 Status of Recruitment of International Professional Staff

Agenda 4.2a 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 was June 06, 2004 and then revised to read "application will be considered until the position is filled".

A report on the status of this recruitment will be presented during the Human Resources Committee meeting of the Board.

4.3 Information on new International Professional Staff

Agenda 4.3a **Director, D1**
Public Health Science Division

Dr. Marjorie Anne Koblinsky, an American national, Senior Scientist of Population and Family Health Sciences faculty, Johns Hopkins University, USA joined the Centre on September 01, 2004 as the Director, Public Health Sciences Division on a Secondment Agreement between Johns Hopkins University (JHU) and ICDDR,B for an initial period of three years. Dr. Koblinsky has been recruited through the Centre's competitive recruitment process.

This is for the information of the Board.

4.4 Renewal of Contracts

Agenda 4.4a **Director, Finance, P5**
Executive Director's Division

The first 3 (three) years' fixed-term employment contract of Mr. Aniruddha Neogi as the Director, Finance under the Executive Director's Division at pay level P5 will expire on November 17, 2005.

The Centre seeks the Boards' decision for further action to be taken for this position.

Agenda 4.4b **Operations Research Scientist, P4**
Health Systems and Infectious Diseases Division

The first 3 (three) years' fixed-term employment contract of Mr. Alec J. Mercer, Operations Research Scientist, Health Systems and Infectious Diseases Division at pay level P4 will expire on September 28, 2005.

The Centre seeks the Boards' decision for further action to be taken for this position.

Agenda 4.4c **Health Economist, P4**
Health Systems and Infectious Diseases Division

The first 3 (three) years' fixed-term employment contract of Dr. Beena Varghese, Health Economist, Health Systems and Infectious Diseases Division at pay level P4 will expire on October 09, 2005.

The Centre seeks the Boards' decision for further action to be taken for this position.

4.5 Status of Seconded Staff Contracts

Agenda 4.5a **Director, D1**
Health Systems and Infectious Diseases Division

The three years' secondment agreement of Dr. Charles P. Larson, Associate Professor of Department of Pediatrics at the Faculty of Medicine of McGill University, Canada will expire on April 30, 2005. Initially appointed as Senior Operations Research Scientist under the Health Systems and Infectious Diseases Division, Dr. Larson has been appointed as the Director, Health Systems and Infectious Diseases Division effective June 13, 2004 after the approval of the Board.

The Centre will now approach McGill University to seek an extension of Dr. Larson's Secondment Agreement.

This is for information of the Board.

Agenda 4.5b **Scientist, P4**
Health Systems and Infectious Diseases Division

The three years' secondment agreement of Dr. W. Abdullah Brooks, a faculty member of Bloomberg School of Public Health, Johns Hopkins University (JHU), USA will expire on June 30, 2005.

The Centre seeks the Board's decision for further action to be taken for this position.

4.6 Renewal Contract of Adjunct Scientist

Agenda 4.6a **Prof. Frances E. Aboud**

The current Adjunct Scientist contract of Prof. Frances E. Aboud, a faculty member of Department of Psychology, McGill University, Canada to ICDDR,B will expire on March 17, 2005.

The Centre seeks the Board's decision for further action to be taken for this position.

Agenda 4.6b **Prof. Yoshifumi Takeda**

The current Adjunct Scientist contract of Prof. Yoshifumi Takeda, Professor Emeritus, Faculty of Human Life Sciences, Jissen Women's University, Japan to ICDDR,B will expire on February 13, 2005.

The Centre seeks the Board's decision for further action to be taken for this position.

4.7 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	Abolished in June 2004 BOT
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	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

4.7 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	Vacant
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

Promotion of Bangladeshi Scientists to International Professional Levels

A report on this agenda item will be presented during the meeting of Human Resources Committee of the Board.

Review of 6 years' rule for International Professional Staff

DRAFT 26-Oct-04

RECOMMENDATIONS FOR NEW POLICY ON THE "SIX-YEAR RULE"

These recommendations are divided into those recommendations for a) renewal of contracts, and b) renewal of Division Directors. These recommendations do not apply to the post of Executive Director since the rules regarding this post are covered in the Ordinance.

Renewal of Contracts

1. Usual contracts for International level staff should continue to be for three years.

2. The three year clock should start from the time of the most recent appointment (e.g. if a staff member successfully competes for a higher post, the three year contract re-starts from the time of the new appointment and does not accumulate for the total period at the Centre.)

3. Renewal of the first three year contract should be at the discretion of the Executive Director in consultation with the relevant Division Director (with approval from the Board of Trustees for those at the P5 and above), keeping in mind the performance of the staff member, the priorities and possible changing needs of the Centre. The needs of the Centre will take precedence over the personal desires of the individual staff member, and there is no implied guarantee from the Centre that the first contract will be extended for a second 3 year contract.

4. At the end of the 5th year (e.g. shortly prior to the start of the 6th year), the staff member (or his/her Division in the case of Division Director) should be reviewed by a small committee (Executive Director, Director of HR, Head of the HR subcommittee and another Board member) to review the wisdom of the incumbent continuing at the Centre. This committee will make a recommendation to the full Board at its next meeting and the incumbent will be informed as soon as possible after the Board meeting of the offer to continue or not. The assumption of the committee should be: if the incumbent is performing exceptionally well, and if the post continues to be needed, then he/she should be offered an opportunity to continue. However, the Board will make their decision based on the needs of the Centre. They will have the following choices: a) offer a renewal to the same post, b) not offer a renewal to the post and begin recruitment, c) not offer a renewal and abolish the post.

5. If the incumbent is nearing the end of his/her eighth year, again a committee (Executive Director, Director of HR, Head of the HR subcommittee and another Board member) will again review the wisdom of the incumbent continuing, and will make a recommendation to the full Board as to whether the incumbent should be offered another contract. The assumption at this point should be: the post should be re-advertised with selection of a new person unless there are extenuating factors that make it imperative to continue the contract. Again the Board will make their decision based on the needs of the Centre. They will have the following choices: a) offer a one year contract to the same post to provide time for recruitment of a new person, b) not offer a renewal to the post and recruit immediately, c) not offer a renewal and abolish the post. The decision to continue beyond nine years should be made very rarely and only to allow for a smooth transition.

6. Currently the staff rules provide a special bonus for those staff members who are employed at the Centre for more than 10 years[1]. These bonus provisions will be abolished for international staff.

Renewal Of Division Directors

1. The rules for Division Directors will be the same as for the other contracts described above. However, since the Division Director is a key member of the Centre and is a member of the CD, additional importance is given to renewal of these contracts.

2. At the time of the evaluations at the end of the fourth and eighth years, the needs of the Division will be assessed by the committee.

3. In some cases the evaluation committee might recommend that the post of Division Director be re-advertised and that the incumbent be offered a post other than that of Division Director.

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[1] **Rule 375. End of Service Grant [for international staff]**
A staff member holding a fixed term appointment whose appointment is not renewed after he [she] has completed ten years of continuous qualifying service shall be entitled to a grant based on his [her] years of service unless he [she] has either received and declined an offer of renewal of his [her] appointment or has reached 60 years of age. The amount of the grant shall be fixed according to the schedule in Rule 1050.4 for termination of fixed term appointments.

Rule 1050.4 A staff member whose appointment is terminated under this Rule shall be paid an indemnity in accordance with the following schedule and with due regard to Rule 380.2.

Years of service	Staff holding fixed term appointments
1 – 9 years	NA for international staff
10 years	9.5 months
11	10 months
12	10.5 months
13	11 months
14	11.5 months
15 or more	12

Response to 6-year rule document:

Perspectives on the "6-year rule" at the ICDDR,B

- Dr Rita Colwell
- Mr. Jacques Martin
- Dr Roger Eeckels
- Prof. Marian E Jacobs
- Prof. Henry Mosley
- Prof. Demissie Habte
- Dr. William Greenough
- Dr. Ralph Henderson
- Prof. Ricardo Uauy

Perspectives on the "6-year rule" at the ICDDRB

1. **The Ordinance.** The Ordinance, drafted in 1978, specifies that the director will serve for a maximum of six years. This was later changed in 1995 to be nine years. The limitation to a specified number of years was only for the director and did not apply to other international staff. My understanding of the rationale for this term limit was to prevent a single person from dominating the agenda of the Centre for a very long time which might diminish the international character of the Centre as well as result in its stagnation.

2. **Expansion of the "six-year rule."** In November 1985, during a time of financial crisis, the Centre's Board decided, to expand the 6-year rule to include other international staff, and also to impose a "strict nepotism rule." Because of the financial crisis, it seemed at the time that there was a crucial need to reduce the number of international positions. Some factors leading to this decision included
    a. The Centre was facing a severe financial crisis that threatened the existence of the Centre.
    b. Shortly prior to this meeting, several lower level IPO posts (P1 and P2) had been approved for administrative staff and the costs for these posts added to the projected deficit.
    c. Several people (all nationals of Bangladesh) were completing 6 years as international scientists.
    d. Three couples (six people) were working as international scientists at the Centre. Two couples were from the US and one couple was from Bangladesh.

    Though not specifically stated in the minutes of the meeting, it seemed that the urgent need to reduce the budget led the Board to make the following decisions:
    e. Not renew the contracts of those scientists who were completing six years.
    f. Reverse the decisions to reclassify several posts from IPO 1 and IPO 2 to NO posts.
    g. Terminate the contracts for three women with international contracts who were married to others at the Centre who also had international contracts.

    It is not clear if the Board understood that they were expanding the six year rule, or whether they felt that they were simply enforcing the "six year rule of the ordinance" as they interpreted it. This is not stated in the minutes, but I believe their intention was the latter. The decision to reverse the IPO1 and 2 positions was simply a judgement decision that these posts had been created inappropriately.
    The decision to terminate the contracts of the women was thought to be enforcement of a WHO rule against nepotism.

3. **"Slippage" of the "six-year rule."** Although the 1985 policy seemed to be clearly in favor or a 6-year rule, during the 1990's, at least two scientists continued as international scientists for many years beyond six years. It is not clear if the decision to continue these long tenures beyond six years was considered to be in violation of the earlier decisions.[1]

4. **Revision of the six year rule, 1999.** During its November 1999 meeting (and the first meeting with Dr Sack as director) the Board clarified its position on the six year to make allowance for international staff to continue beyond 6 years, but under limited circumstances. The resolution from 1999 is copied here.

15/BT/Nov 99
The Board in clarifying the "6-year limitation rule" for incumbents of international professional posts, confirms the following policy:

- *That the first contract of 3 years is, in principle "renewable and may be followed by another 3 year contract, subject to (i) the post still being needed; (ii) the post not having been re-defined.*

- *That in case the post is no longer needed and / or the incumbent's performance is less than expected, this information be communicated to the incumbent at the time of the second annual performance evaluation discussion.;*

- *That on completion of the second 3-year contract (and assuming there is a continued need for the post), the normal expectation would be for the vacancy to be filled with a new staff member;*

- *That under exceptional circumstances, when it is in the best interests of the ICDDR,B, another new contract not exceeding 18 months may be considered and granted to the current incumbent;*
  - *When a unique is making critical contribution; and/or*
  - *When the terms of of tenure and the terms of contract requirements do not coincide;*
- *That even in either of these cases the vacancy be widely advertised, thus allowing open and fair competition on an equal footing by any and all interested.*

5. **Comparison of the rules of the Centre with other academic / development institutions.**

   a. In general, the Centre provides three year contracts to its international staff. The business model used for these contracts is more like a long term consultant than a regular staff position since there is no expectation of the position being a "career" position. This is in contrast to most universities or other development organizations where senior staff generally are able to "build a career." The lack of a career

[1] If long tenure is considered as the norm, the Centre should consider changing some of its staff rules to diminish the financial impact of a "terminal payment". Staff working longer than 10.5 years are eligible for a large payment based on their final salary.

structure suggests that the Centre is being maintained by the NO staff and that the international staff simply come for a few years as "long term consultants." One would question whether this is a suitable business model for the Centre.

b. As an "international Centre" it seems logical that the Centre should have sites, in addition to the Headquarters in Bangladesh. For example, the International Agricultural Centres are located in more than 20 sites and staff frequently move between the different sites. An agricultural economist, for example, might apply his/her talents to a rice institute or a potato institute. Since the ICDDRB is the only international health research institute, this kind of movement is not possible. If there were other international health research Centres (or if the ICDDRB had additional sites), this type of Centre would clearly need senior staff with career prospects.

c. Recruitment of high level scientists to Dhaka is difficult and expensive, and replacing people who have completed 6 years may not be appropriate when one considers the effort, expense, and the lost opportunity.

d. Most universities have an "up or out policy" suggesting that junior faculty are expected to achieve promotions within a certain period of time. Within a certain period of time, a decision is made to either promote the person or else ask him/her to find work elsewhere. This policy results in potential for career development as well as some movement of staff (e.g. avoiding stagnation). This opportunity does not currently exist at the ICDDRB.

6. **Potential conflicts between the six-year rule and the promotion of Bangladeshi scientist to the international rank policy**. The Board approved a policy to allow Bangladeshi scientists to have international rank[2] and this policy allowed for Bangladeshi scientists who occupied international posts through competition would automatically revert to the rules of this new policy when they completed 6 years. The Centre will need to be careful to implement policies that do not discriminate between international staff depending on their nationality. That is, if a new policy allows international staff from other countries to exceed 6 years, there should be a clear non-discriminating rationale.

7. **Changes in the ICDDRB scientific agenda**. The Centre's scientific methods have changed significantly over its 25 years. In the past, the protocols were heavily based in the CSD and LSD divisions where scientists carried out discreet clinical or lab based projects. These could generally be completed in a period of one to three years. This type of project is still being carried out, but increasingly, the Centre's research depends on implementation of field projects that is carried out over a number of years. Examples are the Minimat study or the Zinc scale up project with implementation and measurements

[2] Actual salary depends on the amount of project support they receive.

likely to continue for 5+ (or even 10) years. Another example is the HDSS which is an ongoing project since 1966 with outcomes continuing for an indefinite period. Frequent changes in the leadership of such projects would severely hamper the success of the project and the productivity of the Centre.

8. **Is the six year rule a substitute for performance evaluations**? There may have been times in the past when termination of the contract at the end of the six-year contract period was easier to justify than was a discussion of the continued need for the post, or the individual's performance. Obviously, the needs of the Centre in fulfilling its strategic plan should be the key determinant for staff continuing to work at the Centre, and the Centre needs to have flexibility to continue or discontinue the services of a particular person. Loosing a job at the Centre should not necessarily be seen as a failure of the person, but more likely it will suggest a miss-match between the individual's skills and those needed by the Centre at the time. That is, a job at the Centre should not be viewed as a "civil service position" with extensive protections for its staff, but equally true, if a person is contributing to the overall mission of the Centre, the Centre's rules should not artificially limit the term of service.

9. **Interaction of project funds and core needs of the Centre**. In the early days of the Centre, when most funds were core funds, the Centre could determine how to use its funds. With increasing proportion of funds from projects, there is increasing need to match positions with the funding, thus, the need to be flexible with regard to increasing and decreasing the numbers of international staff. This need for flexibility does not always match with our salary structure; e.g. a stable position with a modest salary may be attractive, and an unstable position with a high salary may be attractive, but an unstable position with a modest salary is difficult to fill.[3]

[3] This is our current situation.

----- Original Message -----
From: Rita Colwell
To: David A Sack, MD
Sent: Monday, July 12, 2004 11:57 PM
Subject: Re: Fw: 6-year rule

Dear David:

Your letter and attachment address one of the most fundamental issues influencing success (or failure) of the Centre. Basically, the financing of the Centre cannot support permanent staff who are unproductive. Thus, "tenure" with full salary guaranteed, without mandatory retirement at age 70, and regardless of productivity, would have potentially disastrous consequences for the Centre. This e-mail arrives too late for input to the Board of Trustees meeting and decisions will have been made by the time my e-mail arrives. I apologize for the delayed response, but I have been heavily engaged in establishing new facilities for Canon US Life Sciences, as well as starting programs at the University of Maryland, College Park, and Johns Hopkins School of Public Health.

Indeed, my recollection is that the actions of the Board were to reinforce the six-year rule of the Ordinance. My experience at the National Science Foundation is clearly in favor of the six-year limit for "rotators," who come to the NSF for a three-year contract, renewable for three years, and then return to their universities or take a new job elsewhere. This has proven critical to the vitality and strength of the NSF. There are "Career slots" at NSF, but these are predominantly clerical and nonscience or engineering administration.

My experience at several universities is that tenure is a mixed blessing. too often, those cloaked in tenure do not perform as well on average as nontenured counterparts. Obviously, there are many, many exceptions. However, rigorous evaluation by EXTERNAL peer reviews and panels precede conferring tenure. My perspective of the ICDDR,B is that it is, overall, well served by the six-year rule, applicable to both Nationals and Internationals. The Centre must be a dynamic, flexible place to do cutting-edge research. It cannot become "tenured in" or it will die a scientific death and become just another ossified place where more or less routine, "nonrisky" research is done. A compromise, if there is pressure to do something now, might be extension to nine years, but I'd be rigid in no exceptions beyond nine years. Even then, exception to the six-year rule should require rigorous performance evaluation.

This is not an easy issue to resolve. I will be very interested in what the Board decided (if any change was made).

Best wishes,

Rita

Dr. David Sack

From: <Jacques.Martin@deza.admin.ch>
To: <dsack@icddrb.org>
Sent: Friday, June 11, 2004 12:44 PM
Attach: ICDDR-B-Employment.doc
Subject: RE: 6-year rule

Dear David,
I have pleasure in responding to your request for comments.
I am doing so within 24 hours in order for this input to be useful for your BoT meeting.
Hoping you'll find my comments of interest.
Best wishes and see you soon.
Jacques

Meilleures salutations de / Best regards from
Jacques MARTIN

Senior Advisor (Health + Population)
Deputy Head - UN-Development Division - SDC
DFAE, CH-3003 Berne, Switzerland

Phone : + 41 (0) 31 322 34 47 **Fax : + 41 (0) 31 324 13 47**

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- Bureau / office: jacques.martin@deza.admin.ch
- Privé / home: J.Martin@dplanet.ch

Mobile : +41 (0)76 348 34 47

-----Original Message-----
From: David A Sack, MD [mailto:dsack@icddrb.org]
Sent: Donnerstag, 10. Juni 2004 10:15
To: Jacques.Martin@deza.admin.ch
Subject: Fw: 6-year rule

----- Original Message -----
From: David A Sack, MD
To: Jacques.Martin@iued.unige.ch ; Jacques Martin
Sent: Saturday, May 22, 2004 11:53 AM
Subject: 6-year rule

Dear Jacques:

Please find attached a letter on the above subject, together with an attachment which is self-explanatory.

I will look forward to receiving your response at the earliest.

With best wishes,

David A. Sack, MD
Executive Director, ICDDR,B
GPO Box 128
Dhaka 1000, Bangladesh
880-2-882-3031 (office telephone)

Berne / Lausanne, June 10th 2004

Dear David,

Thank you for your consulting me on your views regarding what you called the "six years rule" but which I see as covering also (and quite rightly) a broader array of questions regarding employment and career at the Centre.

I'll take the liberty not to answer too narrowly to the "six years rule", though I can already confirm that the broad lines of you understanding seems correct to me.

Without embarking into a long study I would share the following views with you (in my "Swiss English style" as Rita Colwell use to say !).

The Centre:

- is a research institution somewhat similar to an academic institution as we know them in developed countries
- should try and attract highly qualified scientists to carry on its activities
- should, as a sound, basic management rule, avoid retaining staff whose performance is not satisfactory; or retain staff because of family ties or for other reasons having nothing to do with the intrinsic qualities expected from someone to fill a given position (anti-nepotism rule)
- has to avoid keeping the same people in the same position for too long...
- should have a performance evaluation **system** in place, in order to review (ideally on a yearly basis) each individual performances
- should, as a consequence of this system, be allowed to terminate people, based on objective and transparent criterias, when the evaluation is not satisfactory or when the position is no more required and the person unable to take up another vacant position in the institution
- is not and should not become a public service.... As you know, David, we have fought hard in 1998-99 to keep the Centre lean and fighting fit, as we had observed that donors had started to have doubts regarding its shape ! Close to two hundreds posts had to be severed and this was done with as little pain as possible.
- ...

This being said, some flexibility is never out of place as long as it does not end-up in *laissez-faire* or is used as an excuse not to make hard-to-make decisions.

BUT.... the Centre also have the following characteristics :

- it is neither fully a Bangladeshi institution nor a developed country type of institution. As per the Ordinance it is an international institution based in Bangladesh and legally grounded in Bangladesh (there is no international convention, if I am not mistaken, having served as a base for the Centre creation);
- from this perspective the Centre is UNIQUE (as many people or things we like, we are happy to call it unique);
- however the centre is also quite a common set-up, from the financial support perspective : it is indeed fully supported by generous donorsand from this angle it is an international project / programme, not much different from several others, even if one can be happy to have the Government of Bangladesh as one of the serious donors [1];
- the governance of the Centre has both unique traits and quite common ones too : the Board of Trustees does have a master above its head and Trustees do not represent governments; this makes it somewhat unique for a donor supported development programme;
  on the other hand this Board is not disconnected from its international environment as there are permanently Board members "representing" WHO and UNICEF and also, besides the very much needed scientists, a few development generalists with a broader picture perspective;
- international expertise is originating from the two following worlds : one with pure academic background and one drawing from an international expertise background pool. The former may come with international experience too but those falling in this category have mostly worked in academic circles, the latter may have worked with various types of organisations, such as aid agencies, WHO, the World bank or UNICEF, to mention a few;
  private sector experience is here and there also available;
- unlike pure development projects, the Centre does not have to eventually become a national institution, thus does not have as a final aim to replace all international positions by local positions;
- it is wise and very appropriate however to have Bangladeshi senior staff (including at the managerial level) working at the Centre.

What am I aiming at with theses two sets of elements : the assertions and the nuances ?

1. in view of the above, there should be a **balance** between, on the one hand, an academic institution approach and search for solutions and, on the other hand, an international programme approach and search for solutions.

[1] which make the Centre unique, once again

2. **donors** (not represented as such on the BoT) should not be forgotten :
    a. they live outside the Centre and spend most of their time in dealing with the permanently changing world;
    b. they want the programs they support to follow certain course of action in view of the international financial / health / research agendas;
    c. they may want to see the programs reorganizing themselves and accepting fresh blood expertise more often then what those responsible for the Centre would deem necessary;
    d. they have vested interests : they would like to be able to post expertise they have at hand and would like to see rotate in their career;
    e. they have some interest in seeing the centre remaining truly international and multicultural;
    f. they see the merit to integrate the Centre in inter-institutional linkages (and obviously the Centre finds it valuable too);
    g. they may want (but I don't support it) to "instrumentalize" the Centre to make us of it for some of their own agendas;
    h. they are interested in measurable and visible results, not for the sake of the science itself, but for broader development objectives.

Based on the above, I would think that the Centre should **not** become a place where internationally recruited scientists would make a career and stay for many years. In an intercultural set-up, the ± six years rule is not a bad one; we also aim at it in other fields, such as development activities :

- the first year the person gets acquainted with a new reality;
- the second and consecutive years, the person elaborates and gives impulses based on its experience from earlier assignments (fresh blood); conception, planning and implementation ... this is the case for a few years (2-4, usually);
- soon the person starts to know a bit too well how things happen in his/her foreign environment and stops being fully creative; he or she becomes adaptative and survival or by-passing strategies based on efficiency become the way to operate;
- some people tend to stick to the post abroad as they are much better paid than if they were back home;
- some people fear competition and find it more relaxed to stay where they are.

In conclusion there are many good reasons not to extend internationally recruited staff much beyond a 5-6 years limit. Exceptions should probably be possible, but should remain such, avoiding creating precedents leading to a change of the rule.

Though not a scientist myself, as you well know, I would also consider that the Centre, as a center of excellence, should also take advantage of the most advanced state of the art, thus favouring mobility and rotation.

If one person seems particularly good and willing to work at and for ICDDR,B, why not consider having her or him come back after a reasonable time (say 3-5 years) spent doing something else somewhere else ? (just an idea)

I hope this is of help and would advocate (in a donor perspective) that the Centre sticks to something like a "six years rule".

Looking forward meeting you and colleagues next month.

Warm regards

Jacques

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To be included in the 6-year rule folder

Perspectives on the "6-year rule" at the ICDDRB

(Comments of Roger Eeckels, June 2004)

1. **The Ordinance**. The Ordinance, drafted in 1978, specifies that the director will serve for a maximum of six years. This was later changed in 1995 to be nine years. The limitation to a specified number of years was only for the director and did not apply to other international staff. My understanding of the rationale for this term limit was to prevent a single person from dominating the agenda of the Centre for a very long time, which might diminish the international character of the Centre as well as result in its stagnation.

   From the beginning of my rather troubled period at the Centre, I was made to understand that the 6-year rule applied to ALL international staff. Staff members could reapply after international advertisements. The idea was to bring in 'new blood' if a better candidate presented himself. ...

2. **Expansion of the "six-year rule."** In November 1985, during a time of financial crisis, the Centre's Board decided, to expand the 6-year rule to include other international staff, and also to impose a "strict nepotism rule."

   Allow me to be pedantic; in Latin, 'nepos' means nephew. Spouse rule would be a better name; spouse comes from the Latin 'sponsa.' Anyhow, that IS a UN rule. At least, I was made to understand that by different persons!). But I don't think it's a good rule for ICDDR,B.

   Because of the financial crisis, it seemed at the time that there was a crucial need to reduce the number of international positions.

   Costs HAD to be reduced. There was no alternative. ...

   Some factors leading to this decision included
   a. The Centre was facing a severe financial crisis that threatened the existence of the Centre. (***Right!***)
   b. Shortly prior to this meeting, several lower level IPO posts (P1 and P2) had been approved for administrative staff and the costs for these posts added to the projected deficit.
      ...
   c. Non-competitive appointments of local staff to international posts was again considered against UN rules.
   d. Several people (all nationals of Bangladesh) were completing 6 years as international scientists.

      That was definitely NOT the main issue. Yet, the fact that most were senior Bangladeshi persons did stir up many ill feelings amongst the Bangladeshi elite. ...

e. Three couples (six people) were working as international scientists at the Centre. Two couples were from the US and one couple was from Bangladesh. ...

Though not specifically stated in the minutes of the meeting, it seemed that the urgent need to reduce the budget led the Board to make the following decisions:

f. Not renew the contracts of those scientists who were completing six years. ...
g. Reverse the decisions to reclassify several posts from IPO 1 and IPO 2 to NO posts. (***Right***)
h. Terminate the contracts for three women with international contracts who were married to others at the Centre who also had international contracts (***Right***).

It is not clear if the Board understood that they were expanding the six year rule, or whether they felt that they were simply enforcing the "six year rule of the ordinance" as they interpreted it. This is not stated in the minutes, but I believe their intention was the latter. (***You are right there***) The decision to reverse the IPO1 and 2 positions was simply a judgement decision that these posts had been created inappropriately.

That's right again...

The decision to terminate the contracts of the women was thought to be enforcement of a WHO rule against nepotism.

Right again. ...

3. **"Slippage" of the "six-year rule."** Although the 1985 policy seemed to be clearly in favor or a 6-year rule, during the 1990's, at least two scientists continued as international scientists for many years beyond six years. It is not clear if the decision to continue these long tenures beyond six years was considered to be in violation of the earlier decisions.[1]

Re your footnote, *I do not think there was any such terminal payment in my days!*

4. **Revision of the six year rule, 1999.** During its November 1999 meeting (and the first meeting with Dr Sack as director) the Board clarified its position on the six year to make allowance for international staff to continue beyond 6 years, but under limited circumstances. The resolution from 1999 is copied here.

15/BT/Nov 99
The Board in clarifying the "6-year limitation rule" for incumbents of international professional posts, confirms the following policy:

[1] If long tenure is considered as the norm, the Centre should consider changing some of its staff rules to diminish the financial impact of a "terminal payment". Staff working longer than 10.5 years are eligible for a large payment based on their final salary.

• *That the first contract of 3 years is, in principle "renewable and may be followed by another 3 year contract, subject to (i) the post still being needed; (ii) the post not having been re-defined.*

• *That in case the post is no longer needed and / or the incumbent's performance is less than expected, this information be communicated to the incumbent at the time of the second annual performance evaluation discussion.;*

• *That on completion of the second 3-year contract (and assuming there is a continued need for the post), the normal expectation would be for the vacancy to be filled with a new staff member;*

• *That under exceptional circumstances, when it is in the best interests of the ICDDR,B, another new contract not exceeding 18 months may be considered and granted to the current incumbent;*

- *When a unique is making critical contribution; and/or*
- *When the terms of of tenure and the terms of contract requirements do not coincide;*

• *That even in either of these cases the vacancy be widely advertised, thus allowing open and fair competition on an equal footing by any and all interested.*

5. **Comparison of the rules of the Centre with other academic / development institutions.**
   a. In general, the Centre provides three-year contracts to its international staff. The business model used for these contracts is more like a long term consultant than a regular staff position since there is no expectation of the position being a "career" position. This is in contrast to most universities or other development organizations where senior staff generally are able to "build a career."

I wonder here. You do not get a tenured position in the US (or in Europe) without having proved that you deserve it. Even then, you can be kicked out (think of poor Tom Butler!). Moreover, when you get tenure, you either are a national or you choose to become a permanent resident, is it not? How many people from rich countries will want to settle and raise a family in Bangladesh?

The lack of a career structure suggests that the Centre is being maintained by the NO staff and that the international staff simply come for a few years as "long term consultants." One would question whether this is a suitable business model for the Centre.

It probably is not, but is there an alternative? Consider that in colonial days, expatriate 'colonials' were very well paid and could retire with handsome pensions after some 20 years of service. Usually in their early or mid-forties, they would then start a new career in their countries of origin ...

Also, note that if a WHO international salary is very attractive for

people from poor countries, it is a pittance for people from rich countries. At least, that is my personal experience!

Consider also that 'consultants' like Lincoln Chen, Dick Cash, Roger Glass or Andre Briend built their careers on their work at ICDDR,B but they gave much in return during their stay at the Centre.

You need a more stable staff than the Centre ever had. But you also need young, eager and able researchers (I don't know how to resolve that paradox). As to the latter, a probably unrealistic solution would be to have agreements with Western universities. They would offer a stay in Dhaka to some of their young staff members as part of their career tracks AND continue to pay them, instead of having the Centre pay for them. For example, the Bill & Melinda Gates Foundation should be rich enough to support such a scheme.

b. As an "international Centre" it seems logical that the Centre should have sites, in addition to the Headquarters in Bangladesh. For example, the International Agricultural Centres are located in more than 20 sites and staff frequently move between the different sites. An agricultural economist, for example, might apply his/her talents to a rice institute or a potato institute. Since the ICDDRB is the only international health research institute, this kind of movement is not possible. If there were other international health research Centres (or if the ICDDRB had additional sites), this type of Centre would clearly need senior staff with career prospects.

I agree! The late Bill Mashler dreamt of several ICDDR's, hence the final "B." Halftan Mahler was strongly opposed to such an idea. He clearly told me so. Perhaps the present WHO director would be less hostile... It IS a shame that the World Bank never gave its support to the Centre, more is the pity! Still, David, if there were an International Sickle Cell Centre in Lagos or Ibadan, I don't see expatriates moving from Bangladesh to Nigeria.

The MRC/Wellcome Africa Centre in Durban (where they do a lot of demographic surveillance bur little medicine) might learn a lot from the Centre's long experience. Would Michael Bennish be interested in a kind of exchange scheme? I would love to see young Africans receiving proper training in Dhaka! But even the late Ransome Kuti, an old friend of mine, when he was Nigeria's minister of health and came to visit ICDDR,B never could get such an arrangement from the ground.

This brings us to the topic of linking up, collaboration and exchanges with other institutions. I may be wrong but in my days, the Centre lived very much on its own. I'll return to that in my memo to you.

c. Recruitment of high level scientists to Dhaka is difficult and expensive, and replacing people who have completed 6 years may not be appropriate when one considers the effort, expense, and the lost opportunity.

d. Most universities have an "up or out policy" suggesting that junior faculty are expected to achieve promotions within a certain period of time. Within a certain period of time, a decision is made to either promote the person or else ask him/her to find work elsewhere. This policy results in potential for career development as well as some movement of staff (e.g. avoiding stagnation). This opportunity does not currently exist at the ICDDR,B.

No, it does not but the Centre might be too small for that. 'Going up' means leaving ICDDR,B and finding a better job elsewhere. There are many examples, as you know. The Centre is a hatchery for young scientific talent!

6. **Potential conflicts between the six-year rule and the promotion of Bangladeshi scientist to the international rank policy**. The Board approved a policy to allow Bangladeshi scientists to have international rank[2] and this policy allowed for Bangladeshi scientists who occupied international posts through competition would automatically revert to the rules of this new policy when they completed 6 years. The Centre will need to be careful to implement policies that do not discriminate between international staff depending on their nationality. That is, if a new policy allows international staff from other countries to exceed 6 years, there should be a clear non-discriminating rationale.

David, I don't understand the first sentence of the above paragraph. Anyhow, you are absolutely right. A person like Abdus Salaam (how's he doing?), if performing well, ought NOT to fall back on his prior status after 6 years. It would be cruel and silly. But should he get a life-long appointment?

7. **Changes in the ICDDRB scientific agenda**. The Centre's scientific methods have changed significantly over its 25 years. In the past, the protocols were heavily based in the CSD and LSD divisions where scientists carried out discreet clinical or lab based projects. These could generally be completed in a period of one to three years. This type of project is still being carried out, but increasingly, the Centre's research depends on implementation of field projects that is carried out over a number of years. Examples are the Minimat study or the Zinc scale-up project with implementation and measurements likely to continue for 5+ (or even 10) years. Another example is the HDSS, which is an ongoing project since 1966 with outcomes continuing for an indefinite period. Frequent changes in the leadership of such projects would severely hamper the success of the project and the productivity of the Centre.

[2] Actual salary depends on the amount of project support they receive.

I could not agree more. Longitudinal studies should be one of the strengths of the Centre!

8. **Is the six year rule a substitute for performance evaluations**? There may have been times in the past when termination of the contract at the end of the six-year contract period was easier to justify than was a discussion of the continued need for the post, or the individual's performance. Obviously, the needs of the Centre in fulfilling its strategic plan should be the key determinant for staff continuing to work at the Centre, and the Centre needs to have flexibility to continue or discontinue the services of a particular person. Loosing a job at the Centre should not necessarily be seen as a failure of the person, but more likely, it will suggest a miss-match between the individual's skills and those needed by the Centre at the time. That is, a job at the Centre should not be viewed as a "civil service position" with extensive protections for its staff, but equally true, if a person is contributing to the overall mission of the Centre, the Centre's rules should not artificially limit the term of service.

   You are right again. Yet, proper evaluation of staff is very difficult indeed. I tried to implement it with guidance from WHO experts but it never worked. It does not work at the Louvain University or any other place I know. Possibly all staff at Johns Hopkins or rather Stanford are at least near-geniuses. In most institutions, you get some very good people, some rather poor ones and in between decent chaps. The strength of the 'Johns Hopkins arrangement' with the Centre is that most people it sent out (including you) were very good, and young enough to be creative.

9. **Interaction of project funds and core needs of the Centre**. In the early days of the Centre, when most funds were core funds, the Centre could determine how to use its funds. With increasing proportion of funds from projects, there is increasing need to match positions with the funding, thus, the need to be flexible with regard to increasing and decreasing the numbers of international staff. This need for flexibility does not always match with our salary structure; e.g., a stable position with a modest salary may be attractive, and an unstable position with a high salary may be attractive, but an unstable position with a modest salary is difficult to fill.[3]

   Quite right! We get back to more core funds via e.g., the World Bank (not realistic) or another mentality of the donors (even less realistic). Again, what about 'contracts' with universities? The main problem is that rich countries and their citizens are not interested in poor countries and people living there. But some of us must go on, fighting the good fight! ...
   With my very best regards,

   Roger

[3] This is our current situation.

30 May 2004

Dear David and Ricardo

COMMENT ON "6 YEAR RULE"

Thank you for presenting the history and the issues related to the 6 year rule so clearly and concisely. I also appreciate the opportunity to make comment on a policy, some aspects of the implementation of which were very dear to my heart during my tenure as a member of the Board of the Centre.

I trust that my comments will be interpreted against a background of having been away from the Board for the past three years, and not being absolutely certain about what direction the Centre has decided to take in the coming years. This knowledge will be helpful in contextualizing my suggestions for how best this rule may need to be modified / implemented to secure a strong infrastructure of human resources relevant to the chosen direction.

1. The model of the Centre

I am not sure that contrasting the Centre's contractual agreements with those of academic institutions is useful, since the circumstances which led to the formulation of the six year rule – budgetary constraints – are the same as those driving our institutions in the same direction. In our setting at the University, as well as that of the SA Medical Research Council (with which I am most familiar), the trend is towards a decline in the number of tenured positions relative to contract positions. This is not only in response to decrease in the proportion of core relative to project funding in the budget, but also as one means to ensure quality and productivity.

However, I do agree that having a critical mass of tenured staff is essential to maintaining and developing a centre of excellence, and careful consideration regarding how this can be achieved - at the requisite level of excellence (and remuneration!) - is vital. In this model, the Centre would have a small core of permanent staff / staff with tenure for at least 10 – 15 years, complemented by a larger pool of shorter term research staff, and supported by a strong infrastructure of tenured administrative and other support staff.

2. An "international centre" based in one country / multi-countried

My understanding of the "international" character of the centre is two fold:

(i) The work of the Centre is focused on global health priorities, ie issues of international relevance; and

(ii) the staff of the centre are international in composition.

Because the focus is in line with the national priorities of Bangladesh, in my view there is no reason why the Centre should be multi-country in location. Instead, it can continue to

operate in Bangladesh, from where it can collaborate with national institutes in other countries, and with similar priorities.

In South Africa's case, many staff from our national Universities and research centres are world class, and do in fact migrate to other centres conducting work on global priorities, losing their tenure at the source institution. This is sadly the way the world seems to work, and if the Centre is seeking to establish a single Institution with satellites in many countries, this will certainly be novel in my experience. I am aware that the NIH has been considering multi-country sites (Gerald Keusch presented this at the conference of the Global Forum for Health Research in Arusha, Tanzania, two years ago), but I also know that this idea met with great resistance, especially from "southern" country institutional representatives.

3. Staffing an international centre, located in one country, with international staff
I am aware of the difficulties of relocation for a short period of time, and know that this is a dilemma not only experienced by the Centre, but also by other global institutions. One may argue that relocating to Geneva is easier than to Dhaka, and in some ways this may be true. However, when the history of the Centre is written (and we had a taste of this when we met the alumni at the Global Health Council award ceremony\in Washington some years ago), it will show that – despite the short term nature of the posts - the limited ICDDRB experience proved a highly effective springboard for many who have gone places in global health.

The other option is the secondment arrangement, through which world class scientists, concerned with research on the Centre's (and Bangladesh's) priorities, spend a limited (almost extended sabbatical) time away from the base institution, through a clear contractual agreement between the host (ICDDRB) and the sending institution.

This seems to have worked well over the years with institutions like Johns Hopkins, Gotebourg, the London School of Tropical Medicine and Hygiene and, more recently, CDC, and there is no reason why this sort of arrangement should not be extended to other institutions in the south like Ifakara in Tanzania, Oswaldo Cruz in Brazil, the University of Manila in the Phillipines, and, of course, the University of Cape Town and the Medical Research Council in South Africa.

For these "southern" scientists, the remuneration package and total costs may not have to be as high as those of their "northern" counterparts, and the return could be the same. The arrangement could even be extended to an exchange, rather than a unidirectional move to Dhaka (and perhaps the current experience of Abdullah Bacqi refers). This policy is already in place in some "southern" institutions (Professor MaryAnn Lansang is about to return to her base institution – University of Manila – after three years at the helm of INCLEN) and this can be explored further.

However, this practice will have to be located in the context of having a permanent core of excellent research staff to sustain the work and the leadership.

4. Career development and promotion based on performance review
I agree that during my time on the Board, this was a serious gap in both the structuring of posts and the performance review system, and deserves attention.

One recommendation may be to have a longer career trajectory within the Centre – maybe 10 – 15, rather than 6 years, with performance reviews at more frequent intervals (every three years), and multiple exit / promotion points.

The other area for attention is, of course, the post structure, which follows the UN system for "internationals", and some other system for Bangladeshis. Having the system proposed may also eliminate the "them" and "us" divide which has plagued staff relations for so long.

5. Bangladeshi nationals vs Internationals; a potential for conflict
This is a vexed issue with implications of inequity, and was always of particular concern to me as a newly democratised South African with an apartheid history!

In this area, the direction and long-term vision for the Centre is crucial in determining the course of action to be adopted. HR policies in our institutions are governed by a goal of redress of the inequities imposed by apartheid, and the strategies target institutional transformation and meeting HR equity targets, supported by national legislation. This may be one long-term vision; another may be to build an international centre of excellence in global health research, with sites all over the world and a staff of international scientists.

The two pathways for reducing the potential conflict may then be as follows:

(a) If the long-term intention is to ensure national "ownership" of international standards, HR and other policies and plans will have to be crafted accordingly to "affirm" Bangladeshi.

(b) On the other hand, if the long-term intention is to take the ICDDRB brand into the international community – in terms of staff and location – the strategy will have less emphasis on the retention and development of Bangladeshi nationals.

There are three levels at which this issue could be addressed:

(i) Retaining a long-term core of internationals (including Bangladeshis)
My feeling is that the best way to retain a Centre focusing on global priorities in a national setting is to have a large proportion of high quality internationals at the centre. These positions should be globally bench-marked and the criteria for appointment should be the same for all applicants. Where two applicants (Bangaldeshi and other) apply for the position(s), the Bangladeshi should be given preference if pathway (a) above is pursued.

(ii) Providing career pathways for all, including Bangladeshis, as described above

In this scenario, the challenge will be to ensure that the same criteria apply to all.

At the end of the 10 – 15 year path (as suggested), if pathway (b) is followed, a crucial decision will then have to be – how to retain the Bangladeshis??

(iii) Keeping a pool of Bangladeshi who move sideways and stay in, rather than up and out at every level of the career pathway. In our setting, performance assessment may result in promotion, staying the same, or having "remedial " intervention, after which "out" (but not up!) is possible.

This will need very careful consideration from the point of view of staff management, but especially from the available finance. However, having performance assessments for everyone – including support staff – is a very good component of HR systems, and in complex societies (like ours and tour at the Centre), having such tools is absolutely essential.

6. The challenges of the scientific agenda and its methods

There is no doubt that six years is a very short time in terms of the needs of cohort studies, large randomised control trials, vaccine studies and other interventive research projects.

It will therefore be very worthwhile to consider some of the large protocols in progress as a case study for providing an evidence base for changing from 6 years to x years.

Under circumstances where the principal investigator needs to be in place for a longer period than prescribed by the policy, there must be clear guidelines in place for directing decisions, rather than ad hoc agreements between individuals. Introducing such transparent and evidence-based policies will go a long way to building trust and reducing allegations of "nepotism".

7. Project funding vs core needs

This will continue to be a challenge as the opportunities for accessing core funding decrease. Clearly, the decisions about human resources must follow available financial resources, which in turn follow the scientific agenda.

Final comment

I believe that the issues which David raises in his message deserve priority attention as they have plagued the Centre and its operations for too long. The Board and executive need to make a decision about their vision for the governance and operations of the Centre in 25 years, and then take bold steps to realize that vision.

There may be hard realities of having to jettison ICDDRB traditional practices, in favour of rational practices, and I wish the leadership of the Board and the Centre well in taking the first steps along that path.

Dr. David Sack

From: "Henry Mosley" <hmosley@jhsph.edu>
To: "'David A Sack, MD'" <dsack@icddrb.org>
Cc: "Henry Mosley (E-mail)" <hmosley@jhsph.edu>
Sent: Sunday, May 30, 2004 8:45 AM
Subject: RE: 6-year rule

David - sorry not to have gotten back to you sooner on this. One reason is that this is a complicated issue that really should involve much more discussion that I can give by mail communication.

First, while I do not have the detailed minutes of the discussion of the ICDDR,B charter, I think you analysis of the basis for the 6 year rule is essentially correct. There was a concern about stagnation, and probably also about to avoid some people being able to hold onto their international positions because of political connections)nationally or internationally) so that removal would be difficult. But things are very different now, and new ways of looking at the problems are needed.

I read you letter and our "perspectives" but I am still a little unclear exactly what the issue is. In your last paragraph you talk about an "unstable position with a modest salary" as being the current situation that is not desirable. So I presume you are saying that given the compensation levels for international scientists, their positions should be "stable" - meaning longer than 3-6 years. But do you mean open-ended with regular reviews (like Hopkins faculty, more or less), or still have term contracts, but renewable without any limit? I am assuming you mean the latter, but for all practical purposes, these are not really different, is some kind of objective review is undertaken from time to time.

From this perspective, here is my thoughts on the matter. First, how would you define an "international" scientist. Are foreigners "international" by definition? So, an person like an American research associate or Assistant Professor would get "international" compensation, while a Bangladeshi person with the same credentials would be a "national" scientist. I say this, because maybe the issue isn't "international" versus "national", but rather, what does the market for scientists demand as compensation. After all, many good Bangladeshi scientists are very competitive for "international" compensation, both working for international organizations locally as well as internationally.

In this context, would it not be appropriate just to have one salary scale across the board for scientists - It could be quite a long scale, but based on the competitive market values for the expertise. For example, here at Hopkins, the salary levels for technically qualified people range from about $1,000/month to $20,000/month or even more. I know that this may sound "beyond imagination", but if the issue is keeping good people over the long haul, the driving force is the market place in Bangladesh as much as it is in Africa, or the USA. It is not really "international" versus "national".

This may not be what you wanted to hear, but maybe if you just change the paradigm for the discussion about getting and keeping the best people, you and the Trustees may come up with a real long term solution.

Henry Mosley

W. Henry Mosley, MD, MPH, Professor
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-----Original Message-----
From: David A Sack, MD [mailto:dsack@icddrb.org]
Sent: Saturday, May 22, 2004 1:53 AM
To: hmosley@jhsph.edu
Subject: 6-year rule

Dr. David Sack

From: <Dhabte@worldbank.org>
To: "David A Sack, MD" <dsack@icddrb.org>
Sent: Wednesday, May 26, 2004 9:52 PM
Subject: Re: 6-year rule

Dear David,

Thank you for seeking my views on the 6 yr rule. I found your analysis and conclusions in "Perspectives on the 6 yr rule at ICDDR,B", to be factual, perceptive and compelling. I agree that conditions have emerged that demand reconsideration of the rule. The genesis of the 6 yr rule for international staff was budgetary. It also provided at the time a ready tool to settle vexing and sensitive personnel issues. I was on the board and recall the discussions then.

To the best of my recollection, the subsequent wider interpretation of the rule was influenced by the practices of the International Agricultural Centers (from which many of the personnel and financial procedures were drawn). Also, the rule was 'exploited' or used to get rid of unproductive staff (in lieu of performance appraisal) in a non-combative and culturally acceptable manner, and also to make it easy for a new director to recruit the skill mix that reflects his/her priorities.

I believe that your suggestion to adapt the rule to existing circumstances is rational. I hope though that you take heed of the imperative to reflect the international character of the Center through recruitment of an international core of talented staff from different parts of the world.

I hope this is useful.

Warm regards,

Demissie.

Dr. David Sack

From: "william greenough" <wgreenou@hotmail.com>
To: <dsack@icddrb.org>
Cc: <trigsby@jhmi.edu>
Sent: Monday, May 24, 2004 5:52 AM
Subject: RE: 6-year rule

Dear David:

I am leaving for Chicago in about 12 hours but wanted to answer your letter concerning the "six year rule". It will be in the form of "bullet" points rather than a longer discussion. My thoughts are as follows:

1. The rule was to avoid entrenchment of individuals or groups of any nationality in order to insure continuation of an organization that provided equal opportunity for international level positions based in so far as possible on merit alone.

2. Therefore whatever pollicy is adopted by the Centre it should in so far a possible treat all nationalities equally as well as genders.

3. There is, however no "magic" in six years. Historically I think this time frame was adopted simply because that was the number negotiated for the Director. I believe the BOT has authority to set whatever policy is best for the Centre in this regard. I do believe that it is very important to seek some balance in the nations and regions of origin of senior staff. The tendency will be to recruit from neighboring areas thus potentially setting up an overweight of Indian and Bangladeshi scientists in control and making it harder for non indigenous scientists to be recruited. This is of course not necessarily the case and common sense should prevail.

4. Evaluation based on performance should always trump any rigid rules and there should be latitude fro exceptional performance and individuals.

5. I believe it is necessary for an international level staff member to have a "stake" in the Centre as a faculty member has in his or her university. I do not like the consultant model or think it is an effective way to go. All too often the Centre may be exploited by those with primary allegiances to their outside of Bangladesh institution setting the Centre up as more an expoitable resource rather than the principal institution driving the research agenda. This will in the long run defeat the whole concept on which the Centre was founded and conceived - at least in my mind.

6. Historically when international level Bangladeshi staff have moved on they have attained equal or higher rank in the institutions which recruited them. This should be reassuring to those who have administered the selection of local scientific staff to the international level.

I would personally favor a more flexible approach to this issue bearing in mind at all times the hazards of entrenchment and the deterioration of productivity that can accompany it. I will give this more consideration over the next week or so and add any further thoughts at that

time.

With Best Wishes, Buck Greenough
(W< B< Greenough, III, M.D.)

>From: "David A Sack, MD" <dsack@icddrb.org>
>Reply-To: "David A Sack, MD" <dsack@icddrb.org>
>To: <wgreenou@hotmail.com>
>Subject: 6-year rule
>Date: Sat, 22 May 2004 11:53:48 +0600
>
>Dear Bucky:
>
>Please find attached a letter on the above subject together with an
>attachment which is self-explanatory.
>
>I will look forward to receiving your response at the earliest.
>
>With best wishes,
>
>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
><< 6-yearlettertoformerDirs.doc >>
><< Perspectivesonthesixyearrule.doc >>

6-year rule

Dr. David Sack

From: "Ralph Henderson" <rafeandilze@earthlink.net>
To: "'David A Sack, MD'" <dsack@icddrb.org>
Cc: <ilze33@earthlink.net>
Sent: Monday, May 24, 2004 8:30 PM
Subject: RE: 6-year rule

Hi David. Clearly an important and complex issue. I do not see an easy black or white answer supporting or rejecting the 6 year rule. I do feel uncomfortable in having no term limits at all. How would you rationalize the term limits for the Director if there were none for others? And, with unlimited terms, you would probably have to do more to protect the rights of the incumbents, getting into the difficult bureaucratic mess of trying to fire an unsatisfactory employee—but fair to the employee if he or she is there expecting a life-time of employment. I do think the opportunities for 'up or out' would be helpful to have, but in the project dominated funding the Center now has, how realistic is this? I am pretty sure most of us would want to support a policy favored by the Director, who at least should be in the best position to judge what would be helpful. You may not have time before the Board in June, but they, like the rest of us, would probably do best if we had a specific set of recommendations to critique rather than trying to resolve the many issues by trying to create our own answers. With warm regards, Rafe Henderson

-----Original Message-----
From: David A Sack, MD [mailto:dsack@icddrb.org]
Sent: Saturday, May 22, 2004 2:50 AM
To: rafeandilze@earthlink.net
Subject: Fw: 6-year rule
Importance: High

----- Original Message -----
From: David A Sack, MD
To: Rafe Henderson
Sent: Saturday, May 22, 2004 11:55 AM
Subject: 6-year rule

Dear Rafe:

Please find attached a letter on the above subject, together with an attachment, which is self-explanatory.

I will look forward to receiving your response at the earliest.

With best wishes,

David

David A. Sack, MD
Executive Director, ICDDR,B
GPO Box 128
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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

6-Year rule

Dr. David Sack

From: "RICARDO UAUY" <ruauy@hotmail.com>
To: "David A Sack, MD" <dsack@icddrb.org>
Sent: Saturday, May 22, 2004 4:33 PM
Subject: Re: Board Matters

Dear David:

I am in full agreement on taking the suggested steps. A small, subtle change in the letter to former directors and board chairs. This is intended to highlight their contribution to the process.

.....

The purpose of the future Board decisions will be to determine what is best for the Centre in the future. **However to do this well, we need to ponder based on your experience and lessons learnt from the past.**

.....

I suggest we do not link the decision to Kim's contract, but define Kim's contract as a temporary measure until we have defined what to do with the 6 year rule. I favor a temporary renewal for 12 months. I think we should have a BOT position by then.

However, I agree with you that a fijnal decision should be taken in november after a BOT discussion, this is a critical issue for the center.

Best regards

Ricardo Uauy

----- Original Message -----
From: David A Sack, MD
To: ricardo uauy
Sent: Saturday, May 22, 2004 6:58 AM
Subject: Re: Board Matters

Dear Ricardo:

Thank you for your comments and the sensitivity of the issue was the reason I was requesting your advice. I agree we need full Board discussion and all we could do in June would be to introduce the topic and define the need for additional information gathering. The reason this came up now was the potential renewal of Kim's contract, and we will have to deal with that decision. It may be we could renew for 18 months, pending further Board discussion. I'll take item 10 out before sending and will also send to recent Board members for their guidance and former directors.

Best wishes,

David.

PS:
I am sending the attached letters to: Marian, Rita Colwell, Ralph Henderson, Jacques Martin, Rolf Carriere and Mike Merson (former Board members) and
Demissie, Roger, Bucky, Mr Bashir, Henry Mosley (former Directors).

----- Original Message -----
From: ricardo uauy
To: dsack@icddrb.org

Md. Shah Alam

From: David A Sack MD [dsack@icddrb.org]
Sent: Tuesday, October 19, 2004 4:31 PM
To: shahalam@icddrb.org
Subject: Fw: Board Matters

Do you have this on our 6-year rule file?
----- Original Message -----
From: ricardo uauy
To: dsack@icddrb.org
Sent: Thursday, May 20, 2004 6:21 PM
Subject: RE: Board Matters

Dear David:

I have examined the document, I think we need full BOT discussion on this.

I have made some comments to the draft see attached. I suggest this does not take substantive time of the June meeting, since we need full BOT discussion before establishing a change in policy. Process is vital to keep the BOT together in this matter, you may recall how in the recent past some key BOT members felt this rule should not be modified in any way. I clearly do not share that view, but as chair need to secure full discussion by all BOT members so we reach consensus on this critical issue.

I suggest keeping item 10 (the preliminary proposal') out of the document. Circulate the document to BOT members, have a preliminary discussion in the phone conference mainly to get all BOT members to express their views on process, then providing ample time for written input , say till August 04. Based on this we can ask administration to prepare a proposal for full BOT discussion and approval in Nov.

I hate to appear focus on procedure but I think this topic has the potential for polarization, thus should be treated with utmost care. I would even circulate the document to past BOT chairs including Rita Caldwell, and former center directors after our June meeting requesting input by Aug 04.

I fully agree we need a decision by the BOT in Nov 04. So this intensified process should not delay action.

Best regards

Ricardo Uauy

>From: "David A Sack, MD" <dsack@icddrb.org>
>Reply-To: "David A Sack, MD" <dsack@icddrb.org>
>To: "Dr. Ricardo Uauy Dagach" <ruauy@hotmail.com>
>Subject: Board Matters
>Date: Thu, 20 May 2004 10:08:12 +0600
>
>Dear Ricardo:
>
>An item which may need to be introduced during the upcoming meeting and finalized at the November meeting is a revision of the "6-year rule". Since such "rules" may be perceived to be developed for specific individuals, the rule is potentially sensitive. Thus I am seeking your advice on how to handle it at this meeting.
>
>I am attaching to this email my perspectives concerning the "6-year rule", along with a history describing its evolution.
>
>My preference is to include my document in a "confidential" envelope to the members of the Board. I have discussed it at the Centre Directorate meeting, but would prefer that the Board discussion be in a closed/closed session. Do you have thoughts on this ?
>
>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
><< Perspectivesonthesixyearrule.doc >>

Perspectives on the "6-year rule" at the ICDDRB

1. **The Ordinance.** The Ordinance, drafted in 1978, specifies that the director will serve for a maximum of six years. This was later changed in 1995 to be nine years. The limitation to a specified number of years was only for the director and did not apply to other international staff. My understanding of the rationale for this term limit was to prevent a single person from dominating the agenda of the Centre for a very long time which might diminish the international character of the Centre as well as result in its stagnation.

2. **Expansion of the "six-year rule."** In November 1985, during a time of financial crisis, the Centre's Board decided, to expand the 6-year rule to include other international staff, and also to impose a "strict nepotism rule." Because of the financial crisis, it seemed at the time that there was a crucial need to reduce the number of international positions. Some factors leading to this decision included
    a. The Centre was facing a severe financial crisis that threatened the existence of the Centre.
    b. Shortly prior to this meeting, several lower level IPO posts (P1 and P2) had been approved for administrative staff and the costs for these posts added to the projected deficit.
    c. Several people (all nationals of Bangladesh) were completing 6 years as international scientists.
    d. Three couples (six people) were working as international scientists at the Centre. Two couples were from the US and one couple was from Bangladesh.

    Though not specifically stated in the minutes of the meeting, it seemed that the urgent need to reduce the budget led the Board to make the following decisions:
    e. Not renew the contracts of those scientists who were completing six years.
    f. Reverse the decisions to reclassify several posts from IPO 1 and IPO 2 to NO posts.
    g. Terminate the contracts for three women with international contracts who were married to others at the Centre who also had international contracts.

    It is not clear if the Board understood that they were expanding the six year rule, or whether they felt that they were simply enforcing the "six year rule of the ordinance" as they interpreted it. This is not stated in the minutes, but I believe their intention was the latter. The decision to reverse the IPO1 and 2 positions was simply a judgement decision that these posts had been created inappropriately.

The decision to terminate the contracts of the women was thought to be enforcement of a WHO rule against nepotism and this move was strongly supported by the WHO representative on the Board at the time.[1]

3. **"Slippage" of the "six-year rule."** Although the 1985 policy seemed to be clearly in favor or a 6-year rule, during the 1990's, at least two scientists continued as international scientists for many years beyond six years. It is not clear if the decision to continue these long tenures beyond six years was considered to be in violation of the earlier decisions.[2]

4. **Revision of the six year rule, 1999.** During its November 1999 meeting (and the first meeting with Dr Sack as director) the Board clarified its position on the six year to make allowance for international staff to continue beyond 6 years, but under limited circumstances. The resolution from 1999 is copied here.

15/BT/Nov 99
The Board in clarifying the "6-year limitation rule" for incumbents of international professional posts, confirms the following policy:

- *That the first contract of 3 years is, in principle "renewable and may be followed by another 3 year contract, subject to (i) the post still being needed; (ii) the post not having been re-defined.*

- *That in case the post is no longer needed and / or the incumbent's performance is less than expected, this information be communicated to the incumbent at the time of the second annual performance evaluation discussion.;*

- *That on completion of the second 3-year contract (and assuming there is a continued need for the post), the normal expectation would be for the vacancy to be filled with a new staff member;*

- *That under exceptional circumstances, when it is in the best interests of the ICDDR,B, another new contract not exceeding 18 months may be considered and granted to the current incumbent;*
    - *When a unique person is making critical contribution; and/or*
    - *When the terms of tenure and the terms of contract requirements do not coincide;*
- *That even in either of these cases the vacancy be widely advertised, thus allowing open and fair competition on an equal footing by any and all interested.*

---

[1] In retrospect, this nepotism rule was likely misunderstood by the board since there are many examples of spouses being employed at WHO as long as they are not supervising one another. Also, the manner in which the female scientists were selected for termination is, in retrospect, clearly in violation of any gender policy. In all of the cases in which the women were released, the female scientists were equally qualified and productive as their husbands.

[2] If long tenure is considered as the norm, the Centre should consider changing some of its staff rules to diminish the financial impact of a "terminal payment." Staff working longer than 10.5 years are eligible for a large payment based on their final salary.

5. **Comparison of the rules of the Centre with other academic / development institutions.**

   a. In general, the Centre provides three year contracts to its international staff. The business model used for these contracts is more like a long term consultant than a regular staff position since there is no expectation of the position being a "career" position. This is in contrast to most universities or other development organizations where senior staff generally are able to "build a career." The lack of a career structure suggests that the Centre is being maintained by the NO staff and that the international staff simply come for a few years as "long term consultants." One would question whether this is a suitable business model for the Centre.

   b. As an "international Centre" it seems logical that the Centre should have sites, in addition to the Headquarters in Bangladesh. For example, the International Agricultural Centres are located in more than 20 sites and staff frequently move between the different sites. An agricultural economist, for example, might apply his/her talents to a rice institute or a potato institute. Since the ICDDRB is the only international health research institute, this kind of movement is not possible. If there were other international health research Centres (or if the ICDDRB had additional sites), this type of Centre would clearly need senior staff with career prospects.

   c. Recruitment of high level scientists to Dhaka is difficult and expensive, and replacing people who have completed 6 years may not be appropriate when one considers the effort, expense, and the lost opportunity.

   d. Most universities have an "up or out policy" suggesting that junior faculty are expected to achieve promotions within a certain period of time. Within a certain period of time, a decision is made to either promote the person or else ask him/her to find work elsewhere. This policy results in potential for career development as well as some movement of staff (e.g. avoiding stagnation). This opportunity does not currently exist at the ICDDRB.

6. **Potential conflicts between the six-year rule and the promotion of Bangladeshi scientist to the international rank policy**. The Board approved a policy to allow Bangladeshi scientists to have international rank[3] and this policy allowed for Bangladeshi scientists who occupied international posts through competition would automatically revert to the rules of this new policy when they completed 6 years. The Centre will need to be careful to implement policies that do not discriminate between international staff depending on their nationality. That is, if a new policy allows international staff from other countries to exceed 6 years, there should be a clear non-discriminating rationale.

[3] Actual salary depends on the amount of project support they receive.

7. **Changes in the ICDDRB scientific agenda**. The Centre's scientific methods have changed significantly over its 25 years. In the past, the protocols were heavily based in the CSD and LSD divisions where scientists carried out discreet clinical or lab based projects. These could generally be completed in a period of one to three years. This type of project is still being carried out, but increasingly, the Centre's research depends on implementation of field projects that is carried out over a number of years. Examples are the Minimat study or the Zinc scale up project with implementation and measurements likely to continue for 5+ (or even 10) years. Another example is the HDSS which is an ongoing project since 1966 with outcomes continuing for an indefinite period. Frequent changes in the leadership of such projects would severely hamper the success of the project and the productivity of the Centre.

8. **Is the six year rule a substitute for performance evaluations**? There may have been times in the past when termination of the contract at the end of the six-year contract period was easier to justify than was a discussion of the continued need for the post, or the individual's performance. Obviously, the needs of the Centre in fulfilling its strategic plan should be the key determinant for staff continuing to work at the Centre, and the Centre needs to have flexibility to continue or discontinue the services of a particular person. Loosing a job at the Centre should not necessarily be seen as a failure of the person, but more likely it will suggest a miss-match between the individual's skills and those needed by the Centre at the time. That is, a job at the Centre should not be viewed as a "civil service position" with extensive protections for its staff, but equally true, if a person is contributing to the overall mission of the Centre, the Centre's rules should not artificially limit the term of service.

9. **Interaction of project funds and core needs of the Centre**. In the early days of the Centre, when most funds were core funds, the Centre could determine how to use its funds. With increasing proportion of funds from projects, there is increasing need to match positions with the funding, thus, the need to be flexible with regard to increasing and decreasing the numbers of international staff. This need for flexibility does not always match with our salary structure; e.g. a stable position with a modest salary may be attractive, and an unstable position with a high salary may be attractive, but an unstable position with a modest salary is difficult to fill.[4]

10. Preliminary suggestions on a clarification of the limitation of service rules

a. The Centre should have posts that are designated as "Key International Posts (Scientific/Administrative)[5]" and these should normally be filled by persons who have three to five year contracts

[4] This is our current situation.

[5] Key International Scientific Administrative Posts include Directors of Scientific Divisions, HR and Finance and Heads of HDSS, and perhaps others.

(negotiated with the incumbent), with a first year as probationary[6]. A comprehensive internal evaluation of the person and the post should be completed at the end of the probationary period and a year prior to the end of contract and suggestions should be made concerning continuation of the person. If a change is needed, the position can be advertised. If it is in the interests of the Centre for the person to continue and the person is willing to continue, the job will not be advertised. If the person continues for up to ten years[7], another evaluation should be carried out with a strong preference for replacing the individual. If the evaluation concludes that the person is crucial to the plan of the Centre, the incumbent may continue. This ten year evaluation would be carried out by a team that includes a Board member.

b. For international positions that are not listed as "Key International Scientific Administrative Posts," but as "International Posts," the positions will be considered more as "faculty" at a university with person being recruited on a two year - renewable contract but subject to an up-or-out policy. The two-year contract period will allow a review the financial situation of the Centre and of the individual's projects to avoid long-term, unfunded situations. Consideration will be needed in this policy to insure non-discriminatory and fair treatment of Bangladeshi and expatriate staff. For more junior scientists, the Centre should have an up-or-out policy. Within a fixed number of years, if promotion is not appropriate for the scientist, continuation would be discouraged.

10. The views of the board are urgently sought in this matter of the "6-year rule."

[6] This will give the Centre an "out" in case the person is not suitable.

[7] The Centre's Director continues to be subject to conditions of the Ordinance.

Human Resources Agenda Update

7.1 Introduction

Human Resources has the overall responsibility for recruitment, compensation and benefits, contracts administration, staff development, gender equality, the staff clinic and data management. In addition, with the departure of the Senior Manager Support Services in September, the Transport, General Services and Cafeteria Services Units are now reporting to Human Resources.

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 284 individuals to the Centre, processed 1,140 contract extensions and 742 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.

Human Resources is presently recruiting for a Senior Manager, HR after the departure of S.K. Deb in August 2004 who took an international post in Kuwait.

7.2 Human Resource Information System

The stabilization of the system and using the system capabilities has kept Human Resources busy during the past 6 months. The staff from PWC, who were involved with the development of the HR module left in June. Since then the HR staff have been resolving all queries related to HR activities in Suchona. HR is executing payroll related processes independently.

HR continues to assist users center wide in their day today use of the system. All fixed term staff have been trained to access information from "My information" Menu in Suchona. As a result all leave application are now process on-line.

We have started the developments of pending reports to make maximize the use of the information in the system for analysis purposes. As expected with the implementation of such a large system, there is on-going maintenance and enhancements.

The progress, which has been achieved since the Centre went live with the system, has been tremendous and the efforts of all staff members involved should be recognized.

Human Resources Agenda Update

7.3 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, which were to be completed, have been delayed with the departure of the Senior HR Manager. 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.

7.4 Gender Equality

The annual progress report has been submitted as a separate agenda item.

7.5 Salary Survey

HR commissioned a salary survey and results will be discussed during HR committee meeting of the board.

Agenda 8 **BOT/HR/NOV/2004**

Gender Policy – Annual Report

The following documents are included:

1. Annual Progress Report, Gender Development Activities.
2. Gender Organizational Review, Executive Summary.
3. ICDDR,B Gender Policy Action Plan Framework.

Annual Progress Report
Gender Development Activities
(January-December 2004)

Introduction
The Centre has historically addressed issues related to gender equalities both at the organizational and activity level. In response to a growing realisation of the importance of addressing gender issues in a systematic way a Gender Equality Committee was formed in 2000 and a Gender Policy was approved by the Board of Trustees in June 2003. The Gender Equality Committee, as stated in the policy is required to submit to the Board of Trustees an annual progress report.

Important achievements of the period
The implementation of the Gender Policy started with the appointment of the Gender Specialist. The 'Gender Organizational Review' is a significant achievement for the Centre this year. The review assessed key organisational structures and procedures to identify whether and how they promote or hinder the gender equality goals as formulated in the Gender Policy, and identify possible measures to overcome these biases.

Key Challenge
The initial challenges of the Centre have been to make the staff understand the importance of addressing gender issues in a scientific research organization such as ICDDR,B. There is somewhat of a denial syndrome for gender consideration among staff as well as the management. It appears that for the Centre staff, addressing gender issues is a *nice thing to do* but not a *must* or even *useful thing to do*. However, this is not unexpected in an organization, which has traditionally not systematically addressed gender related issues. The major challenge is not only awareness to gender issues but having staff take ownership and make a sincere effort for mainstreaming gender in ICDDR,B.

Environmental Factors
The devastating flood and rain during August-September 2004 affected the scheduled programme for gender awareness and dissemination workshops.

Sl.	Activities	Responsibilities	Timeframe	Expected output	Present Status
1	Recruitment of Gender Specialist Task: • Prepare Job Description for Gender Specialist • Advertise the position • Short-listing the candidates • Interview process • Appointing the Gender Specialist	Director HR	Feb. 2004	Center will have a competent Gender Specialist to look after gender related issues	Completed Gender Specialist is appointed
2	Translation and Printing of the Gender Policy Task: • Translate the Gender Policy into Bangla • Provide requisition for printing the policy • Provide both English and Bangla version of the Policy to the printer • Monitor printing activities and proof reading	Director HR Gender Specialist	March-May 2004	Centre will have a specific policy to act on gender related issues	Completed 1500 Gender Policy booklets printed in English and Bangla

Sl.	Activities	Responsibilities	Timeframe	Expected output	Present Status
3	Conduct training for GEC Members on Gender Analysis Task: • External resource persons were selected • Prepare a two-day training program with handouts • Conduct the training	Director HR Gender Specialist	April, 2004	Gender competencies among Gender Equality Committee (GEC) members are enhanced resulting in the application of gender issues in the activities of ICDDR,B.	Completed A two-day training was conducted for the GEC members
4	Conduct Gender Awareness Workshop for staff Task: • Develop a module on Gender Awareness for dissemination of gender policy • Piloting the module with a group of staff • Finalize the module • Translate the module into Bangla • Conduct Gender Awareness Workshops for the staff	Director HR Gender Specialist	June - December 2004	Staff members are aware of the gender policy and concepts related to gender resulting in the application of gender issues in the program activities of the Centre.	Gender training module developed both in English and Bangla. To date 106 staff (men=56, women=50) from different levels have received an orientation on gender awareness and the Centre's gender policy.

Sl.	Activities	Responsibilities	Timeframe	Expected output	Present Status
5	Gender Organizational Review Task: • Contact and select a consulting organization with a strong gender background for the review • Finalize the methodology and procedure. • Review existing policies and procedures • Conduct questionnaire survey on randomly selected 260 staff • Conduct 14 consultation workshop with the staff at different levels • Interview with key stakeholders • Draft report prepared • Discussion meetings with GEC and provide comment • Finalize the Report	Director HR Gender Specialist	February-October 2004	All policies and procedure reviewed in light of the gender policy. The gaps are identified to take further actions.	Completed Executive Summary is submitted to BoT Review Report presented to the CD in November 2004

Sl.	Activities	Responsibilities	Timeframe	Expected output	Present Status
6	Develop Gender Action Plan for 2005-2006 Task: • Conduct discussion meeting with GEC members and other key stakeholders for Prioritize the issues/action for implementation • Develop the draft action plan for year 2005-2006 with the help of International consultant • Conduct meetings with GEC and various stakeholders on final draft	Director HR Gender Specialist GEC Members	October 2004	ICDDR,B is recognized as a gender sensitive organization and working towards gender equality	In progress A draft action plan developed and to be presented to the various stakeholders of the Centre
7	Gender Equality Committee (GEC) meetings Task: • Identify dates and venue for GEC meeting • Identify agenda for the meeting • Send memo to all GEC members informing the dates and agenda prior to the meeting • Write meeting minutes and distribute to the members.	Gender Specialist GEC Members	Every two months (if required can be more frequently)	Centre will have a strong, committed advocacy group to deal with current gender issues	6 GEC meetings conducted and meeting minutes prepared

Sl.	Activities	Responsibilities	Timeframe	Expected output	Present Status
8	Observation of International Women's Day Task: • Plan & take preparation for the day • Implement the special program	Director HR Gender Specialist	March 8, 2004	Staff members are aware of the significance of International Women's Day.	International Women's Day observed by the Centre
9	Networking with other organizations working on gender issues	Director HR Gender Specialist	Throughout the year and this is a continuous process	ICDDR,B establishes linkages with gender promoting groups and organizations and acquire knowledge, current information on gender issues and also be a part of national activities on gender.	Representation of ICDDR,B in different gender forum A Report on achievement of ICDDR,B on the basis of Beijing Platform for Action was submitted to NGO Coalition on Beijing Process (NCBP), Bangladesh in September 2004
10	Reporting on Gender related Activities	Director HR Gender Specialist	June 04 and Dec. 04	A consolidated report is available to assess the progress	Report submitted to BoT, November 2004
11	Address any emerging issues related to gender	Director HR Gender Specialist GEC Members	Throughout the year and this is a continuous process	If and when any emerging issue came up it was solved with efficiency	Few internal issues were addressed • staff clinic • SWA activities

Action Plan for Gender Development Activities (January-December 2004)

Sl.	Activities	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
1	Recruitment of Gender Specialist												
2	Translation and Printing of the Gender Policy												
3	Conduct training for GEC Members on Gender Analysis												
4	Conduct Gender Awareness Workshop for staff												
5	Gender Organizational Review												
6	Develop Gender Action Plan for 2005-2006												
7	Gender Equality Committee (GEC) meetings												
8	Observation of International Women's Day												
9	Networking with other organizations working on gender issues												
10	Reporting on Gender related Activities												
11	Address any emerging issues related to gender												

Gender Organisational Review

ICDDR,B: Centre for Health and Population Research

April - October, 2004

Carried out by
Naripokkho on behalf of
Human Resources, ICDDR,B

Team Members:
Maheen Sultan (Team Leader)
Sheepa Hafiza
Ranjan Karmakar
Anisa Khatoon
Rina Roy

Advisors
Ann Gauvin Walton
Shamima Nasrin Mili
Gender Equality Committee Members

Executive Summary

Background to the Review: ICDDR,B: Centre for Health and Population Research, is a non-profit, international research, training and service institution based in Dhaka, Bangladesh. The Centre's work encompasses a full spectrum of issues related to child health, infectious disease and vaccine sciences, reproductive health, nutrition, population sciences, health and family planning systems research, HIV/AIDS and poverty and health. In response to a growing realisation of the importance of addressing gender issues in a systematic way a Gender Equality Committee was formed in 2000 and a Gender Policy was approved by the Board of Trustees in June 2003. As part of Policy it is envisaged that "All policies and procedures will be reviewed in the light of the gender policy. Any discriminatory policies and procedures will be amended and measures necessary for facilitating and promoting the increased participation of women will be identified." The present review was designed to respond to the above.

The **objectives of the Review** are to review key organisational structures and procedures to identify whether and how they promote or hinder the gender equality goals as formulated in the Gender Policy, and identify possible measures to overcome these biases. This implies a review of ICDDR,B as an organisation from a gender perspective, using the gender policy as the criteria for, or basis of, the review.

The **methodology** included desk review of various documents, especially policies, 14 consultations were carried out with 231 staff (127 women and 104 men); seven key informant interviews; thirteen interviews with a number of ICDDR,B management and senior staff; staff questionnaire survey of 238 respondents (a response rate of 78%) and various key structures and committees were reviewed and the role of management in promoting gender equity was reviewed.

The fact that ICDDR,B is an international organisation is an important aspect of its **image.** This means that it has an outside reputation and an international identity. The Centre has a reputation as a good employer: it provides job security, salaries are paid on time, and it is considered to be a "decent" amount. The Centre also has the image of being a training or learning ground. The **culture** of the Centre is seen to be hierarchical and patriarchal. Seniority is a predominant value and most of the senior staff are men. The "looking up to the seniors" is compounded by the "ageism" in the Bangladeshi culture. The senior, older staff are mainly all men and young women staff are at the bottom of the ladder in terms of power, both because of their gender and because of their age. Professional excellence and academic achievements are valued. Along with competition value is given to hard work and dedication to one's work. Senior staff acknowledges that staying after hours was encouraged among the researchers and people were implicitly encouraged to sacrifice their families and social life for their profession.

The ratio between men and women staff have been constant for the last 4 years with men varying between 52 to 53% of total workforce and women accounting for 47 to 48% of the workforce. Certain job families are heavily biased towards men. An analysis of sex and grade show that women are in fact heavily represented in lower categories (GS1 being the exception in having 157 men to 28 women) and having more women than men in GS 2, GS3 and GS6. Men staff ratio is high (61%) in fixed term jobs. On the other hand women staff ratio is high as Contractual Service Agreement (CSA) staff (60%) and as daily wagers (56%), where the benefits are less.

While there may not be equal numbers of women applying for all posts, there is a perception that women are not given equal opportunities and we can see the results in terms of lesser women recruited, especially at higher levels and posts. The questionnaire responses indicate that the staff believe that the recruitment process is inclined towards supporting male appointments and women staff are not very comfortable about it. In the consultations women expressed the feeling that men were given preference for higher positions. There is also a feeling that not only is there a preference for men but more generally that recruitment and applications for new posts are influenced by Favouritism and Partiality.

It is evident from the survey and consultations that, in general, ICDDR,B provides good **work facilities**. However, staff feel working conditions could be improved, particularly in the area of leave, overtime system, promotion, professional development, transport and transfer policies. The perception of staff is that the rules and regulations are not uniformly applied to women and men. They mentioned that biases against gender and religion persist. In most of the cases women at the general services level face more problems related to changing rooms, staff clinic, toilets and office accommodation. GS women believe that they are not treated well by their Supervisors.

On the issue of **working overtime** gender differences can be seen. After office hour work and excessive workload is a big issue of most staff and results in overburdened women, as they are often responsible for household welfare and family care. Clearly senior managers value long and late hours of work. The tendency to encourage and reward long hours of work overburdens women. They face a constant struggle to balance work and family demands and are exposed to more risk during night travel. Women would be more interested in doing overtime if the Centre could provide transportation home. However this is subject to the supervisor putting in a requisition, the cost of which is then charged to the Unit or project. They would also need prior warning to be able to deal with family responsibilities.

Shift duty is mainly applicable for nurses, doctors and certain laboratory staff. During the consultations and also as observed in the Hospital, evening work for nurses is more overburdening as there is inadequate administrative support due to the absence of any person to undertake patient registration, and inadequate presence of guards leads to a more insecure work environment for nurses.

Staff, especially nurses, feel work and facilities related to **hartal** is biased towards Doctors, as they get the transport service, whereas nurses- mostly women- are deprived of the benefit.

Although there are provisions for **leave** and also **compensatory time off**, at the field level and for nurses, staff have complained that they cannot avail of their leave because of lack of staff. Like some other benefits, four months paid maternity leave with reimbursement of child delivery related medical expenses, is available only to fixed term staff. Paternity leave is not foreseen in the staff rules. Contractual staff, by definition, is not eligible for any leave, including maternity.

In some working stations the issue of adequate **space** and **physical facilities** is affecting the staff and in particular women. Field offices do not always have separate toilets and changing rooms. The consultations as well as the hospital observations raised issues of lack of space and physical facilities for related staff. There are differences between the facilities available for nurses and other staff. A point mentioned several times is the fact that the wards in the hospital are unisex: men, women and children are in beds next to each other and the attendants of each are also in the wards.

With regard to **interpersonal behaviour**, the key informants during interview identified two types of behaviour that they are "subjected to" by some men. One is the "father or guardian model" versus professional colleague. And the other is that of "sex object" versus "human being" model. Various sources of information also mentioned that staff, both men and women, had to face unsatisfactory behaviour from staff in Finance, Procurement, Transport and Human Resources. A common issue in the consultations was the relationship between supervisor and staff. This was specially mentioned by those who are in the position of being supervised. Some even felt that for them the supervisors were more powerful that the PIs or even the Centre Director. Women mentioned that their supervisors were more often men.

All fixed term employees may use **transport facilities** for pick-up and drop service. The staff members working shifts at the hospital are provided transportation as well as those working 8:30 to 5 pm. Under the questionnaire survey, in response to whether or not both women and men staff members are treated equally by the transport unit, women clearly feel that they are not treated equally. A common complaint during the consultations was the misbehaviour from the drivers towards women, especially the younger women.

From the various questions in the questionnaire survey about field trips and **accommodations** it is evident that in general women staff face much more problems than men, in terms of finding the right kind of secure accommodation. Again while men staff have mentioned that field offices help them to find secure accommodation, not many women staff agreed to that. It seems that support for women staff are not adequate or not addressing their needs.

All fixed term staff and their families are eligible for **medical care** from the Centre and the Staff Clinic. Staff members working outside the main Centre had complained that it is difficult for them to access the staff clinic (field sites). Another issue raised during the consultations was that senior people, including doctors, did not respect the line and appointments made by the others and just went into the doctors' rooms. The Team also observed that the family members of lower grade staff were addressed and treated more casually and even callously. In response to whether or not both women and men staff are treated equally by staff clinic, 1.5% men and 21% women from Centre and 3% men and 6% women from Field said they are not treated equally.

Staff development is promoted by the Centre with the ultimate objective of benefiting itself i.e. it will support staff developing themselves in the areas of expertise that are the most relevant to the Centre's work. Staff training and capacity building is not particularly geared to women capacity development, and there is an absence of gender awareness observed in general. The logic and understanding of gender equality is clearly absent from the capacity building system and process. Training opportunities are more 'competitive' than 'supportive' for women. Another important means of staff development is "mentoring". Although most senior staff that the Review Team talked to recognized this an important function that they are to play, there is also a feeling that the concept is understood differently by different people.

Generally ICDDR,B management recognizes that the **performance appraisal** system is not entirely satisfactory and various steps are being taken to prepare for a reform of the system, including carrying out job reclassifications and identifying job families. From the responses to the questionnaire survey it is clear that both men and women staff feel they face problems in terms of their performance being appraised properly, but in the field more women have problems than men.

ICDDR,B has procedures for **reclassification** of posts as well as **promotions**. These various procedures and the differences between them do not seem to be clear to most staff. It is envisaged that ICDDR,B will move towards a system of merit-based compensation. This is not very familiar to all levels of staff and they do not all feel comfortable about it. A common complaint in the consultations was that promotion processes are not transparent and candidates are pre-selected. Certain categories of women staff were most vocal about problems of promotion to the supervisor level.

The Board of Trustee and the CD have expressed their open support for the Gender Policy and commitment towards gender equality. Among senior management attitudes towards gender equality are positive but understanding of gender discrimination and inequalities and commitment towards ensuring gender equality vary.

ICDDR,B has a number of **key decision making bodies**. The presence of women on these committees is quite low. The different bodies vary in their interest and follow-up on gender related issues. From an organisational perspective, apart from the ERC, which has the provision of one member being responsible or representing "women's affairs", none of the other committees has a person designated to address gender issues. When asked in the questionnaire survey "Are you comfortable voicing your opinion at different levels of management" it was found that the Centre Directorate is least accessible for men and women, but more so for women and also more so for Field Staff. Other levels are more accessible, with PIs being the most accessible. The figures show that there is room for improvement in terms of interactions between different levels of management and general staff.

In order to ensure mainstreaming of gender equality various **polices, procedures, and rules have to be revised** such as the byelaws and guidelines of key committees (BOT, CD, ERC, RRC) should be reviewed and revised to ensure adequate participation of women and discussion on gender related issues. Staff rules need to be reviewed and revised, performance appraisal systems modified; greater transparency ensured in recruitment and selections; a strategy for staff development formulated with special considerations for women and various measures taken to ensure that working conditions are congenial for both women and men staff.

Various kinds of **knowledge and attitudes** throughout the Centre also need to be changed. This includes knowledge about staff rules; norms for interpersonal behaviour; attitudes towards work after office hours; the value given to women's opinions and the chances they have to develop their skills and knowledge.

Also in order to ensure mainstreaming of gender equality various **practices** have to be revised. These include what jobs are done by women and men; increasing employment of women scientists and also women in administration; ensuring women have space in meetings (physical and also in terms of discussions); encouraging networking among women and making financial allocations to ensure gender mainstreaming, both at project and core budget levels, to demonstrate organisational commitment towards gender equality.

ICDDR,B Gender Policy Action Plan Framework

1 **Introduction**: In order to take forward ICDDR,B's Gender Policy (GP), a draft action plan has been outlined for consideration by the stakeholders in the following areas identified by the Policy:

Organizational: An in depth review has been undertaken of the organizational aspects of ICDDR,B, which has provided a range of recommendations. These recommendations, combined with the objectives and activities in the Policy, have formed the basis of the following short / medium / long term objectives and short-term action plan.

Research, Interventions, Service and Training: To allow the development of an action plan that has been agreed by those in key positions to influence change, the first step is to carry out a review of current systems and need.

2 **Short / Medium / Long Term**: The following is an outline of the timeframe and what has been included in the objectives grid and action plans described below.

Term	Timeframe	Objectives	Action Plan
Short term	2005 - 2006	First steps to be taken	• needs assessment • establishing baselines • development of plans • initial implementation of plans
Medium term	2007 - 2008	Review	• Reviewing plans • Firming targets • Ongoing implementation
Long term	2009 - 2010	GP broadly achieved	• Implementation • 2010: review of achievements

3 **Objectives**: Broad objectives have been suggested for each of the Policy's areas.

Organizational: Long, medium and short-term objectives have been set for the following activities in relation to the overarching GP objectives. There is some overlap between a number of the categories, such as *Review and revision of policies and procedures* and *Conducive Environment*.

Mainstreaming policy: organizational commitment / resource allocation	Awareness raising	Conducive Environment
• Gender mainstreaming accountability / responsibility • Increased women's participation and representation • Review and revision of policies and procedures	• Awareness raising	• Supporting childcare responsibilities • Ensuring safe transport • Ensure safe accommodation • Equal services for males and females from the Staff Clinic

Research, Interventions, Service and Training: There is a single, long term objective to address the overall objective of ensuring all activities of the Centre are carried out equitably, as appropriate.

4 **Action Plan**: The action plan identifies activities to be undertaken in the short term (2004–2006), with indicators, time, responsibility and cost (and comments/ assumptions). Because there are very detailed recommendations from the Organizational Review for *recruitment* and *working conditions*, these sections are general and will require consideration by HR (the will lead for most of this area of work) of which recommendations will be implemented.

5 **Next Steps**: The Draft Short/ Medium/ Long Term Objectives and Action Plan will be taken to a wider audience in ICDDR,B for costing and final agreement.

Staff Salaries

Agenda 9.1 National Officer & General Services Categories

A report on this agenda item will be presented during the meeting of Human Resources Committee of the Board.

Staff Salaries

Agenda 9.2 International Professional Category

A report on this agenda item will be presented during the meeting of Human Resources Committee of the Board.

Any other business

5/BT/NOV 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

November 2004

ICDDR,B BOARD OF TRUSTEES MEETING

FINANCE COMMITTEE MEETING - NOVEMBER 28, 2004

AGENDA

1. Approval of Agenda
2. 2004 Forecast
3. 2005 Budget
4. Staff Salaries and Allowances: [paper copy not enclosed]
   a) National
   b) International
5. Update on:
   a) Hospital Endowment Fund
   b) Centre Endowment Fund
   c) Reserve Fund
6. Other Items:
   a) Overdraft Facilities
   b) Cheque Signatories
   c) Exchange Rates
   d) Update on banking arrangements
   e) Accounting Policies
7. Draft Resolutions

Tables [2002 – 2005] :

Table I	Revenue and Expenditure
Table II	Unrestricted and Restricted Revenue and Expenditure
Table III	Contributions
Table IV	Contributions by Unrestricted and Restricted Funds
Table V	Unrestricted Projects/Programs and Management Expenditure (Net)

Annexure:

A - Report of the Finance Committee: June 2004
B - Accounting Policies
C - Glossary of Acronyms and Abbreviations

2004 FORECAST

REVENUE

Contributions from Donors, Endowment Funds and other receipts (including exchange gain) increased by $3,083,000 (19%) from $16,559,000 to $19,642,000 in November forecast. The increase comprises:

	TABLE	2004 November FORECAST	2004 June FORECAST	Increase/(Decrease) Amount	%
RESTRICTED					
Direct : Operating	II	11,417,000	9,527,000	1,890,000	20
Capital	II	560,000	283,000	277,000	50
Endowment Funds	IV	205,000	201,000	4,000	80
Restricted Direct	II	**12,182,000**	**10,011,000**	**2,171,000**	**22**
Indirect	II	1,897,000	1,660,000	237,000	12
Projects/Programs		**14,079,000**	**11,671,000**	**2,408,000**	**21**
UNRESTRICTED					
Contribution		4,801,000	4,168,000	633,000	13
Exchange gain		100,000	100,000	-	
Other Receipts		662,000	620,000	42,000	6
Total Revenue	II	**$ 19,642,000**	**16,559,000**	**3,083,000**	**19**

Restricted direct revenue increased in November due to implementation of new projects and increased level of spending in projects funded by Government of Bangladesh (GoB) ($260), Center for Disease Control and Prevention (CDC) ($170), Gates-GoB ($65), The Netherlands ($250), Sida/SAREC ($200), United Kingdom /DFID ($100), USAID/Dhaka ($275), USA/ National Institute of Health (NIH) ($275), US other sources ($350), WHO ($83) and other smaller donors ($470).

Restricted indirect revenue increased mainly in line with spending as mentioned above.

Unrestricted revenue increased mainly due to additional fund received for Flood Relief Activities 2004 from UNDP ($374), USAID/Dhaka, Japan, American Express Bank Ltd., and individual donors. This increase is partially reduced due to unfavorable exchange rate against currencies of Australia, Canada, The Netherlands and Sweden – Sida/SAREC.

2004 FORECAST

EXPENDITURE

Operating expenditure before depreciation increased in November forecast by $2,811,000 (16%) from $ 17,169,000 in June to $19,980,000. The increase comprises:

	TABLE	2004 November FORECAST	2004 June FORECAST	Increase/(Decrease) Amount	%
RESTRICTED					
Direct - Operating		11,622,000	9,728,000	1,894,000	19
- Capital		560,000	283,000	277,000	98
Restricted Direct	II	**12,182,000**	**10,011,000**	**2,171,000**	**22**
UNRESTRICTED					
Projects/Programs		5,973,000	5,119,000	854,000	17
Management		1,825,000	2,039,000	(214,000)	(11)
Total Unrestricted		**7,798,000**	**7,158,000**	**640,000**	**9**
Operating Expenditure (a)	II	19,980,000	17,169,000	2,811,000	16
Total Revenue (b)	II	19,642,000	16,559,000	3,083,000	19
Projected Gap (b-a)	II	**(338,000)**	**(610,000)**	**(272,000)**	**(45)**
Depreciation	II	1,027,000	912,000	115,000	13

Restricted expenditure increased in line with restricted revenue as elaborated under revenue.

Unrestricted expenditure in projects/programs increased primarily due to expenditure incurred for flood relief activities in the recent devastating flood.

Unrestricted management expenditure decreased primarily more recovery against services.

Depreciation increased by $115,000 (13%) from $912,000 to $1,027,000 in November due to acquisition of assets.

Projected Gap (Shortfall) before depreciation reduced by $272,000 (45%) from $610,000 in June to $338,000 in November because of the net effect of changes in revenue and expenditure as noted above. With inflow of few funds at the end of the year management is hopeful to have a small surplus in 2004.

2005 BUDGET

REVENUE

Contributions from Donors, Endowment Funds and other receipts (including exchange gain) are budgeted at $15,267,000 compared to a forecast of $19,642,000 for 2004. This decrease of $4,375,000 (22%) comprises:

	TABLE	2005 BUDGET	2004 FORECAST	Increase/(Decrease) Amount	%
RESTRICTED					
Direct : Operating	II	7,866,000	11,417,000	(3,551,000)	(31)
Capital	II	373,000	560,000	(187,000)	(33)
Centre Endowment Fund	IV	0	5,000	(5,000)	(100)
Hospital Endowment Funds	IV	200,000	200,000		
Restricted Direct	II	**8,439,000**	**12,182,000**	**(3,743,000)**	**(31)**
Indirect	II	1,480,000	1,897,000	(417,000)	(22)
Projects/Programs		**9,919,000**	**14,079,000**	**(4,160,000)**	**(30)**
UNRESTRICTED					
Contribution		4,592,000	4,801,000	(209,000)	(4)
Exchange gain		100,000	100,000	0	0
Other Receipts		658,000	662,000	4,000	0.6
Total Revenue	II	**$ 15,269,000**	**19,642,000**	**(4,373,000)**	**(22)**

Restricted direct revenue is budgeted at $9,919,000 which is lessen by $4,160,000 (30%) from $14,079,000 forecast of November 2004. This decrease is primarily due to projected reduced level of spending and nearing completion of the projects funded by the GoB($686), CDC ($153), Gates-GoB ($425), The Netherlands ($91), New England Medical Center (NEMC) ($86), Sida/SAREC ($684), UK/DFID ($222), USAID/Dhaka ($719), USA/NIH ($200) Other US sources ($432), International Vaccine Institute (IVI) ($270), The Wellcome Trust and some smaller donors, and completion of projects of CIDA, EU, and Swiss Red Cross (SRC). This decrease is partially offset by increased level of spending in projects funded by Gates Foundation ($400), Global Forum for Health Research, UNICEF, Unocal Corporation, International Center for Research on Women, WHO and some small donors.

Restricted indirect revenue is expected to decrease by $417,000 (22%) from a forecast of $1,897,000 to $1,480,000 mainly due to decrease in level of spending as mentioned above.

Unrestricted direct revenue is higher in 2004 by $209,000 (4%) due to receipt of one off contribution for flood relief activities. This decrease in 2005 is partially reduced by increased level of funding by Sida/SAREC ($214).

2005 BUDGET

EXPENDITURE

Operating expenditure for 2005 is budgeted at $17,285,000 compared to $19,980,000 forecast for 2004. This decrease of $2,695,000 (13%) comprises:

	TABLE	2005 BUDGET	2004 FORECAST	Increase/(Decrease) Amount	%
RESTRICTED					
Direct - Operating		8,066,000	11,622,000	(3,556,000)	(31)
- Capital		373,000	560,000	(187,000)	(33)
Restricted Direct	II	**8,439,000**	**12,182,000**	**(3,743,000)**	**(31)**
UNRESTRICTED					
Projects/Programs		6,592,000	5,973,000	619,000	10
Management		2,254,000	1,825,000	429,000	24
Total Unrestricted		**8,846,000**	**7,798,000**	**1,050,000**	**13**
Operating Expenditure (a)	II	17,285,000	19,980,000	(2,695,000)	(13)
Total Revenue (b)	II	15,269,000	19,642,000	(4,373,000)	(22)
Projected Gap (b-a)	II	**(2,016,000)**	**(338,000)**	**(1,678,000)**	**(496)**
Depreciation	II	1,028,000	1,027,000	1,000	

Restricted expenditure is expected to decrease in line with restricted revenue.

Unrestricted projects/programs expenditures are increased mainly due to budgeting of full year's salary support of Director PHSD and few local new positions.

Unrestricted expenditure by management is increased due to budgeting for the position of Deputy Executive Director and 2-3 new local position and other small expenses.

Depreciation is budgeted at $1,028,000 and is expected to increase slightly by $1,000 from $1,027,000 in forecast.

Projected Gap (Shortfall) before depreciation for 2005 is projected at $2,016,000, an increase of $1,678,000 (496%) from 2004 forecast of $338,000 because of the net effect of changes in revenue and expenditure as the budget noted above.

The budget is prepared on a conservative basis including only those funding sources, where we have signed agreements with donors. Management expects that donors will approve other project funding proposals, which are in pipeline. In addition, funding of projects by Sida/SAREC 2005-2007, Global Forum for Health Research, USAID, PATH, WHO, GfATM and many other donors are awaiting formal approval from the donors. The Projected gap as budgeted will be narrowed down by forthcoming contributions in the near future.

UPDATE ON:

a) Hospital Endowment Fund:

	Market value(US$)
Balance as at January 01, 2004	5,925,000
Add: Donations and fund raised	25,000
	5,950,000
Net income from investment	57,000
	6,007,000
Unrealized Gain	31,000
Balance as on September 30, 2004	6,038,000

The funds were invested in money market, equity mutual funds and fixed income mutual funds managed by TIAA-CREF Trust Company, USA (68%) [59.60% in Equities and 40.40% in Debt Instruments]; Time Deposits with American Express Bank in Singapore (27%); and Government Bonds, Equities and Debentures in Bangladesh (5%).

b) Centre Endowment Fund:

	Market value(US$)
Balance as at January 01, 2004	3,834,000
Add: Net income from investment	54,000
	3,888,000
Unrealized Gain	31,000
Balance as on September 30, 2004	3,919,000

All the funds are invested in money market funds, equity mutual funds and fixed income mutual funds managed by TIAA-CREF Trust Company in USA. 60% of the Fund is presently held in Equities and 40% in Debt Instruments.

Management has proposed a transfer up to $120,000 from the Centre Endowment Fund in 2005. This amount will be used for Institutional development activities, further development of the interdivisional thematic programs and other activities approved by the Executive Director.

c) Reserve Fund:

The Reserve Fund was established in 1982 with a fund capital of $1,342,000 (built over the years) 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 $2,005,000 on January 1, 2004. In 2004 this fund is expected to earn $25,000 investment income at an average rate of 1.5% per annum; and $25,000 is expected to be transferred to Operating Fund to offset the cumulative operating deficit.

Time Deposit made out of this fund is under lien to American Express Bank Ltd., to the extent of the Centre's overdraft facility of $2,000,000.

OTHER ITEMS:

a) Overdraft Facilities:

Bank Overdraft:

The Centre's current $2 million overdraft facility with American Express Bank carries no commitment fees is authorized through July 31, 2005. Interest rates are the bank's prime rate in USA (currently 4.75%) and the special rate (8.25%) negotiated by the Centre with the bank. The facility is used to meet temporary shortfall in operating fund. In consequence of the large cumulative deficit and time lag in receiving contributions, there will be perennial need for overdraft time to time to meet operating costs. This overdraft facility is secured by time deposits of the Reserve Fund.

Interest expenses is forecast to be $23,000 in 2004 and budgeted at the same level in 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) Cheque Signatories:

Dr. Marjorie Koblinsky, is the Director PHSD effective September 01, 2004. Management recommends that the name of Dr. Koblinsky be inducted as authorized signatory from Group II.

Dr. Charles P. Larson, is the Director HSID effective July 01, 2004. Management recommends that the name of Dr. Larson be inducted as authorized signatory from Group II.

c) Exchange Rates:

Presently Bangladesh currency is floated with other basket of currencies, and as such the question of devaluation / currency adjustment does not arise. But as a result of continued global recessions and booming oil price, it is apparent from the recent trend that the Taka vis-à-vis US Dollar is under pressure and in future there may be continuation of depreciation of the local currency. In this backdrop of exchange rate, the current rate of inflation is 5.83%, although the popular notion is a double-digit figure based upon the current escalation of prices of essentials during the past few months.

d) Update on banking arrangements:

The main banker of ICDDR,B is American Express Bank Ltd.(AMEX), and at present the Centre has accounts relationship with its Head Office based in New York as well its branches located in Dhaka, Singapore and London. In the middle of September 2004 AMEX announced to close its general banking activities in Bangladesh and by June 2005 the activities of this bank will be taken over by some other multi-national banks based in Bangladesh. The Centre is carefully examining the activities and efficiency of other multi-banks vis-à-vis our global banking requirements, and has a consensus that the accounts maintained with AMEX-Dhaka will be shifted to a multi-national bank, which would be best suited for the Centre.

e) Accounting policies:

Accounting policies are the set of guidelines the management use of classify and measure the financial transaction in order to reflect it true and fairly in the Financial Statements. While preparing the Financial Statements management exercise certain judgments and make certain estimates. During audit the Auditors' assess whether the accounting principles used and significant estimates made by management, are in conformity with the accounting policies disclosed as a note, which forms a part of the Financial Statements.

Accounting policies of the Centre are based on the generally accepted accounting principles applicable for "not for profit" organization and consistently followed from the inception. The accounting policies are enclosed as Annexure -B.

These accounting policies are approved by the Board of Trustees as a part of their approval to the Financial Statements. However, these are not adopted separately by way of resolution in earlier board meetings. This policies are required to be formally adopted vide a board resolution after necessary discussion.

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 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 $338,000 shortfall in 2004.

RESOLUTION – 02 (Agenda No. 3)

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

The Board agrees to approve the 2005 budget as presented noting that in June 2006 the Board will review the financial position of the Centre based on the Break-even plan of the Centre Directorate. The Management is encouraged to continue to take all measures possible to avoid the projected gap of $2,016,000 in 2005.

RESOLUTION – 03 (Agenda No. 5a)

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

The Board authorizes $200,000 to be transferred from the Hospital Endowment Fund to operations in 2005 as deemed necessary by the Executive Director.

RESOLUTION – 04 (Agenda No. 5b)

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

The Board authorizes the transfer of up to $120,000 from the Centre Endowment Fund in 2005 and that such unexpended monies may be carried over into 2006.

RESOLUTION – 05 (Agenda No. 5c)

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 in 2005.

RESOLUTION – 06 (Agenda No. 6a)

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 Ltd. for the year to July 31, 2006.

RESOLUTION – 07 (Agenda No. 6b)

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

Dr. Marjorie Koblinsky, is the Director PHSD effective September 01, 2004. Management recommends that the name of Dr. Koblinsky be inducted as authorized signatory from Group II.

Dr. Charles P. Larson, is the Director HSID effective July 01, 2004. Management recommends that the name of Dr. Larson be inducted as authorized signatory from Group II.

RESOLUTION – 08 (Agenda No. 6e)

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

The Board reviews the enclosed accounting policies and resolves to adopt the policies. Henceforth, any changes in the accounting policies will be approved/ratified by the Board of Trustees.

RESOLUTION – 09 (Agenda No. 4)

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

The Board approves a salary increase of ------% for all NO and GS staff effective January 1, 2005 and a ------% salary increase for all international staff effective January 1, 2005.

Tables

TABLE - I
ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
REVENUE AND EXPENDITURE 2002 - 2005

(Amount in US$ '000)

	2002 ACTUAL		2003 ACTUAL		2004 Jun. FORECAST		2004 Nov. FORECAST		2005 BUDGET		INCREASE/ (DECREASE) FORECAST vs. BUDGET	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	AMOUNT	%
REVENUE												
UNRESTRICTED FUNDS	3,486	22	4,638	27	4,168	25	4,801	24	4,592	30	(209)	(4)
RESTRICTED FUNDS											-	
- INDIRECT	1,848	12	1,594	9	1,660	10	1,897	10	1,480	10	(417)	(22)
- PROJECTS / PROGRAMS	9,942	62	10,279	60	9,948	60	12,112	62	8,373	55	(3,739)	(31)
CONTRIBUTIONS	**15,276**	**96**	**16,511**	**96**	**15,776**	**95**	**18,810**	**96**	**14,445**	**95**	(4,365)	(23)
EXCHANGE GAINS / (LOSS) (NET)	45	-	(6)	-	100	1	100	1	100	1	-	-
OTHER RECEIPTS	670	4	676	4	683	4	732	4	722	5	(10)	(1)
TOTAL REVENUE	**15,991**	**100**	**17,181**	**100**	**16,559**	**100**	**19,642**	**100**	**15,267**	**100**	(4,375)	(22)
EXPENDITURE:												
SALARIES AND BENEFITS - LOCAL	7,100	45	7,563	44	7,692	45	8,158	41	7,249	42	(909)	(11)
SALARIES AND BENEFITS - INTERNATIONAL	2,648	17	2,914	17	3,091	18	3,268	16	3,386	20	118	4
CONSULTANCY	254	2	155	1	221	1	227	1	141	1	(86)	(38)
MANDATORY COMMITTEE	85	1	117	1	113	1	92	-	108	1	16	17
TRAVEL	577	4	549	3	428	2	628	3	426	2	(202)	(32)
SUPPLIES AND MATERIALS	2,066	13	1,975	12	2,422	14	3,009	15	1,700	10	(1,309)	(44)
REPAIRS AND MAINTENANCE	175	1	186	1	168	1	182	1	212	1	30	16
RENT, COMMUNICATION AND UTILITIES	490	3	540	3	463	3	550	3	488	3	(62)	(11)
PRINTING AND PUBLICATIONS	260	2	288	2	340	2	362	2	330	2	(32)	(9)
TRAINING AND DISSEMINATION	171	1	172	1	139	1	146	1	120	1	(26)	(18)
STAFF DEVELOPMENT	152	1	113	1	69	-	65	-	94	1	29	45
OTHER EXPENDITURE	1,238	8	1,586	9	1,586	9	2,579	13	2,459	14	(120)	(5)
CAPITAL EXPENDITURE	702	4	860	5	437	3	714	4	570	3	(144)	(20)
TOTAL OPERATING EXPENDITURE	**15,918**	**100**	**17,018**	**100**	**17,169**	**100**	**19,980**	**100**	**17,283**	**100**	(2,697)	**(13)**
SURPLUS/(SHORTFALL) BEFORE DEPRECIATION	**73**		**163**		**(610)**		**(338)**		**(2,016)**		(1,678)	**496**
DEPRECIATION	956		1,001		912		1,027		1,028		1	-
SHORTFALL AFTER DEPRECIATION	**(883)**		**(838)**		**(1,522)**		**(1,365)**		**(3,044)**		(1,679)	**123**

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

TABLE - II
ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
UNRESTRICTED AND RESTRICTED REVENUE AND EXPENDITURE 2002 - 2005

(Amount in US$ '000)

	2002 ACTUAL			2003 ACTUAL			JUN. 2004 FORECAST			NOV. 2004 FORECAST			2005 BUDGET		
	UNRESTR	RESTR.	TOTAL	UNRESTR	RESTR.	TOTAL	UNRESTR	RESTR.	TOTAL	UNRESTR	RESTR.	TOTAL	UNRESTR	RESTR.	TOTAL
REVENUE															
UNRESTRICTED FUNDS	3,486		3,486	4,638		4,638	4,168		4,168	4,801		4,801	4,592		4,592
RESTRICTED FUNDS															
- INDIRECT	1,848		1,848	1,594		1,594	1,660		1,660	1,897		1,897	1,480		1,480
- PROJECTS / PROGRAMS		9,942	9,942		10,279	10,279		9,948	9,948		12,112	12,112		8,373	8,373
CONTRIBUTIONS	**5,334**	**9,942**	**15,276**	**6,232**	**10,279**	**16,511**	**5,828**	**9,948**	**15,776**	**6,698**	**12,112**	**18,810**	**6,072**	**8,373**	**14,445**
EXCHANGE GAINS / (LOSS) (NET)	45		45	(6)		(6)	100		100	100		100	100		100
OTHER RECEIPTS	633	37	670	635	41	676	620	63	683	662	70	732	658	64	722
TOTAL REVENUE	**6,012**	**9,979**	**15,991**	**6,861**	**10,320**	**17,181**	**6,548**	**10,011**	**16,559**	**7,460**	**12,182**	**19,642**	6,830	8,437	**15,267**
EXPENDITURE:															
SALARIES AND BENEFITS - LOCAL	3,213	3,887	7,100	3,987	3,576	7,563	3,960	3,732	7,692	4,042	4,116	8,158	4,259	2,990	7,249
SALARIES AND BENEFITS - INTERNATIONAL	1,153	1,495	2,648	1,324	1,590	2,914	1,654	1,437	3,091	1,600	1,668	3,268	2,084	1,302	3,386
CONSULTANCY	33	221	254	8	147	155	7	214	221	18	209	227	18	123	141
MANDATORY COMMITTEE	85	-	85	117	-	117	113	-	113	91	1	92	108	-	108
TRAVEL	(68)	645	577	(85)	634	549	(207)	635	428	(154)	782	628	4	422	426
SUPPLIES AND MATERIALS	946	1,120	2,066	1,020	955	1,975	847	1,575	2,422	1,335	1,674	3,009	1,054	646	1,700
REPAIRS AND MAINTENANCE	79	96	175	67	119	186	115	53	168	83	99	182	122	90	212
RENT, COMMUNICATION AND UTILITIES	266	224	490	303	237	540	234	229	463	278	272	550	333	155	488
PRINTING AND PUBLICATIONS	116	144	260	204	84	288	204	136	340	220	142	362	237	93	330
TRAINING AND DISSEMINATION	7	164	171	12	160	172	17	122	139	17	129	146	9	111	120
STAFF DEVELOPMENT	(96)	248	152	(74)	187	113	(71)	140	69	(47)	112	65	48	46	94
OTHER EXPENDITURE	489	749	1,238	(89)	1,675	1,586	363	1,223	1,586	373	2,206	2,579	479	1,980	2,459
INTERDEPARTMENTAL SERVICES	(454)	454	-	(302)	302	-	(232)	232	-	(212)	212	-	(106)	106	-
	5,769	9,447	15,216	6,492	9,666	16,158	7,004	9,728	16,732	7,644	11,622	19,266	8,649	8,064	16,713
CAPITAL EXPENDITURE	170	532	702	206	654	860	154	283	437	154	560	714	197	373	570
TOTAL OPERATING EXPENDITURE	**5,939**	**9,979**	**15,918**	**6,698**	**10,320**	**17,018**	**7,158**	**10,011**	**17,169**	**7,798**	**12,182**	**19,980**	**8,846**	**8,437**	**17,283**
SURPLUS/(SHORTFALL) BEFORE DEPRECIATION	**73**	-	**73**	**163**	-	**163**	**(610)**	-	**(610)**	**(338)**	-	**(338)**	**(2,016)**	-	**(2,016)**
DEPRECIATION	956		956	1,001		1,001	912		912	1,027		1,027	1,028		1,028
SHORTFALL AFTER DEPRECIATION	**(883)**	-	**(883)**	**(838)**	-	**(838)**	**(1,522)**	-	**(1,522)**	**(1,365)**	-	**(1,365)**	**(3,044)**	-	**(3,044)**

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

Table - III

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

CONTRIBUTIONS 2002 - 2005

(Amount in US$ '000)

Donors	2002 ACTUAL Amount	%	2003 ACTUAL Amount	%	2004 Jun. FORECAST Amount	%	2004 Nov. FORECAST Amount	%	2005 BUDGET Amount	%
Australia - AusAID	214	1.4	292	1.8	267	1.7	285	1.5	220	1.5
Bangladesh	766	5.0	970	5.9	860	5.5	1,115	5.9	434	3.0
Belgium - BADC/BTC	128	0.8	111	0.7	72	0.5	43	0.2		
Canada - CIDA	94	0.6	892	5.4	1,067	6.8	1,175	6.2	1,216	8.4
Centre for Disease Control & Prevn. (CDC)	117	0.8	281	1.7	317	2.0	488	2.6	335	2.3
Centre Endowment Fund	71	0.5	46	0.3	1	-	5	-		
European Union - BHARP	293	1.9	(9)	(0.1)			39	0.2		
Ford Foundation	243	1.6								
Gates Foundation			311	1.9	2,299	14.6	2,248	12.0	2,647	18.3
Gates - GoB Award	413	2.7	729	4.4	442	2.8	507	2.7	82	0.6
Hospital Endowment Fund			400	2.4	200	1.3	200	1.1	200	1.4
International Vaccine Institute (IVI)	352	2.3	545	3.3	286	1.8	291	1.5	21	0.1
Japan	410	2.7					1	-		
Netherlands	1,856	12.1	2,312	14.0	1,243	7.9	1,508	8.0	1,481	10.3
New England Medical Center (NEMC)	147	1.0	137	0.8	106	0.7	86	0.5		
Saudi Arabia	53	0.3	50	0.3	50	0.3	50	0.3		
Sri Lanka			4	-			4	-	4	-
Sweden - Sida/SAREC	711	4.7	937	5.7	968	6.1	1,185	6.3	715	4.9
Switzerland - SDC	500	3.3	750	4.5	1,000	6.3	1,000	5.3	1,000	6.9
Swiss Red Cross (SRC)	162	1.1	161	1.0	82	0.5	97	0.5	15	0.1
Thrasher Research Fund	226	1.5	93	0.6	95	0.6	117	0.6	13	0.1
United Kingdom - DFID	1,507	9.9	1,712	10.4	2,287	14.5	2,384	12.7	2,165	15.0
UNDP/UNOPS - Japan	149	1.0	89	0.5						
UNICEF	230	1.5	118	0.7			32	0.2	57	0.4
USAID - Dhaka	2,291	15.0	2,445	14.8	1,520	9.6	1,716	9.1	997	6.9
USAID - Washington	1,875	12.3	525	3.2						
USA - National Institute of Health (NIH)	442	2.9	470	2.8	964	6.1	1,239	6.6	1,038	7.2
USA - Other Sources	289	1.9	560	3.4	583	3.7	933	5.0	501	3.5
Wyeth Pharmaceuticals, Inc.	186	1.2	124	0.7			3	-		
WHO	439	2.9	163	1.0	184	1.2	267	1.4	190	1.3
Self Sustaining	82	0.5	64	0.4	136	0.9	92	0.5	214	1.5
Others	1,031	6.8	1,229	7.4	746	4.7	1,700	9.0	900	6.2
Total Contributions	**15,276**	**100**	**16,511**	**100**	**15,776**	**100**	**18,810**	**100**	**14,445**	**100**

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

TABLE 14

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH
CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 2002 - 2005

(Amount in US$ '000)

Donors	2002 Actual		2003 Actual				2004 Jun Forecast				2004 Nov Forecast				2005 Budget			
	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%
Unrestricted Funds																		
Australia - AusAID	163	1.1	219		219	1.3	201		201	1.3	220		220	1.2	220		220	1.5
Bangladesh	174	1.1	335		335	2.0	339		339	2.1	334		334	1.8	339		339	2.3
Belgium - BADC/BTC	59	0.4				-				-				-				-
Canada - CIDA	48	0.3	859		859	5.2	1,066		1,066	6.8	1,174		1,174	6.2	1,216		1,216	8.4
Netherlands	1,845	12.1	2,116		2,116	12.8	1,186		1,186	7.5	1,200		1,200	6.4	1,264		1,264	8.8
Saudi Arabia	53	0.3	50		50	0.3	50		50	0.3	50		50	0.3				-
Sri Lanka		-	4		4	-				-	4		4	-	4		4	-
Sweden - Sida/SAREC	269	1.8	305		305	1.8	326		326	2.1	335		335	1.8	549		549	3.8
Switzerland - SDC	500	3.3	750		750	4.5	1,000		1,000	6.3	1,000		1,000	5.3	1,000		1,000	6.9
USAID - Washington	338	2.2				-				-				-				-
Others	38	0.2				-				-	484		484	2.6				-
Total Unrestricted	**3,486**	**22.8**	**4,638**		**4,638**	**28.1**	**4,168**		**4,168**	**26.4**	**4,801**		**4,801**	**25.5**	**4,592**		**4,592**	**31.8**
Restricted Funds																		
Australia - AusAID	51	0.3	14	58	72	0.4	13	53	67	0.4	13	52	65	0.3				-
Bangladesh	592	3.9	94	540	634	3.8	104	417	522	3.3	103	678	781	4.2	19	76	95	0.7
Belgium - BADC/BTC	69	0.4		111	111	0.7		72	72	0.5		43	43	0.2				-
Canada - CIDA	46	0.3	1	32	33	0.2		1	1	0.0		1	1	-				-
Centre for Disease Control & Prevn. (CDC)	117	0.8	47	234	281	1.7	49	269	317	2.0	84	404	488	2.6	79	256	335	2.3
Centre Endowment Fund	71	0.5		46	46	0.3		1	1	-		5	5	-				-
European Union - BHARP	293	1.9		-9	-9	-0.1				-		39	39	0.2				-
Ford Foundation	243	1.6				-				-				-				-
Gates Foundation		-	75	236	311	1.9	557	1,742	2,299	14.6	545	1,703	2,248	12.0	642	2,005	2,647	18.3
Gates - GoB Award	413	2.7	29	700	729	4.4	7	435	442	2.8	7	500	507	2.7	1	81	82	0.6
Hospital Endowment Fund		-		400	400	2.4		200	200	1.3		200	200	1.1		200	200	1.4
International Vaccine Institute (IVI)	352	2.3	103	442	545	3.3	57	229	286	1.8	58	233	291	1.5	4	17	21	0.1
Japan	410	2.7				-				-		1	1	-				-
Netherlands	11	0.1	2	194	196	1.2	7	49	57	0.4	4	304	308	1.6	3	214	217	1.5
New England Medical Center (NEMC)	147	1.0	32	104	137	0.8	25	81	106	0.7	19	67	86	0.5				-
Sweden - Sida/SAREC	442	2.9	112	520	632	3.8	118	524	642	4.1	157	693	850	4.5	23	143	166	1.1
Switzerland - SDC		-				-				-				-				-
Swiss Red Cross (SRC)	162	1.1	21	140	161	1.0	11	71	82	0.5	13	84	97	0.5	2	13	15	0.1
Thrasher Research Fund	226	1.5	6	87	93	0.6	6	89	95	0.6	8	109	117	0.6	1	12	13	0.1
United Kingdom - DFID	1,507	9.9	176	1,537	1,712	10.4	235	2,052	2,287	14.5	236	2,148	2,384	12.7	269	1,896	2,165	15.0
UNDP/UNOPS - Japan	149	1.0		89	89	0.5				-				-				-
UNICEF	230	1.5	-5	123	118	0.7				-	1	31	32	0.2		57	57	0.4
USAID - Dhaka	2,291	15.0	578	1,867	2,445	14.8	302	1,218	1,520	9.6	347	1,369	1,716	9.1	203	794	997	6.9
USAID - Washington	1,537	10.1	105	420	525	3.2				-				-				-
USA - National Institute of Health (NIH)	442	2.9	16	454	470	2.8	27	937	964	6.1	38	1,201	1,239	6.6	25	1,013	1,038	7.2
USA - Other Sources	289	1.9	52	508	560	3.4	68	515	583	3.7	131	802	933	5.0	77	424	501	3.5
Wyeth Pharmaceuticals, Inc.	186	1.2	28	96	124	0.7				-	1	2	3	-				-
WHO	439	2.9		163	163	1.0		184	184	1.2		267	267	1.4		190	190	1.3
Self Sustaining	82	0.5		64	64	0.4		136	136	0.9		92	92	0.5		214	214	1.5
Others	993	6.5	108	1,122	1,229	7.4	73	673	746	4.7	132	1,084	1,216	6.5	132	768	900	6.2
Total Restricted	**11,790**	**77.2**	**1,594**	**10,279**	**11,872**	**71.9**	**1,660**	**9,948**	**11,608**	**73.6**	**1,897**	**12,112**	**14,009**	**74.5**	**1,480**	**8,373**	**9,853**	**68.2**
Total Contributions	**15,276**	**100**	**6,232**	**10,279**	**16,511**	**100**	**5,828**	**9,948**	**15,776**	**100**	**6,698**	**12,112**	**18,810**	**100**	**6,072**	**8,373**	**14,445**	**100**

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

TABLE - V

ICDDR,B : CENTRE FOR HEALTH AND POPULATION RESEARCH

UNRESTRICTED PROJECTS/PROGRAMS AND MANAGEMENT EXPENDITURE (NET) 2002 - 2005

(Amount in US$ '000)

	2002 ACTUAL		2003 ACTUAL				2004 Jun. FORECAST				2004 Nov. FORECAST				2005 BUDGET			
	Net Costs	%	Gross Costs	Recovery	Net Costs	%	Gross Costs	Recovery	Net Costs	%	Gross Costs	Recovery	Net Costs	%	Gross Costs	Recovery	Net Costs	%
PROJECTS/PROGRAMS																		
Clinical Sciences Division	**1,427**	**27**	**1,081**	**(112)**	**969**	**16**	**1,801**	**(74)**	**1,727**	**26**	**2,170**	**(119)**	**2,051**	**29**	**2,211**	**(139)**	**2,072**	**25**
Divisional Activity	2	-	129	-	129	2	336	-	336	5	170		170	2	184		184	2
Support Services	65	1	145	(84)	61	1	152	(74)	78	1	178	(108)	70	1	298	(138)	160	2
Core Funded Research	47	1	24	-	24	-	13	-	13	-	128		128	2	140		140	2
Hospital Services	1,313	25	783	(28)	755	12	1,300	-	1,300	20	1,694	(11)	1,683	24	1,589	(1)	1,588	19
Laboratory Sciences Division	**65**	**1**	**1,554**	**(923)**	**631**	**10**	**1,344**	**(958)**	**386**	**6**	**1,604**	**(935)**	**669**	**9**	**1,625**	**(851)**	**774**	**9**
Divisional Activity	216	4	275	(17)	258	4	309	(7)	302	5	259	(11)	248	3	243		243	3
Support Services	(151)	-3	1,040	(906)	134	2	1,035	(951)	84	1	1,070	(919)	151	2	1,077	(841)	236	3
Core Funded Research	-	-	239	-	239	4	-	-	-	-	275	(5)	270	4	305	(10)	295	4
Public Health Sciences Division	**1,126**	**21**	**1,841**	**(185)**	**1,656**	**27**	**1,662**	**(190)**	**1,472**	**23**	**1,760**	**(186)**	**1,574**	**22**	**2,032**	**(144)**	**1,888**	**23**
Divisional Activity	294	6	113	(7)	106	2	345	-	345	5	166		166	2	296		296	4
Support Services	118	2	239	(178)	61	1	228	(190)	38	1	387	(184)	203	3	409	(144)	265	3
Core Funded Research	304	6	1,043	-	1,043	17	578	-	578	9	712	(2)	710	10	881		881	11
Hospital Services	410	8	446	-	446	7	511	-	511	8	495		495	7	446		446	5
Health Systems and Infectious Diseases Division	**473**	**9**	**563**	**(3)**	**560**	**9**	**641**	**(3)**	**638**	**10**	**761**	**(3)**	**758**	**11**	**718**	**(2)**	**716**	**9**
Divisional Activity	91	2	200	-	200	3	288	-	288	4	105		105	1	74		74	1
Core Funded Research	382	7	363	(3)	360	6	353	(3)	350	5	656	(3)	653	9	644	(2)	642	8
Information Sciences Division	**356**	**7**	**622**	**(199)**	**423**	**7**	**641**	**(225)**	**416**	**6**	**688**	**(249)**	**439**	**6**	**786**	**(147)**	**639**	**8**
Divisional Activity	53	1	53	-	53	1	19	-	19	-	71		71	1	57		57	1
Support Services	303	6	569	(199)	370	6	622	(225)	397	6	617	(249)	368	5	729	(147)	582	7
TOTAL PROJECTS/PROGRAMS	**3,447**	**65**	**5,661**	**(1,422)**	**4,239**	**70**	**6,089**	**(1,450)**	**4,639**	**71**	**6,983**	**(1,492)**	**5,491**	**77**	**7,372**	**(1,283)**	**6,089**	**74**
MANAGEMENT		-				-				-				-				-
Executive Director's Office	334	6	284	-	284	5	480	-	480	7	564		564	8	741		741	9
External Relations & Institutional Development	185	3	249	-	249	4	216	-	216	3	218		218	3	238		238	3
Policy and Planning	153	3	144	-	144	2	55	-	55	1	57		57	1	-		-	-
Bot and Committee	99	2	149	-	149	2	145	-	145	2	145		145	2	150		150	2
Support Services	262	5	796	(667)	129	2	674	(589)	85	1	771	(718)	53	1	810	(657)	153	2
Human Resources	200	4	269	-	269	4	275	-	275	4	177		177	2	230		230	3
Finance	483	9	534	(93)	441	7	576	(120)	456	7	497	(164)	333	5	487	(100)	387	5
Other	143	3	281	(122)	159	3	356	(169)	187	3	153	(56)	97	1	256	(55)	201	2
TOTAL MANAGEMENT	**1,859**	**35**	**2,706**	**(882)**	**1,824**	**30**	**2,777**	**(878)**	**1,899**	**29**	**2,582**	**(938)**	**1,644**	**23**	**2,912**	**(812)**	**2,100**	**26**
TOTAL PROJECTS/PROGRAMS AND MANAGEMENT	**5,306**	**100**	**8,367**	**(2,304)**	**6,063**	**100**	**8,866**	**(2,328)**	**6,538**	**100**	**9,565**	**(2,430)**	**7,135**	**100**	**10,284**	**(2,095)**	**8,189**	**100**

Annexure

A - Report of the Finance Committee: June 2004

B - Accounting Policies

C - Glossary of Acronyms and Abbreviations

Annexure - A

Minutes
Meeting of the Finance Committee
11 June 2004

A meeting of the Finance Committee of the Board of Trustees (BoT) was held on 11 June 2004 at 4.00 pm in the Sasakawa Training Lecture Room.

Present:

Dr. Ricardo Uauy Dagach (Chair, BoT)
Prof. Azad Khan (Chair, Finance Committee)
Mr AFM Sarwar Kamal (Chair, National Liaison Committee)
Dr. Claudio Lanata (Chair, HR Committee)
Dr. David A Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:

Dr. Kul Gautam (Chair, Fund Development Committee)

Invited: Scientific Council

Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach welcomed the Scientific Council to the meeting and invited Prof. Azad Khan to Chair the proceedings.

Prof. Azad Khan presented an overview of the items presented for discussion and invited Mr. Aniruddha Neogi, Director, Finance to make his presentation.

Presenting the 2003 Statement of Activity, Mr. Neogi presented detailed information on the revenues (core/project/other), expenditures, surplus before depreciation and shortfall after depreciation. A total of 58 donors supported the Centre in 2003, the largest being USAID/Dhaka, The Netherlands, United Kingdom (DFID), Bangladesh, Sweden/SIDA, Canada/CIDA, Switzerland, Gates-GoB award, USA (other sources) and IVI.

He said the auditor's have qualified the deferment of ERP implementation costs amounting to $320,000. This was deferred as implementation was not completed within 2003. This expenditure will be amortized in two equal installments in 2004 and 2005 against earmarked funds.

The second qualification was for non-inclusion of assets and liabilities of the "Employees Separation Payment Fund" (ESPF). The Management does not agree with those qualifications since these funds belong to the staff and therefore does not constitute an asset of the Centre. Moreover, the inclusion of such funds in the Centre's Statement of Financial

Position would materially distort the true financial position of the Centre. The auditors have also issued a management letter to the Board indicating two issues:

1. the formation of the ESPF Trust: following this observation the process of setting up an Independent Trust for this Fund has been initiated which will manage the Fund on behalf of the participating employees. The Board agreed to this decision and requested that a draft of the relevant by-laws after approval of the SWA be presented at the November meeting after considering all legal implications.

2. 62% exposure to equity instruments - Endowment Funds investment with overseas TIAA/CREF Trust Company. The Management responded that it considers investments against Endowment Funds as long-term investment and the objective of these investments is to provide stable returns along with a steady growth of the Corpus and to optimize returns and minimize risks a balanced portfolio is maintained. The Debt Equity ratio of these investments is 40:60.

A snapshot of the 2004 forecast was presented which indicated a shortfall of $ 610,000 before depreciation. Plans to reconcile the shortfall from US$ 926,000 (2004 budget) to $ 610,000 by receipt of more overheads from projects that are in the process of being started and contribution from the Hospital Endowment Fund was also presented.

The Board was pleased to receive information on core costs (net) by Division. Core costs (net) for each division was further segregated into different categories namely, Divisional activity, core funded scientific activity, and service. The major category was further broken down by activities.

A plan for Activity Review was presented as follows:

Essential core activities
Core funded activities
Funded core activities
Funded non-research activities
Services
Self-sustaining activities

The following information necessary for review will be forthcoming from the Divisions:

Does the Programme correspond to an activity
Themes that correspond to the activity
Collaborating institutions, if any,
Relevance to Centre's priority
3-year budget estimates
Activity period – "Sunset Clause"
Brief description and funding source.

The activities will follow an "approval process flow". The following criteria will be followed when reviewing the activity:

Type of activity
Relevance with Strategic Plan
Relevance with Centre's priority
Budget trends and cost effectiveness
Prospects for funding
Possibilities of cost optimization

Apart from this one-time review a mechanism has been built into Suchona to track the progress on a periodical basis.

Mr. Neogi reported on the tasks accomplished under the Sustainability Plan. He said, guidelines have been laid out based on the Centre's Strategic Plan, a broad review of overall costs of the Centre as well as that of each Division has been carried out, strategies for cost optimization which have relevance with Centre's activities have been identified based on "Best Practices", following discussions with all divisions revenue augmentation opportunities have been identified, draft model plans on hospital and diagnostic labs based on various options have been prepared.

During the last six months market research has been completed. Exit interviews of laboratory services were carried out by the Health Systems and Economics Unit of HSID for which the ground work was done in February/March and completed in May. The list of findings is provided below:

- Clients are mostly educated and belong to the upper strata of the society
- Quality factor
- Satisfied clients
- The Centre will be able to retain 84% of clientele if fees are increased in the region of 10-15%
- 75 prefer delivery of report by courier or messenger service on payment basis
- majority feel that fees are comparable with other service providers
- patients felt that physical facilities should be upgraded
- missed opportunities – ECG, X-Rays & Ultrasound
- there are prospects of growth in revenue as well as in margin if we include these services
- 82% preferred ICDDR,B run counters near home.

Mr. Neogi further presented information on the proportion of clients by location and proceeded to show the way forward with regard to the Sustainability Plan as follows:

- Customize strategies for cost optimization and estimate potential savings
- Revisit the Revenue Augmentation Areas and work out feasibility
- Finalize hospital plan based on input 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.
- 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 for BoT for approval
- Roll-out the approved plan in phases and monitor.

The Board recommended that the CD should assist in this exercise.

Mr. Neogi concluded his presentation by providing a brief update on "Suchona". He said so far the implementation is satisfactory and we believe that the users will be able to realize the benefits of Suchona in the near future. It is hoped that in the future a more refined report will be presented to the Board.

Prof. Azad Khan thanked Mr. Neogi for his very clear, concise and informative presentation. Rounding up on the activities to-date he said,

Break-even plan for 2003 has been implemented,
The finances show a small surplus in 2003 – 5th year in a row.
$ 400,000 has been withdrawn from the Endowment Fund (carried over from previous years)
the 2004 forecast shows improved situation
the Endowment Funds are back in the path of growth
Integrated system in operation
Process to determine Essential Core has begun (Activity Review)
Steps have been taken to form the ESPF Trust
Sustainability Plan – Market Research & Exit Interviews have been completed.

Responding to the comment by Dr. Uauy on the utilization of funds from the Endowment Funds the Board queried whether it is easier for the Centre to balance the budget by using Endowment funds and how does the Centre see this practice in the future -- should not some of the structural changes that occur in the budget need to be faced – Mr. Neogi reported that the income from the Endowment Fund is used and not the Capital and that it is important to tell the donors how we have used these funds. He said, we should however use these funds in a prudent manner and within the terms and conditions laid down ijn the by-laws of the Fund. Prof. Azad corrected that the deficit is however getting less without borrowing from the Endowment Funds.

Dr. Uauy also queried whether an investment plan is in place for money expected from prospective donors so as the Centre faces the implementation of the Strategic Plan what would be the financial needs to do this and that this should be a part of the financial plan to accompany the Strategic Plan.

Congratulating the Centre for the progress made with regard to "Suchona" Dr. Marcel Tanner commented that though it is great to see the many elements come together and is a good tool for the management, the Centre should be more active in projecting directions so that the donors are convinced and this should be done at the Directorate level.

Prof. Azad Khan thanked Prof. Marcel Tanner for raising this issue which he strongly felt the Centre should consider.

Prof. Azad Khan thanked the Finance staff on behalf of the Board for having worked extremely hard to achieve the results presented at this meeting.

Resolutions: The suggestions recommended by the Board were incorporated in the draft resolutions formulated.

The meeting concluded at 5.00 pm.

Finance Committee

RES/17/BT/June 04

The Board accepts the audited Financial Statements of the Centre for the year ended December 31, 2003.

RES/18/BT/June 04

The Board accepts the management response to the auditors' letter to the Board of Trustees.

RES/19/BT/June 04

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.

RES/20/BT/June 04

The Board 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 will review the Break-even plan for the operating deficit for 2004 of the Centre Directorate in its November 2004 Board of Trustees meeting.

RES/21/BT/June 04

The Board approves the transfer of $400,000 from Hospital Endowment Fund to the Operating fund in 2003 based on previously authorized (Res/3/Nov 00; Res/4/Nov 01; Res/5/Nov 02) unutilized carried over amounts of $200,000 each from 2001 and 2002.

RES/22/BT/June 04

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.

RES/23/BT/June 04

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.

RES/24/BT/June 04

The Board authorizes the transfer from the Reserve Fund to the Operating Fund of all funds in excess of $2,000,000.

RES/25/BT/June 04

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.

RES/26/BT/June 04

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.

RES/27/BT/June 04

The Board accepts the audited financial statements of the ICDDR,B Employees Separation Payment Fund for the year ended December 31, 2003.

RES/28/BT/June 04

The Board noted the action taken by the Centre with regard to the Employees Separation Payment Fund which will 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;
- the Deputy Executive Director (and in his absence 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 of the relevant by-laws after approval of SWA should be presented to the BoT at the November 2004 Board of Trustees meeting after considering all legal implications.

RES/29/BT/June 04

The Board resolved to authorize to write off $96,804 being irrecoverable old receivables from a Donor in 2004.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

SIGNIFICANT ACCOUNTING POLICIES:

a) The financial statements are been prepared on a going concern basis, in accordance with generally accepted accounting principles on the historical cost convention and in the manner as prescribed and approved by the Board of Trustees.

b) "Revenue" and "Expenditure" are accounted for on accrual basis, unless otherwise stated.

c) Contributions are considered as revenue on the following basis:
Unrestricted (core) funds are accounted for to the extent they relate to the current period and those pertaining to future periods are carried forward.

Restricted (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. Restricted funds include overhead recoveries at rates indicated in various agreements with the donors.

d) Grants in kind by way of various services rendered by different donors and those directly paid by donor(s) to other organization(s) and institution(s) for project/service work carried out by them on behalf of the Centre are not considered in the accounts. Donated fixed assets are valued at $1 in books of account.

e) Capital expenditure (expenditure on restricted and unrestricted support facilities and equipment) is expensed in the year in which it is incurred and the fixed assets (items costing more than $1000) are recognized in the accounts with a corresponding contra account titled "Fixed Asset Fund". Depreciation on fixed assets is calculated on the "Straight line" method based on the estimated useful life of such assets without any effect on the Operating Fund.

f) 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.

g) Endowment Funds:

Year-end carrying amount of quoted investments are adjusted for shortfall in corresponding market value; unquoted investment are valued at cost of acquisition.

Interest on investment in government securities is recognized in the accounts on realization.

The Board of Trustees may authorize 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.

h) Currency conversion:

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 recognized in the Statement of Activity for the year.

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.

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.

Annexure - C

Glossary of Acronyms and Abbreviations

AFRIM	Armed Forces Research Institute of Medical Sciences
AID	Agency for International Development
AMEX	American Express Bank Ltd.
AusAID	Australian Aid for International Development
BADC	Belgian Administration for Development Cooperation
BHARP	Bangladesh Health and Family Welfare Action Research Project
BoT	Board of Trustees
BTC	Belgian Technical Cooperation
CDC	Center for Disease Control and Prevention; (CDC)
CIDA	Canadian International Development Agency
Co.	Company
CSD	Clinical Sciences Division
DEP	Dependent
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
exp.	expenditure
FACE	Foundation for the Advancement of Clinical Epidemiology Inc.
FHI	Family Health International
FHRP	Family Health Research Project
FIN	Finance
Gates/GoB	Gates - Government of Bangladesh
GoB	Government of the People's Republic of Bangladesh
GS	General Services
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
JHBSPH	The Johns Hopkins Bloomburg School of Public Health
JHU	Johns Hopkins University
JICWELS	Japan International Cooperation of Welfare Services
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
NIH	National Institute of Health

NOV	November
NPA	Non Pensionable Allowance
NPC	Non Pensionable Component
NYUSM	New York University School of Medicine
OFDA	Office of US Foreign Disaster Assistance
ORP	Operations Research Project
p.a.	Per Annum
PA	Post Adjustment
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
TECHNO	Technology
TIAA-CREF	TIAA-CREF Trust Company
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
$	US Dollar

6/BT/NOV 2004

FULL BOARD

BOARD OF TRUSTEES MEETING
NOVEMBER 2004

CENTRE
FOR HEALTH AND
POPULATION RESEARCH

FULL BOARD
28 November 2004

Flights:
BA: arrives and departs Mondays, Thursday, Saturday (early AM)
Emirates: Arrives and departs Tuesday, Wed, Thursday, Sunday (9.35 am)
Thai: arrival/departure all days
Singapore Airways: late night daily.
Malaysian air: on all days except Friday & Sunday (late night)
Biman from New York: arrival & departure on Monday & Thursday (mid afternoon)

DRAFT – 30 Oct 2004

PROGRAMME
MEETING OF THE BOARD OF TRUSTEES
25-29 November 2004

Wednesday 24 November	Board Members Arrive
Wednesday 24 November	
6:30 pm	Board members leave for Rajendrapur
___ pm	Dr I Kaye Wachsmuth & Prof Jane Anita Kusin leave for Rajendrapur on arrival from Jessore)
PM	Dinner at Rajendrapur
Thursday 25 November	
8.30 am	Retreat Commences
Friday 26 November	
AM:	Board Retreat continues
11:00 am	CD & ERID to join Retreat
PM:	BoT & CD return to Dhaka

Saturday 27 November
Programme, Fund Development, National Liaison Committee meetings

Saturday 27 November

8.30 - 9.00 am	Meeting of the Programme Committee - Approval of the Minutes - Response to Nov/June Board Resolutions - Response to BoT Teleconference	BoT, CD

09.00 – 11.00 am	Executive Director's Report Presentation by Division Directors: - Clinical Sciences (Dr M A Salam) - Health Systems and Infectious Diseases (Dr Charles P Larson)	BoT. Scientific staff: GS6 & above, donors
11.00 – 11.15 am	TEA	
11.15 – 12.30 pm	- Laboratory Sciences (Dr G B Nair) - Public Health Sciences (Dr Marge Koblinsky)	
12.30 - 01.30 pm	LUNCH	BoT, SC
01.30 – 02.30 pm	Response to CSD Review	BoT, SC & CSD members
02.30 – 3.30 pm	Meeting of the Fund Development Comm.	BoT, SC
03.30 – 03.45 pm	TEA	BoT, SC
03.45 - 04.45 pm	Meeting of the National Liaison Comm.	BoT. SC
04.45 - 05.30 pm	Change of Name – ICDDR,B	BoT, CD, ER&ID

Sunday 28 November 2004
Human Resources, Finance and Full Board meetings

Sunday 28 November

08.00 – 09.30 am	Meeting of the Finance Committee	BoT, SC
09.30 – 10.45 am	Meeting of the Human Resources Comm.	BoT, CD
10.45 – 11.00 am	TEA	BoT, CD
11.00 – 12.30 pm	Human Resources meeting continued	BoT, CD
12.30 – 1.00 pm	Staff Welfare Association	BoT
01.00 – 02.00 pm	Lunch with invited staff	BoT & invited staff

02.00 – 04.00 pm	Meeting of the Full Board - Approval of the Minutes - Response to Resolutions - Selection of new Trustees/ Process for selection of Board Chair - Dates of next meetings - ISD Review – Dr. T. Hull - Finalize resolutions - Any Other Business	BoT Closed
04.00 – 04.15 pm	TEA	
04.15 – 05.15 pm	Development Partners Group Meeting	BoT, SC
06.30 pm	Reception	

Monday, 29 November 2004
GUEST LECTURE

08.00 – 09.00 am	Board Pending Issues	BoT
09.00 – 10.00 am	Guest Lecture "DOTS expansion and Operational Research". Speaker: Dr Nobukatsu Ishikawa	Auditorium (Open)
10.00 – 10.15 am	TEA	
10.15 – 11.30 am	Report to staff by Chair, BoT and Executive Director, ICDDR,B	Auditorium (Open)
12.00 noon	LUNCH	BoT

Full Board
Sunday 28 November 2004

Agenda:

11.00 - 12.30 pm	Human Resources meeting continued	BoT, CD
12.30 – 1.00 pm	Staff Welfare Association	BoT
01.00 – 02.00 pm	Lunch with invited staff	BoT & invited staff
02.00 – 04.00 pm	Meeting of the Full Board - Approval of the Minutes - Response to Resolutions - Selection of new Trustees/ Process for selection of Board Chair - Dates of next meetings - ISD Review members – Dr. T. Hull - Finalize resolutions - Any Other Business	BoT
04.00 – 04.15 pm	TEA	
04.15 – 05.15 pm	Development Partners Group Meeting	BoT, SC
06.30 pm	Reception	

CENTRE
FOR HEALTH AND
POPULATION 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: November 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 Alalikum* 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:** At this point of time adjustment of local staff salary is the top priority to the all-local staff members of the Centre. The recent devastating flood in the country and subsequent heavy rainfall has already destroyed our country's economy. Most of our staff members have lost their crops, livestock, and dwellings due to the unprecedented natural disaster of the country. They have immerged in debt to rehabilitate themselves. Moreover, prices of every day commodities have gone up to unimaginable level. Besides, due to the declaration of the Government of Bangladesh to enhance the salary of the employees of the republic from January 2005, the market prices have started to increase further. SWA therefore urges your consideration to adjust the salary of local staff members on humanitarian ground to cope with the situation.

   As per ordinance and almost 20 (twenty) years ago since the adoption of the UN pay scale system in the Centre, the issue of realization of UN comparable salary to the ICDDR,B staff members still remains unresolved and unsettled. Unfortunately SWA has to insist on this issue time and again. Currently, local staff members are paid about 45% (average) only of their expected UN scale salary. Staff members consider it as deviation and that resulted degraded morale amongst the staff. We would, therefore, request your honor to resolve the issue urgently once for all so that the local staff members have 100% of UN comparable salary with immediate effect.

2. **Extension of retirement age limit:** Currently the local staff members of the Centre retire from the job at the age of 60 (sixty) years while they are still productive and have the ability to contribute to the Centre in a more organized way. In the past, in order to maintain sustainable high quality productions of the Centre, some of our colleagues were given opportunity to have contractual offer after their scheduled retirement. But, to our consideration, that was never been served as incentive and moreover, the incumbent used

to suffer from insecurity. Apart from the fact of increased life expectancy for Bangladeshis, when a staff member still is in a position to contribute his/her acquired vast experience to the greater need of the Centre, they have to leave to leave the Centre on retirement. SWA consider this as a loss to the Centre and therefore extension of age for retirement for local staff members would be beneficial for the Centre. For comparison sake, we would like to bring to your kind notice that in other UN agencies the retirement age is 62 years.

We, therefore, request your honor to review this issue to extend the limit of retirement age for local staff members.

3. **Extension of age for Dependent allowances:** ICDDR, B staff receives medical support and allowances for their dependent children up to the age of 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 extend the age limit of dependent children up to 25 years for availing both dependent allowances and medical facilities. 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 contributory 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 honorable Board members and the Executive Director of the Centre to make a provision for per diem at a different rate for a fixed period of maximum 7 (seven) days only during the evacuative period. This would help the evacuated staff members to meet other additional expenses such as accommodation, transportation etc.

5. **Field allowances:** The Field stations of ICDDR, B is contributing relentlessly to improve public health in developing countries and that was only possible due to hard work of staff members of the Field stations. The field staff members work in the community under different adverse conditions, such as severe heat, rain, cold. They walk kilometers after kilometers and from door to door 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 the field stations 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 field staff members considering the different nature of their work.

6. **Temporary financial support**: Due to high living costs, high education cost (private educational institutions), and other additional expenses, such as, purchasing a piece of 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 car loan scheme for National Officer's level staff members, 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 of the Centre.

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 only 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 members and for the sake of justice, we would request our honorable board members and the management of the Centre to review the above issues for consideration.

Warm regards,

Dr. Md. Shahadat Hossain
President

Dr.Md. Golam Mostofa
Vice President

Md. Nasir Uddin
Vice President, Matlab

S. M. Yead Ali
General Secretary

Minutes
Full Board Meeting
12 June 2004

A meeting of the Full Board was held on 12 June 2004 at 8.00 am in the Sasakawa Training Lecture Room.

Present:
Dr. Ricardo Uauy Dagach (Chair, BoT)
Prof. A K Azad Khan (Chair, Finance)
Dr. Claudio Lanata (Chair, HR)
Dr. David Sack (Executive Director, ICDDR,B)
Prof. Marcel Tanner (Chair, Programme Committee)

Regrets:
Dr. Kul Gautam (Chair, Fund Development Committee)

Invited:
Centre Directorate
Ms V Brooks, Grants & Contracts Administrator
Ms. Hannah Lemon, Senior Associate, ER&ID

Minutes: Ms Loretta Saldanha

Dr. Ricardo Uauy Dagach opened the meeting.

1. **Approval of the Minutes**

The Minutes were approved.

2. Discussion on November Board Retreat

Dr. Sack reported that Ms. Vanessa Brooks will help him coordinate this retreat. The document jointly prepared in preparation for the Board was earlier circulated for comments. Dr. Sack briefly summarized the 1999 Retreat. Commenting on the evolution Dr. Uauy felt that it is important for the Centre to go through the process and that it would be worthwhile to get a view of how the Centre staff perceives the Board, whether the Board has been effective in supporting the management, in contributing to the Centre's effort in achieving its mission, in providing oversight and anticipating problem areas. It is also important to promote active participation to provide feedback for the Board to reflect upon. The process can be formalized confidentially.

In response to Dr. Sack's query as to whether the Board should be involved in the reviews of the Division's work, the Board felt that a link is required between the external reviewers and the Board and hence it is important for the Board to participate.

Other issues included:

Governance and management issues should not be divided. The question is what kind of Board is needed.
The next retreat should also concentrate on the Strategic Plan and how the Board can assist the Centre in achieving its goals.
The agenda should also include the format for future EC and Full Board meetings;
"parking lot" issues;
The issue of communications;
The Board does provide continuity – how do we build stability and change in an efficient manner – critically how do we build into the system without compromising sometimes the existence of the Centre. The Board also needs to look at the balance of expertise on the Board.

It was also felt that because the Board is largely technical, there is a danger of conflict of interest – how do we handle this. Prof. Azad said that the expertise of the Board Members should be utilized, but the Board should raise themselves above exploiting the Centre for personal gains.
What are the gaps between the EC and the Full Board.
Whether a monitoring system is required to ensure that the resolutions are being followed up step-by-step and the degree of the involvement of the Board.

In preparation for the Retreat and in order not to "reinvent the wheel" the Board with the assistance of the CD updated the document entitled "Formulation of short term and long term critical issues and assignment of responsible individuals and time Frames" outlining the structure of the retreat and asked the senior staff to contribute in defining key issues that should be addressed at the Retreat. The Board also requested Ms. V. Brooks to provide a draft progress report on the status of the issues outlined in this report (p 13-14) to be submitted to the Board by 31 July 2004.

Following some discussion on the venue and logistics, it was agreed that this be left to the discretion of Dr Sack who will explore the most suitable venue to enable the Board to be able to concentrate on their deliberations. Preferably that it be done in Bangladesh but outside Dhaka to allow members of the Bangladeshi government to participate.

SWA Presentation

The EC together with Ms Ann Walton met with members of the SWA Executive Committee. The SWA were assured that their requests will be further discussed at the November meeting.

Name Change for the Centre

An update was provided by Ms. Lemon on the status of actions to date.

Closed Closed meeting of the Board

Appointment to Committees of the Board:

Dr Kaye Wachsmuth and Prof. N.K. Ganguly were appointed as Deputy Chairs of the Fund Development and Finance Committees respectively.

Extension of Term

The Board approved the extension of the term of Professor Marcel Tanner for a second term of 3 years.

Selection of new Trustees

The Board reviewed the CV's received in response to a call for nominations to replace Prof. Carol Vlassoff and resolved that Dr. Margaret Catley-Carlson and Dr. Peter Tugwell be offered the post in this order.

The Board also placed on record its thanks to Prof. Vlassoff for her outstanding contribution to the Centre as a member of the Board since July 1998.

Following the resignation of Dr. Maimunah Bte Hamid due to medical reasons, the Board resolved to accept her resignation and thanked Dr. Maimunah Bte Hamid for her outstanding contribution to the Centre as a member of the Board for a period of 3 years. The Board also reviewed pending CV's. As in the past a request for nominations will be sent and a selection will be made bearing in mind the gender balance.

External Programme Review of the Board

The Board agreed that a Programme Committee Review of the Information Sciences Division be carried out before the June 05 BoT meeting and that Professor Terence Hull act as Chair of the Review Committee and provide advise regarding other members who should participate.

The meeting concluded at 12.30 pm.

Teleconference: 4.00 pm

Report attached.

RESOLUTIONS
Full Board

RES/30/BT/June 04

The Board outlined the structure of the retreat and asked the senior staff to contribute in defining key issues that should be addressed at the November BoT retreat.

The Board also requested the Grants and Contracts Administrator to coordinate with ER&ID and other senior management staff in providing a draft progress report on the status of issues outlined in the Consultant's report p. 13-17. In doing so, the respective roles of the Executive Committee and the Full Board will be examined and the Centre Directorate shall provide input on Board and Management communications. The draft report shall be submitted to the Board by 31 July 2004.

RES/31/BT/June 04

The Board noted the requests presented by the Staff Welfare Association.

RES/32/BT/June 04

The Board resolved to appoint the following Trustees as Deputy Chairs for the following Committee:

Finance: Prof. N.K. Ganguly
Fund Development: Dr. Kaye Wachsmuth

RES/33/June 04

The Board approves the extension of the term of Professor Marcel Tanner for a second term of 3 years with effect from the date of termination of his first three-year term (June 04).

RES/34/BT/June 04

The Board reviewed the CV's received in response to a call for nominations to replace Prof. Carol Vlassoff (term ending June 2004) and resolved that Dr. Margaret Catley-Carlson and Dr. Peter Tugwell be offered the post in this order.

RES/35/BT/June 04

The Board agreed that a Programme Committee Review of the Information Sciences Division be carried out before the June 05 BoT meeting and resolved that Professor Terence Hull act as Chair of the Review Committee.

RES/36/BT/June

Following the resignation of Dr. Maimunah Bte. Hamid as member of the BoT, for personal reasons, the Board resolved to accept her resignation and thanked Dr. Maimunah Bte Hamid for her outstanding contribution to the Centre as a member of the BoT for a period of 3 years, and wished her good health.

RES/37/BT/June

The Board resolved to extend its thanks to Prof. Carol Vlassoff for her outstanding contribution to the Centre as a member of the Board since July 1998.

RESPONSE TO
RESOLUTIONS
Full Board

RES/30/BT/June 04

The Board outlined the structure of the retreat and asked the senior staff to contribute in defining key issues that should be addressed at the November BoT retreat.

The Board also requested the Grants and Contracts Administrator to coordinate with ER&ID and other senior management staff in providing a draft progress report on the status of issues outlined in the Consultant's report p. 13-17. In doing so, the respective roles of the Executive Committee and the Full Board will be examined and the Centre Directorate shall provide input on Board and Management communications. The draft report shall be submitted to the Board by 31 July 2004.

Response: Discussed at the Retreat.

RES/31/BT/June 04

The Board noted the requests presented by the Staff Welfare Association.

RES/32/BT/June 04

The Board resolved to appoint the following Trustees as Deputy Chairs for the following Committee:

Finance: Prof. N.K. Ganguly
Fund Development: Dr. Kaye Wachsmuth

RES/33/June 04

The Board approves the extension of the term of Professor Marcel Tanner for a second term of 3 years with effect from the date of termination of his first three-year term (June 04).

RES/34/BT/June 04

The Board reviewed the CV's received in response to a call for nominations to replace Prof. Carol Vlassoff (term ending June 2004) and resolved that Dr. Margaret Catley-Carlson and Dr. Peter Tugwell be offered the post in this order.

Response: Dr. Peter Tugwell was selected to replace Prof. Carol Vlassoff on the Board.

RES/35/BT/June 04

The Board agreed that a Programme Committee Review of the Information Sciences Division be carried out before the June 05 BoT meeting and resolved that Professor Terence Hull act as Chair of the Review Committee.

RES/36/BT/June

Following the resignation of Dr. Maimunah Bte. Hamid as member of the BoT, for personal reasons, the Board resolved to accept her resignation and thanked Dr. Maimunah Bte Hamid for her outstanding contribution to the Centre as a member of the BoT for a period of 3 years, and wished her good health.

RES/37/BT/June

The Board resolved to extend its thanks to Prof. Carol Vlassoff for her outstanding contribution to the Centre as a member of the Board since July 1998.

Selection of members of the Board of Trustees

Action Required

1. For extension (end of first term): N/A

2. To consider replacement of 4 Board members (end of 2 terms):

   a. Dr Maimunah BA Hamid (resigned June 2004)
   b. Prof Tikki Pang (May 2005)
   c. Dr Ricardo Uauy Dagach (Jun 2005)
   d. Prof AK Azad Khan (Aug 2005)

LIST OF BOARD MEMBERS
WITH NATIONALITY, DISCIPLINE, JOINING AND ENDING DATES
(As at November 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 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	
Dr Marcel Tanner	Switzerland	Tropical Medicine	Jan 2001/Dec 2006*
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
Dr. Peter Tugwell	Canada	Clinical Epidemiology	Jul 2004/Jun 2007

**Unable to serve another term without a break*
*** For extension*

Target membership: 11 members at large
3 GoB
1 Executive 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	Ricardo U Dagach (Chile)	S.Am/Carib
Peter Tugwell (Canada)	Nth American	Dr. Halima RA Mwenesi (Kenya)	Africa

UNICEF: Dr Kul Gautam
WHO : Prof Tikki Pang

Total: 7 Total: 7

Total: 16

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:

7/15 (46.67%) are from developing countries (50%=7)
7/15 (46.67%) are from developed countries (2/3=7)

Gender: M=13
F= 03

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

Three nominations have so far been received and CV's are attached:

1. Dr Jose Ignacio Santos (Mexico) nominated by Dr Claudio Franco Lanata
2. Dr Timothy G. Evans (American and Canadian), WHO
3. Dr Mary Ann D Lansang (Philippines) nominated by Dr David A Sack
4. Dr Suttilak Smitasiri, (Thailand) nominated by Prof. Ricardo U Dagach
5. Dr Siripen Supakankunti (Thailand) nominated by Dr Maimunah Bte A Hamid
6. Dr Nafsiah Mboi (Indonesia) nominated by Dr Tikki Pang

CENTRE FOR HEALTH AND POPULATION RESEARCH

BYLAWS

As per Resolution 33/BT/June 03, the Board agrees that the following Bylaws shall replace Bylaws adopted by the following Board Resolutions: Resolution 7/June 81; Resolution 16/November 81; Resolution 16/November 81; Resolution 7/June 81 and Resolution 8/June 81.

These Bylaws are the operational rules and policies governing the Board of Trustees of ICDDR,B—Centre for Health and Population Research. They are adopted under the authority of, and are intended to be complementary to, the International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance 1978 (Ordinance No. L1 of 1978), [hereinafter "1978 Ordinance"].

In these Bylaws, words denoting the masculine gender shall also denote the feminine gender and vice-versa.

I. Officers of the Board

I.1. Chairperson

I.1.1. The Chairperson shall serve in accordance with the terms set forth in the 1978 Ordinance, Section 9, (1)-(3).

I.1.2. Should the Chairperson be unable to complete his/her term, the Board shall elect a Trustee to serve as Chairperson during the remainder of the unexpired term.

I.2. Director

I.2.1. The Director shall serve as the Member-Secretary of the Board.

I.2.2. The Director shall serve in accordance with the terms set forth in the 1978 Ordinance, Section 13, (1)-(4) and may establish rules and procedures or issue statements as he or she deems necessary for the smooth operation of the Centre, provided these rules or statements do not contravene these Bylaws, other documents approved by the Board of Trustees, or the Ordinance.

I.2.3 The Director may make public statements concerning the work, objectives and policies of the Centre, as long as these conform to decisions of the Board of Trustees, and the Ordinance.

(*5*) Except for the Director, all members shall be appointed to fill three-year terms, except for members of the initial Board. In the initial Board, all members except the Director shall be divided into three classes of approximately equal numbers, these classes serving terms of one, two and three years respecuvely. The Board shall decide how many members shall be in each class, and the members of each class shall be chosen by lot.

(*6*) Vacancies in seats of members at large shall be filled by the Board. A member appointed to a vacancy arising from a cause other than the normal expiration of a term shall serve for the remainder of the term of the member being replaced. No member may serve more than two consecutive three-year terms or portion thereof, except that a member serving a term of less than three years on the initial Board may serve two consecutive three-year terms immediately thereafter.

9. **The Chairman.**—(*1*) The members shall elect one of them except the Director as Chairman for a term to be determined by the Board.

(*2*) The Chairman shall preside over the Board meetings.

(*3*) In the absence of the Chairman, the members present may appoint one of them as the Chairman for that meeting.

10. **Meetings of the Board.**—(*1*) The meetings of the Board shall be held at such time, place and manner as may be prescribed. A majority of the sitting membership shall constitute a quorum.

(*2*) Except for the first year, at least two mettings of the Board shall be held in one calendar year.

(*3*) In the meeting of the Board, each member shall have one vote, but in the event of equality of votes, the Chairman shall have the second or casting vote.

11. **Validity of Proceedings.**—(*1*) No act or proceedings of the Board shall be invalid merely on the grounds of the existence of any vacancy in or defect in the constitution of the Board. A vacancy in the Board or a temporary absence of a member for any reason shall not impair the right of the remaining members to act.

(*2*) All acts done by a person acting in good faith as the Chairman or member shall be valid, notwithstanding that it may afterwards be discovered that his appointment was invalid by reason of any defect or disqualification or had terminated by virtue of any provision of law for the same being in force; but nothing in this section shall be deemed to give validity to any act of the Chairman, member or Director after his appointment has been shown to be invalid or to have been terminated.

12. **Committees.**—(*1*) The Board may designate an Executive Committee of its members who shall have the power to act for the Board in the interim between Board meetings on all matters which the Board delegates to it. The Director and at least one of the Bangladeshi members shall serve as members of the Executive Committee.

(*2*) All interim actions of the Executive Committee shall be reported to the Board at its next subsequent meeting.

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 remains 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
Prof. N.K. Ganguly		Deputy

National Liaison:

Mr AFM Sarwar Kamal	-	Chair
Prof. Azad Khan		Deputy (also Chair of Finance Committee)

Fund Development:

Dr. Kul Gautam	-	Chair
Dr. Kaye Wachsmuth		Member

Md. Shah Alam

From: David A Sack MD [dsack@icddrb.org]
Sent: Wednesday, September 22, 2004 12:12 PM
To: shahalam@icddrb.org
Subject: Fw: ICDDR Board nomination

----- Original Message -----
From: Dr. José Ignacio Santos Preciado
To: dsack@icddrb.org
Cc: Claudio Lanata
Sent: Wednesday, September 22, 2004 6:34 AM
Subject: Re: ICDDR Board nomination

> ----- Original Message -----
> **From:** Dr. José Ignacio Santos Preciado
> **To:** dsack@icddrb.org
> **Cc:** Claudio Lanata
> **Sent:** Tuesday, September 21, 2004 6:27 PM
> **Subject:** ICDDR Board nomination
>
> Dear Dr Sack the attached letter is in followup to conversations and follow up correspondence with Dr. Claudio Lanata regarding possible nomination to the Board of Trustees of ICDDR next June.
> Sincerely,
> José Ignacio Santos MD

HOSPITAL INFANTIL DE MEXICO
FEDERICO GOMEZ
INSTITUTO NACIONAL DE SALUD PÚBLICA
Instituto de Servicio Médico, Enseñanza e Investigación Afiliado a la UNAM
Tel: 57 61 01 81 Fax: 57 61 89 74, Tel: Conmutador 52 28 99 17 Ext. 1478
Dr. Márquez 162, 2do. Piso, Col. Doctores, México, D.F.

DIRECCION GENERAL

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

Dear Dr. Sack,

This letter is pursuant to my possible nomination as a candidate for the Board of Trustees of ICDDR.

If the Board considers that I could serve the Mission of the Center and if selected, I would be honored to serve.

I would greatly appreciate receiving additional information regarding the responsibilities and time commitment that this responsibility would entail.

Sincerely,
José Ignacio Santos M.D.
Director, General

JOSÉ IGNACIO SANTOS, MSc, M.D.

DIRECTOR GENERAL
HOSPITAL INFANTIL DE MEXICO FEDERICO GOMEZ
NATIONAL INSTITUTESS OF HEALTH, MEXICO
&
PROFESSOR OF EXPERIMENTAL MEDICINE
AND INFECTIOUS DISEASES
SCHOOL OF MEDICINE, UNAM

EDUCATION and TRAINING:

CALIF STATE POLYTECHNIC UNIVERSITY, POMONA,	**B.Sc.**	1968	**BIOLOGY**
CALIF STATE POLYTECHNIC UNIVERSITY, POMONA,	**M.Sc.**	1970	**MICROBIOLOGY**
STANFORD UNIVERSITY	**M.D.**	1975	**MEDICINE**
STANFORD UNIVERSITY MEDICAL CENTER	**RESIDENCY**	1977	**PEDIATRICS**
UNIVERSITY OF UTAH,	**FELLOW**	1980	**CLINICAL IMMUNOLOGY & INFECTIOUS DISEASES**

POSITIONS HELD:

1979-1980 **RESEARCH INTRUCTOR,** DEPARTMENT OF PEDIATRICS, SCHOOL OF MEDICINE, UNIVERSITY OF UTAH

1980-1986 **ASSISTANT PROFESSOR OF PEDIATRICS AND PATHOLOGY** BOSTON UNIVERSITY SCHOOL OF MEDICINE

1985-1987 **JOHN F. FOGARTY SENIOR SCHOLAR IN INTERNATIONAL HEALTH**

1987-1990 **ASSOCIATE PROFESSOR OF PEDIATRICS AND PATHOLOGY** BOSTON UNIVERSITY SCHOOL OF MEDICINE.

1987-2003. **LECTURER IN PEDIATRICS**, HARVARD UNIVERSITY SCHOOL OF MEDICINE.

1985-1994 **RESEARCH DIRECTOR**, HOSPITAL INFANTIL DE MEXICO "FEDERICO GOMEZ".

1985-1997 **CHAIRMAN**, DEPARTMENTOF INFECTIOUS DISEASES HOSPITAL INFANTIL DE MEXICO

1993-1996 **DIRECTOR**, IDSA INTERNATIONAL CENTER FOR INFECTIOUS RESEARCH AND TRAINING IN INFECTIOUS DISEASES, MEXICO CITY

1996-PRES. **PROFESSOR OF EXPERIMENTAL MEDICINE AND INFECTIOUS DISEASES,** UNIVERSIDAD NACIONAL AUTONOMA DE MEXICO. (UNAM)

1997--1998 **COORDINATOR OF EPIDEMIOLOGIC SURVEILLANCE,** MINISTRY OF HEALTH, MEXICO

1998-2001 **DIRECTOR, NATIONAL CHILD HEALTH PROGRAM COUNCIL**

1998-2004 **TECHNICAL SECRETARY, NATIONAL IMMUNIZATION COUNCIL**

2001-22004 **DIRECTOR, NATIONAL CENTER FOR INFANT AND ADOLESCENT HEALTH,**

2004-PRES **DIRECTOR GENERAL "HOSPITAL INFANTIL DE MEXICO FEDERICO GÓMEZ" MEXICO'S LEADING CHILDRENS HOSPITAL**

CERTIFIED: AMERICAN BOARD OF PEDIATRICS, 1980
PEDIATRIC INFECTIOUS DISEASES, 1984
PEDIATRICS (MEXICAN ACADEMY OF PEDIATRICS) 1985
PEDIATRIC INFECTIOUS DISEASES (INFECTIOUS DISEASES CERTIFICATION COUNCIL, MEXICO) 1984

MEMBERSHIPS (SELECTED); PAST PRESIDENT, MEXICAN ASSOCIATION FOR INFECTIOUS DISEASES AND CLINICAL MICROBIOLOGY; FELLOW, INFECTIOUS DISEASES OF AMERICA; FELLOW PEDIATRIC INFECTIOUS DISEASES SOCIETY; ASM; IMMUNOCOMPROMISED HOST SOCIETY; NATIONAL ACADEMY OF MEDICINE, MEXICO; NATIONAL INVESTIGATOR OF THE NATIONAL RESEARCH COUNCIL,MEXICO;, **PRESIDENT**, MEXICAN CHAPTER OF APUA. **PRESIDENT**, PANAMERICAN INFECTIOUS DISEASES SOCIETY, 2001-2002

PUBLICATIONS: 263. (203 ORIGINAL ARTICLES AND 60 BOOK CHAPTERS).

BOOKS: 5

ID FELLOWS TRAINED: 61 (38 FROM MEXICO AND 23 FROM 10 OTHER LATIN AMERICAN COUNTRIES)

GRADUATE STUDENT THESIS DIRECTED: 5 DSc; 9 MSc

RESEARCH INTERESTS: MY RESEARCH INTERESTS ARE INTERRELATED IN THE FIELDS OF MICROBIOLOGY, INFECTIOUS DISEASES, CLINICAL IMMUNOLOGY AND PUBLIC HEALTH

SPECIFIC ONGOING RESEARCH PROJECTS:.

A) EVALUATION OF NEW VACCINES AND VACCINE DELIVERY SYSTEMS

B) HOST DETERMINANTS IN THE GENESIS AND IMMUNE RESPONSE TO MEASLES VACCINE

C) MECHANISM OF RESISTENCE AND CRITICAL EVALUATION OF NEW ANTIMICROBIAL AGENTS.

D) IMPACT OF MICRONUTRIENTS ON DIARRHEAL DISEASE BURDEN AND THE IMMUNE RESPONSE.

E) CRITICAL ISSUES IN HEALTH CARE DELIVERY TO MIGRANT FAMILIES IN MEXICO

Dr. David Sack

Board nominee

From: <evanst@who.int>
To: <dsack@icddrb.org>
Sent: Tuesday, June 22, 2004 1:22 PM
Subject: Re: ICDDR,B Board ofTrustees

Thanks David - Tikki will finish his tenure and we'll have DG appoint a successor

Best wishes

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: David A Sack, MD <dsack@icddrb.org>
To: evanst <evanst@who.int>
Sent: Tue Jun 22 05:50:09 2004
Subject: ICDDR,B Board ofTrustees

Dr. Tim Evans
WHO, Geneva

Dear Tim:

Following our recent Board meeting I wanted to get back to you concerning the Board make-up at ICDDR,B. As I indicated to you in Washington, it would be entirely appropriate for you to be the WHO appointed board member, but not an "at large" member. The appointment is made by the DG of WHO. Previous WHO appointments have included Mike Merson (when head of CDD), Rafe Henderson and currently Tikki Pang. Tikki began his tenure in 1999 and would normally serve for a maximum of 6 years. From WHO, you would be an excellent person to join the Board, but an indicated above, this decision is made in Geneva.

With best wishes,

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

WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

Téléphone Central/Exchange: (+41 22) 791.21.11
Direct: (+41 22) 791.10.96
Email: evanst@who.int

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

WORLD HEALTH ORGANIZATION
20, AVENUE APPIA
CH-1211 GENEVA 27
SWITZERLAND

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evanst@who.int

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

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).

David A Sack MD

From: "Mary Ann D. Lansang" <mlansang@inclentrust.org>
To: "David A Sack MD" <dsack@icddrb.org>
Sent: Tuesday, October 12, 2004 12:11 PM
Attach: Lansang ltr to Dr Sack_101204.pdf; MAL_CV1_Oct 04.doc
Subject: Re: Fw: BOT for ICDDRB

Dear David,

Thanks very much for asking me to be involved with ICDDRB in some way... your creative solution is an honor and privilege.
I would be most happy to consider serving in your Board. Indeed, both Marian Jacobs and Marcel Tanner have told me in the past about the stimulating meetings and the extensive outputs of ICDDRB.

As you have suggested, I have attached an "expression of interest" and my CV.

Look forward to hearing from you again.

All the best,
Mary Ann

At 11:57 AM 10/11/2004 +0600, David A Sack MD wrote:

> "urn:schemas-microsoft-com:office:office" xmlns:w = "urn:schemas-microsoft-com:office:word" xmlns:st1 = "urn:schemas-microsoft-com:office:smarttags">
>
> Dear Mary Ann
>
> I can understand your decision to return to the University, but I am still thinking about how to involve you in the life of ICDDRB. We will be having an opening soon for our Board of Trustees and I believe that you could make a significant contribution to this Board. The Board meets twice yearly, usually in November and June, and in recent times the June meeting is an executive meeting with a teleconference with those members who are not in Dhaka. We try to reserve major decisions for November when the entire membership is present in Dhaka. Each meeting is 3 days long. Occasionally additional teleconferences are needed, but these are only occasional. The board is made of 17 members of which a majority must be from developing countries, including 3 from Bangladesh. WHO and Unicef have representatives but all other members serve as individuals. The term of service is 3 years with a maximum of 2 terms (6 years total). The Centre of course pays your travel costs and a token honorarium for the days you participate.
>
> If you are interested in considering this, can I ask that you send your cv and a letter indicating that you would be willing to serve. I can provide other information of course and you may want to see our web site as well (www.icddrb.org). Marcel Tanner is on the Board and you may want to talk to

him about this as well I hope you will consider this since I think you would bring a great of experience and wisdom to the Centre.

David A. Sack, M.D.

Executive Director

ICDDRB: Centre for Health and Population Research

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Mohakhali, Dhaka 1000, Bangladesh

880-2-882-3031 (office telephone)

880-2- 882-3116 (fax in Dhaka)

1-208-955-4437 (fax in the USA, read in Dhaka)

dsack@icddrb.org

10/12/2004

CURRICULUM VITAE

Name	**Lansang, Mary Ann D.**
Office Address	INCLEN Trust Executive Office 5/F Ramon Magsaysay Center 1680 Roxas Boulevard Malate, Manila 1004 Philippines
Residential Address	5420 South Superhighway, Unit 2-F, Bangkal, Makati City, Philippines
Tel/Fax No.	(632) 844 9904 (res.) (632) 400 4374 (ofc.)
Place of Birth	Baguio City, Philippines
Nationality	Filipino
Date of Birth	September 8, 1951

Educational Attainment:

	Name of School	Yr. Graduated	Honors/Degree
Grade School	St. Louis School, Baguio City	1963	Valedictorian
High School	St. Louis High School	1967	Valedictorian
College	St. Louis University	1971	Summa cum laude, B.S. Psychology
College	University of the Philippines Manila	1978	One of Ten Outstanding Clinical Clerks, Doctor of Medicine
Postgraduate	University of Newcastle, Australia	1987	Master of Medical Science (Clinical Epidemiology)

Current Positions:

Executive Director, INCLEN Trust International, Inc., Manila, Philippines, October 2000 to November 2004
Professor, Department of Clinical Epidemiology, and Infectious Diseases Section,
Department of Medicine, UP College of Medicine - Philippine
General Hospital, January 1996 to present (on leave, 2001 – to present)

Diplomate and Fellow, Philippine College of Physicians
Diplomate and Fellow, Philippine Society for Microbiology and Infectious Diseases

Current Affiliations/Extension Services:

International:

Member, Foundation Council of the Global Forum on Health Research, Geneva, Switzerland, 1998-2004
Board member, Alliance on Health Policy & Systems Research, Geneva, Switzerland, 1998-2004
Member, Forum on Ethics Research Committees in the Asia-Pacific Region, 2000 to present

World Health Organization:
Member, Scientific & Technical Advisory Committee, WHO Special Programme on Research & Training in Tropical Diseases (WHO/TDR), 2001 – 2005
Member, Advisory Group, Initiative on Vaccine Research, WHO, 2001 to present
Member, Editorial Board, *Bulletin of WHO*, 1999 to present
Clinical Monitor, WHO/TDR/TDP, 1998 to present

Reviewer:
Reviewer, *Bulletin of WHO*, 1999 to present
Reviewer, *Acta Tropica*, 1996 to present
Reviewer, *Health Policy & Planning*, 1998 to present
Member, Advisory Committee to the Editors for the Disease Control Priorities Project (DCPP), 2003

Local:

Member, Council of Advisers, Philippine Society for Microbiology and Infectious Diseases, 1999 to present
Member, Advisory Board, Field Epidemiology Training Program, Department of Health, Philippines, 1993-present
Member, Ethics Review Board, University of the Philippines College of Medicine 1998-present
Associate editor, *Philippine Journal of Internal Medicine*, 1999 to present

Vice President, Philippines Society of Epidemiology, 1995 to present
Member, Manila Medical Society
Member, International Epidemiology Association
Member, Philippine Hospital Infection Control Society, Inc
Member, National Research Council of the Philippines

Past Positions:

Local:
Consultant, Research Institute for Tropical Medicine, Alabang, Muntinlupa City, June 1996 – Dec. 2000
Assistant Director, Research Institute for Tropical Medicine, Alabang, Muntinlupa City, February 1991 - May 1996
Assistant Professor IV, Clinical Epidemiology Unit and Infectious Diseases Section, Department of Medicine, UP College of Medicine, Philippine General Hospital, 1984 to 1995
Head, Department of Epidemiology and Biostatistics, Research Institute for Tropical Medicine, Alabang, Muntinlupa, 1987 - 1989
Head, Clinical Epidemiology Unit, University of the Philippines Manila, College of Medicine - Philippine General Hospital, 1984 – 1987
Member, Institutional Review Board, Research Institute for Tropical Medicine, 1991-1997

Member, National Infectious Diseases Advisory Council, 2002 - 2004
Member, SARS National Expert Panel, Dept. of Health, Philippines, 2003
Member, Technical Committee for Research Fellowship Program, Philippine Council for Health Research and Development, 1996-2000
Member, Malaria Study Group, Research Institute for Tropical Medicine, 1993-2000
Board member, Essential National Health Research Foundation, Philippines, 1993-1999

President, Philippine Society for Microbiology & Infectious Diseases, 1997; Vice-President, 1996

International:
Member, Technical Review Panel, Global Fund to Fight AIDS, Tuberculosis and Malaria, 2002
Acting Co-Executive Director, International Clinical Epidemiology Network (INCLEN), July – December 2000; Senior Program Consultant, February – June 2000; Chair, INCLEN Capacity Building Subcommittee, 1997-June 2000
Member, Steering Committee on Vaccines for Vaccine Discovery Research, World Health Organization/UNDP/World Bank Special Programme for Research and Training in Tropical Diseases (WHO/TDR), Geneva, Switzerland, 1995-2000
Chair, Task Force on ENHR Competencies, Council on Health Research for Development, Geneva Switzerland, 1997-2000

COHRED Board member, Council on Health Research for Development (COHRED), Geneva, Switzerland, 1993-1998

Member, Preparatory Committee for Global Forum on Health Research, Geneva, Switzerland, 1996-97; Steering Committee for the Global Forum, 1997; Member, Strategic & Technical Advisory Group, Global Forum, 1998-2001

Member, Advisory Committee on Health Research, WHO Western Pacific Regional Office, 1996-1999

Member, Scientific Working Group on "Criteria for Setting Health Research Priorities", WHO Regional Office for South-east Asia, 1999

Member, Working Group on Policies and Strategies to Support WHO in Health Research, WHO, 1999

Scientist (on secondment), Special Programme for Research and Training in Tropical Diseases, World Health Organization, Geneva, Switzerland, 1990

Areas of Interest:

- Infectious and tropical diseases (in particular vaccine-preventable diseases, malaria, tuberculosis, sepsis)
- Clinical epidemiology
- Health systems research
- Research capacity development
- Health research policy
- Research ethics

Honors and awards:

1. 1989 Outstanding Young Scientist (Medicine), given by the National Academy of Science and Technology, Republic of the Philippines, August, 1989.
2. 1993 Outstanding Research Award (Health and Nutrition Category) for paper : Interruption of Maternal-Child HBV Transmission: A Comparison of Various Regimens Using Hepatitis B Immunoglobulin and Hepatitis B Vaccine," co-investigator. Given by the Department of Science and Technology, Philippines.
3. University of the Philippines 1993 Presidential Outstanding Publication Award for paper "Purchase of Antibiotics without Prescription in Manila, the Philippines. Inappropriate Choices and Doses," senior author. Given by the University of the Philippines.
4. HAMIS (Health and Management Information System) Bronze Award for project entitled "The Effectiveness of Community Action in the Planning, Implementation and Evaluation on the Tuberculosis Control Program," an award given to the community organizations in Camalig, Albay, as a result of a joint project between RITM, UP Manila and the people of Camalig; Principal Investigator. Given by the Department of Health and HAMIS, with support from the German Agency for Technical Cooperation, June 19, 1994.
5. 1996 Outstanding Health Researchers, award given to the Liver Study Group, Philippines, by the Philippine Council for Health Research and Development, March 18, 1996.
6. 1997 Most Outstanding Researcher Award, given by the University of the Philippines Manila, June 20, 1997.
7. 1997 Outstanding Health Research Group Awards, for both Basic Sciences and Applied Sciences, given to the RITM Malaria Study Group, by the National Academy of Science and Technology, Republic of the Philippines, July 18, 1997.
8. 1999 International Publication Award for paper "Local knowledge and treatment of malaria in Agusan Sur, the Philippines", co-author. Given by the President of the University of the Philippines, February 29, 2000.
9. 2002 Outstanding Researcher of the University of the Philippines College of Medicine Alumni Association, University of the Philippines Manila, December 22, 2002

Publications:

Lansang MA, Dennis R. Building capacity in health research in the developing world *Bulletin WHO* 2004;82:764-70.

Alejandria MMA, Lansang MA, Dans L, Mantaring B. Intravenous immunoglobulins for sepsis and septic shock. *The Cochrane Database of Systematic Reviews.* 2003;4.

Lansang MA. Access to medicines: reorienting the research agenda. *Medicus Mundi Schweiz.* April 2002, No. 84:8-11.

Pang T, Lansang MA, Haines A. Brain drain and health professionals. *Brit Med J* 2002;324:499-500.

Lansang MA, Crawley FP. The ethics of international biomedical research (editorial). *Brit Med J* 2000;321:777-8.

Miguel CA, Tallo VL, Manderson L, Lansang MA. Local knowledge and treatment of malaria in Agusan del Sur, the Philippines. *Social Science & Medicine* 1999; 48:607-618.

Miguel CM, Manderson L, Lansang MA. Patterns of treatment for malaria in Tayabas, The Philippines: implications for control. *Tropical Medicine and International Health* 1998;3:1-9.

Lansang MA. Screening programmes for hepatitis B virus infection in the community setting. *In:* Zuckerman A, ed. Hepatitis B in the Asian-Pacific Region, Vol. 1: Screening, diagnosis and control. London: Royal College of Physicians of London, 1997.

Lansang MA, Belizario VY, Bustos MDG, Saul A, Aguirre A. Risk factors for infection with malaria in a low endemic community in Bataan, the Philippines. *Acta Tropica* 1997;63:257-65.

Belizario VY, Saul A, Bustos MDG, Lansang MA, Pasay CJ, Gatton M, Salazar NP. Field epidemiological studies on malaria in a low endemic area in the Philippines. *Acta Tropica* 1997;63:241-56.

Saul A, Lansang MA. Malaria in an area of low transmission in the Philippines. *Acta Tropica* 1997;63:191-93.

Lansang MA. Epidemiology and control of hepatitis B infection: A perspective from the Philippines, Asia. *Gut* 1996; 38(suppl 2):S43-S47.

Cronin L, Cook DJ, Carlet J, Heyland DK, King D, Lansang MA, Fisher CJ. Corticosteroid treatment for sepsis: a critical appraisal and meta-analysis of the literature. *Critical Care Medicine* 1995;23:1430-9.

Lansang, M.A. The ABC's of clinical trials for evaluating the usefulness of dermatologic treatments. *Journal of the Philippine Dermatological Society* 1995; 4(1): 7-10.

Lansang MA, Olveda RM. International linkages: strategic bridges for research capacity strengthening. *Acta Tropica* (1994); 57, 159:1-7.

Lansang MA, Domingo EO, Miguel C, Aligui G, Alagon D, Dayrit E. Integrating hepatitis B immunization into the Expanded Program of Immunization. *JAMA Southeast Asia* 1994 (Suppl.); 10:139-42.

Sunico ME, Lansang MA, Aplasca MR, Balis AC, Cerillo MN. Predictors for the transmission of human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) among Filipino women. *Phil Population J* 1994; 10:129-47.

Santana RT, Lansang MA, Saniel MC, Balis A, Salonga A, Atienza MI. Clinical and laboratory profile of bacterial meningitis among Filipinos: 6 year review. *J. of Tropical and Geographical Neurology.* 1992; 2:151-56.

Morrow RH and Lansang MA. The role of clinical epidemiology in establishing essential national health research capabilities in developing countries. *Infectious Disease Clinics of North America.* 1991; 5:235-46.

Aquino R, Lansang MA, Quimpo VS, Sombrero L, Saniel MC. Evaluation of a single Widal test in the diagnosis of enteric fever. *Southeast Asian J Trop Med Public Health.* 1991; 22:375-9.

Lansang MA, Juban N, Macachor L, Kunin C. A Drugstore survey of antibiotic use in a rural community in the Philippines. *Philippine J. Microbiology & Infectious Diseases* 1991; 20:54-58.

Lansang MA, Aquino RL, Tupasi TE, Mina VS, Salazar LS, Juban N, Limjoco TT, Nisperos L, Kunin CM. Purchase of antibiotics without prescription in Manila, the Philippines: Inappropriate choices and doses. *J. of Clinical Epidemiology* 1990; 43:61-7.

Domingo EO, Lingao AL, Lansang MA, et al. Hepatitis B infection in the Philippines: Epidemiology and prospects for control. *Asean J. of Clinical Sciences* , Monograph No. 11 (1990) on hepatitis B virus infections: Current status and recent developments, 81-86.

Lansang MA, Domingo EO, Lingao A, West S. A cost-effectiveness analysis of a simple micromethod for hepatitis B screening in hepatitis B virus control programmes. *International J. of Epidemiology* 1989; (Suppl 2); S38-S43.

Lingao AL, Torres NT, Munoz N, Lansang MA, West SK, Bosch FX, Domingo EO. Mother to child transmission of hepatitis B virus in the Philippines. *Infection* 1989; 17:275-9.

Lingao AL, Torres NT, Munoz N, Lansang MA, West SK, Bosch FX, Domingo EO. Mother to child transmission of hepatitis B virus in the Philippines. *Infection* 1989; 17:275-9.

Munoz N, Lingao A, Lao J, Estever J, Viterbo G, Domingo EO, Lansang MA. Patterns of familial transmission of HBV and the risk of developing liver cancer: a case-control study in the Philippines. *International J of Cancer* 1989; 44:981-4.

Lansang MA et al. Randomized controlled trial of naloxone in septic shock. *Philippine J of Internal Medicine* 1988; 26:289-96.

Lansang MA, Domingo EO, Lingao AL, West SK, Alisaga E. Sensitivity and specificity of capillary blood HBsAg as a surrogate marker for HBeAg in pregnant women. *J. of Gastroenterology & Hepatology* 1987; 2:159-65.

Roa C, Zaldivar CA, Salonga R, Bobadilla J, Lansang MA, Reodica, Jr R, Balgos A, Blanco J, Tanchuco JQ. Normal standards for ventilatory function test in adult Filipinos. *Philippine J Internal Medicine* 1987; 25:185-94.

Abarquez R, Lansang MA. Which Monotherapy for hypertension? *Philippine J Cardiology* 1986; 15: 115-20.

Lingao AL, Domingo EO, West SK, Reyes CM, Gasmen S,Viterbo G, Tiu E, Lansang MA, Seroepidemiology of hepatitis B virus in the Philippines. *American J of Epidemiology* 1986; 123:473-80.

Domingo EO, Lansang MA, et al. Epidemiology and prevention of persistent HBV infection: country report from the Philippines. In *Hepatocellular Carcinoma in Asia,* International Center for Medical Research, Kobe University, Japan, 1985.

Ocampo R, Abarquez AF, Sy RG, Lansang MA, Sison VM Bellosillo A, Morales DD, Canonigo E. Prospective Cross-over study of digitalis effect of parameters of ventricular function among mild hypertensives. *Philippine J Cardiology* 1984; 12:123-9.

Limson B and Lansang MA. Clinical evaluation of ticarcillin in aerobic or anaerobic gram-negative infections. *Philippine J Internal Medicine* 1983; 21:100-2.

Technical Reports/Monographs

Lansang MA, Rebullida MLG, Eds. Towards Improved Health Policy and Systems Research. Essential National Health Research Program, Department of Health. 1998. A series of 8 monographs on: nutrition, environmental health, women's health, lifestyle-related diseases, EPI, HIV/AIDS/STD, tuberculosis in relation to health policy and systems research in the Philippines.

Tiples DR, Casiple L, Solante R, Lansang MA, Montalban C, Velmonte M, Mendoza M. Evaluation of the Comprehensive Antibiotic Assistance Program at the University of the Philippines – Philippine General Hospital. March 1998.

Lansang MA, Gonzaga E. Safety and immunogenicity of a new recombinant hepatitis B vaccine among Filipino children. February 1998.

Council on Health Research for Development. Priority Setting Using the Essential National Health Research Strategy: Lessons Learned. Lansang MA (ed.). Geneva, Switzerland: COHRED, 1997.

Brady B, Lansang MA. HIV/AIDS situation in the Philippines. An analysis prepared for the Philippine Adult Health Program under development by the Department of Health. Funded by the Asian Development Bank, Manila. 1996.

Lansang MA, Miguel C, Aligui, Domingo EO, Alagon D, Dayrit E, Tan S. A multicenter study to evaluate the dose schedule, stability and effectiveness of HB vaccine delivery within the Expanded Program of Immunization in hyperendemic countries. Funded by the International Development Research Center (IDRC), Canada. 1994.

Lansang MA, Domingo EO, Juban N, Alagon D, Tababa JL, Macachor L, Amarillo ML, Lacaya L. Randomized controlled field trial of single dose vs. three doses of hepatitis B vaccine in preventing the HB carrier state in Filipino children. Funded by the International Development Research Center (IDRC), Canada. 1994.

Lansang MA, Miguel CA. A health education program to promote breastfeeding and improved weaning practices: its effect on ARI morbidity in the first year of life. Funded by the Philippine Council for Health Research and Development (PCHRD). 1991.

Lansang MA, Dantes RB. Effectiveness of community action in the planning, implementation and evaluation of the TB control program. Funded by the Department of Health, Philippines. 1993.

Lansang MA, Miguel C. Process documentation on the integration of hepatitis B immunization into the Expanded Program of Immunization. Funded by the Department of Health, Philippines. 1992.

10/04

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

6 February 2003

Dr. Suttilak Smitasri, PhD
Head, Division of Communication and Behavioural Science,
Institute of Nutrition
Mahidol University at Salaya
Phuthamonthon 4 Road
Nakorn Pathom 73170
Thailand

Dear Dr. Suttilak:

Professor Ricardo Uauy Dagach, Chair, ICDDR,B Board of Trustees has kindly nominated you to the Committee set up to select individuals to replace members of our Board of Trustees who have left after completing their terms. The selection will be made in the next meeting in May this year.

Members of the Board of Trustees of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) serve for a period of three years, potentially renewable for a second three year period. ICDDR,B is an international health research organization based in Dhaka, Bangladesh. A 17-member international Board of Trustees governs the Centre, and a majority of the members come from developing countries including three from Bangladesh. One member is from the World Health Organization, and one is from another UN body, currently UNICEF. The Board meets twice yearly, generally in Dhaka for three days, and the meetings are paid by the Centre according to the Centre's travel policy.

You will also find a great deal of information about the Centre at www.icddrb.org. Under separate cover, I will send a copy of the Annual Report as well as the Ordinance of the Centre.

Should you agree to be nominated, we will be pleased if you could kindly send us a copy of your CV together with a letter accepting to serve in the Board if selected.

Please feel free to contact me should you require any further information.

With best wishes,

Sincerely,

David A Sack, MD
Director

Shahalam

From: Loretta [loretta@icddrb.org]
Sent: Thursday, February 06, 2003 4:46 AM
To: shahalam@icddrb.org
Subject: FW: Nomination


sutilaknomi.doc

Can you pleasecopy and return to me.

Thanks

Loretta

-----Original Message-----
From: RICARDO UAUY [mailto:ruauy@hotmail.com]
Sent: Wednesday, February 05, 2003 2:42 PM
To: loretta@icddrb.org
Subject: Re: Nomination

Attached you will find the CV from Sutilak simitarsi from Mahidol U Thailand

I talked to her and she accepted to be considered, can you send her a letter as with the others

Ricardo Uauy

----- Original Message -----
From: "Loretta" <loretta@icddrb.org>
To: <mhamid4@hotmail.com>; <ruauy@hotmail.com>
Sent: Wednesday, February 05, 2003 5:21 PM
Subject: Nomination

>
>
>
> This is just to let you know that Dr. Siripen has accepted and has sent us a
> copy of her CV.
>
> With best wishes,
>
> Loretta
>

CURRICULUM VITAE

Suttilak Smitasiri, Ph.D.
National Researcher: 38-00-0020
Head, Division of Communication and Behavioral Science,
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Personal:

Date of Birth: July 12, 1955, 48 yrs

Place of Birth: Bangkok, Thailand

Citizenship: Thai

Gender: Female

Marital Status: Single with an adopted daughter
Cholthicha DOB: 1/12/75

Education:

Chulalongkorn University, Bangkok, Thailand, 1974-1977, B.Sc., Photographic Science and Printing Technology

Chulalongkorn University, Bangkok, Thailand, 1979-1981, M.A., Development Communications

Stanford University, California, U.S.A., 1982-1984, A.M., Applied Communication Research

Cornell University, New York, U.S.A., July 1983, Certificate, Communication Planning and Strategy

University of Queensland, Brisbane, Australia, 1991-1994, Ph.D., Community Nutrition

Fellowships:

1982-1984	United Nations University
1991-1994	Australian Development Education Program

Awards:

1992	Queen Sirikit Ceres Gold Medal for outstanding contribution to nutritional well-being in Thailand presented by the Food and Agriculture Organization (FAO).
1994	Mahidol University's Outstanding Research Award.
2002	Thailand National Health Foundation's Honorable Research Award for Nutrition Development Work with an Emphasis on Communication and Behavioral Development.

International Positions:

1992-present	Member of International Vitamin A Consultative Group (IVACG) Steering Committee.
1993	Special Advisor to the World Health Organization.
1994-1995	World Bank Consultant on Information, Education and Communication (IEC) in Lao PDR.
1995	World Bank Consultant on Communication and Behavior Change in Vietnam.
	External Examiner for a Ph.D. Thesis on the Social Construction of Development: A View from Bangladesh, Department of Sociology and Anthropology, University of Queensland.
	Member of the FAO Expert Consultation on Nutrition Education for the Public.
1996	UNICEF/Helen Keller International Consultant on Social Marketing in Indonesia.
1996-present	Reviewer for Food and Nutrition Bulletin and Journal of Nutrition Education.
1996-1999	Co-advisor for Ph.D. Thesis on Dental Caries, Oral Hygiene and Dietary

	Habits: A Study of 3-6 Years Old Buddhist and Muslim Thai Children, Royal Dental College, University of Aarhus, Denmark
1997-1999	Member of ACC/SCN Commission on Nutrition for the 21st Century.
1997-2000	World Health Organization Consultant on Social Marketing for Weekly Iron/folate Supplementation Intervention Project in the Philippines and Vietnam.
1998-2002	Member of WHO Multi-disciplinary Expert Advisory Group on Improving Household Food and Nutrition Security.
1999	International Consultant on Information, Education, Communication for the Bangladesh Integrated Nutrition Programme.
1999-2000	Member of IVACG task force on the bioavailability of dietary carotenoids.
2000-2002	World Health Organization Consultant for Combodia Weekly Iron/folate Supplementation Program.
2002-present	Reviewer for African Journal of Food & Nutrition Sciences.
2002--present	Member of Board of Trustees of the International Food Policy Research Institute (IFPRI).

Professional:

Research Associate, Nutrition Education and Public Relations Program, Research Center, Faculty of Medicine, Ramathibodi Hospital. 1977-1980.

Research Associate, Level 3, Institute of Nutrition, Mahidol University, 1980-1981.

Researcher, Level 4, Institute of Nutrition, Mahidol University, 1981-1985.

Researcher, Level 5, Institute of Nutrition, Mahidol University, 1985-1989.

Researcher, Level 6, Institute of Nutrition, Mahidol University, 1989-1994.

Researcher, Level 7, Institute of Nutrition, Mahidol University, 1994-1997.

Researcher, Level 9, Institute of Nutrition, Mahidol University, 1997-present.

Other Professional Appointments:

Head, Division of Communication and Behavioral Science, INMU, 1991-present.

Member of INMU Administrative Committee, 1988-2000.

Member of INMU Strategic Planning Taskforce, 1988-1991.

Member of Public Relations and Education Sub-committee in the National Nutrition Committee,1991-1996.

Member of INMU Steering Committee, 1994-1997.

Member of Administrative Committee, Institute for Health promotion, Thailand National Health Foundation, 1994-2002.

Member of Executive Committee, Thailand National Health Foundation, 1997-present.

Member of Think Tank, Thailand National Health Foundation, 2001-present.

Secretariat, INMU Strategic Formulation Taskforce, 2001-2002.

Member of Transdisciplinary Commons, Mahidol University, 2002-present.

Research and Related Work:

1979-1981	Cassette Tape Technique as a Nutrition Education Approach for Rural Mothers in Northeast Thailand. Funded by The Asia Foundation.
1981-1984	Communication for Behavior Change: Radio versus Video Van. Funded by the Coca-Cola Company and The Rotary International.
1985-1986	Alternative Approaches to Supervision of Community Health Workers in Thailand. Funded by PRICOR, U.S.A.
1986-1988	Food Behavior Modification and Promotion for Rural People in the Lower Part of Northeast Thailand. Funded by the ASEAN Sub-committee on Protein: Food Habits Research and Development.
1988-1989	Problem Analysis of Availability of Vitamin A Rich Foods and Oils Related to Vitamin A and Oil Consumption in Northeastern Thailand. Funded by the Mahidol University Research Fund.
1989-1990	Information Needs of Patients with Chronic diseases (Diabetes,

	Hypertension and Heart Diseases). Funded by the Mahidol University Research Fund.
1988-1991	Social Marketing Vitamin A-Rich Foods in Northeast Thailand. Funded by USAID.
1994-1995	Evaluation of the Sustainability of the Health Communication Process for Behavioral Change. Funded by Health System Research Institute, Thailand.
1994-1995	The Factors Influencing Cultural Food Habits Among Working Women in Bangkok: A Case Study. Funded by The Office of Thailand National Cultural Committee.
1995-1997	Sustaining Behavior Change Through Community and Women-based Nutrition Education. Funded by International Center for Research on Women, U.S.A.
1995-2002	Expansion of a Model Project to Practical Actions in Northeast Thailand to Improve Micronutrient Status of School Children and the Population. Funded by Thailand Toyota Foundation, the Royal Thai Government, UNICEF, and the Micronutrient Initiative.
1997-2000	Model Development of School Lunch Activities to Improve Iron Status of Primary School Students in the Northeast. Funded by Faculty of Graduate Studies, Mahidol University.
1998-1999	Development of Thailand Food Guide Model. Funded by Department of Health, Ministry of Public Health.
1998-1999	Study on Readiness and Alternatives in Enforcing Good Manufacturing Practice (GMP) Regulation in Thailand Canned Food Industry. Funded by Food and Drug Administration, Ministry of Public Health.
1998-1999	Promotion of Vegetable and Fruit Consumption to Improve Dental Health among Thai Children (3-5 years old). Funded by Thailand Toyota Foundation.
1999	Preparation of a Handbook Prototype for GMP Communication among Manufactures in Thailand. Funded by Food and Drug Administration, Ministry of Public Health.
2000-present	Engaging Suburb Communities and Schools in Food Safety and Consumer Protection. Funded by Food and Drug Administration, Ministry of Public Health.

2001	Process and Methods towards the Improvement of Nutrition Well Being of Indigenous Children in Thailand: Application to Micronutrient and Traditional Food Promotion Program. Funded by Food Agricultural Organization.
2001-2002	Development of an Education Tool to Reduce Overweight and Obesity in Primary School Children. Funded by International Life Science Institute, South East Asia.
2002-present	A Provincial Model to Promote School and Community Nutrition. Funded by Thailand Health Promotion Fund, Office of the Prime Minister, Thailand Toyota Foundation and Foundation for Nutrition Promotion.
2002-present	Research and Development of Safe Traditional Sugar Product and Technology Transfer for Community Economy. Funded by Thailand University Bureau.
2002-present	Sustainable Development on Food Cycle in the Thachin and Mae Klong River Basins. Funded by Mahidol University.
2002-present	Technology Transfer: High Calcium Soymilk for Community. Funded by Thailand Bureau of the Budget, Ministry of Finance.
2002-present	Development of Iron Dense Rice Initiative in Thailand. Funded by National Science and Technology Development Agency – Biotech and Foundation for Nutrition Promotion.
2003	Integrative Research network of the Thachin and Mae Klong River Basin: A Transdisciplinary Approach. Funded by Thailand Research Fund.
2003	Study on Models and Management of Research Institutes in Thai Universities. Funded by Health System Research Institute.

Teaching:

1984-1990	Nutrition Communication for Master Degree students (Nutrition Science) organized by Institute of Nutrition and Faculty of Medicine, Ramathibodi Hospital.
1987-1994	Nutrition Communication and Behavior Change for Master Degree students(International Community Nutrition) organized by Institute of Nutrition, Mahidol University and Nutrition Programs, University of Queensland.
1987-present	Nutrition Education/Communication and Social Marketing for Ph.D.

students (Nutrition Science) organized by Institute of Nutrition and Faculty of Medicine, Ramathibodi Hospital.

1992-present Communication for Behavioral Modification for Master Degree students(Applied Food and Nutrition for Development) organized by Institute of Nutrition and Graduate Program of Mahidol University.

1994-present Applied Communication for Nutrition Interventions for M.S. and Ph.D. students (Population and Social Study) organized by Institute for Population and Social Research, Faculty of Social Science, Faculty of Public Health and Institute of Language and Culture for Rural Development, Mahidol University.

1994-present Communication for Community Development for senior dental students organized by Faculty of Dentistry, Prince Songkla University.

1994-present Communication Projects for Nutritional Development for Her Royal Highness Princess Maha Chakri Sirindhorn and her staff organized by Institute of Nutrition.

1994-present Communication Techniques for Scientific Presentation for Master Degree students(Food Science and Nutrition, Toxicology and Applied Food and Nutrition for Development) organized by Institute of Nutrition.

1994-present Occasionally providing special lectures on Communication and Behavior Development for members of faculties, students and officers in various universities and ministries.

1994-present Occasionally providing consultation to Master and Ph.D graduate students in Thailand and elsewhere on thesis related to nutrition communication and health development.

Training:

1989 A workshop on Strategies and Techniques for Community-based Participatory Interventions for 25 project coordinators under the University of Leeds' Health Behavior and Environmental Sanitation Project in Northeast Thailand.

1990 A workshop on the Process of Community Study for 16 project coordinators under the University of Leeds' Health Behavior and Environmental Sanitation Project in Northeast Thailand.

1991 A special training on Nutrition and Health Education for two medical doctors from Macau under WHO fellowship.

A special training on Social Marketing of Vitamin A-rich Foods for five senior officers from the Ministry of Health, Botswana.

A policy seminar on School Nutrition for 44 senior officers from related ministries and NGOs.

A policy seminar on Communication Strategies for Prevention and Control of Diseases for 41 senior officers and academics from the Ministry of Public Health and universities.

1993 A special training on Social Marketing of Iodine Salt for 15 middle-level officers from the Ministry of Public Health.

A special training on Social marketing of Vitamin A-rich Foods for 12 middle-level officers from the Ministry of Public Health.

A special training on Techniques of Using Public Address System for Health Communication for 197 middle-level officers from the Ministry of Public Health.

1994 A special training on Formative Research for Nutrition Interventions for 15 middle-level officers from the Ministry of Public Health.

A special training on Nutrition Communication for a nutrition researcher from Indonesia under WHO fellowship.

A special training on Nutrition Communication for Public Health for a senior officer from Lao PDR under WHO fellowship.

A special training on Social Marketing of Vitamin A-rich Foods for a project coordinator from Bangladesh under FAO sponsorship.

A special training on media development and production for a medical doctor from the Institute for Health Education, Ministry of Health, Lao PDR under WHO fellowship.

A special training on Strategic Communication Planning for Health for 35 public health officers of the Ministry of Health, Lao PDR under the World Bank's Health Project.

A special training on Nutrition Communication for a senior officer from Islamic Republic of Iran and a project coordinator from Bhutan under FAO sponsorship.

1995 A workshop on Communication Planning for Health for 35 public health

officers of the Ministry of Health, Lao PDR under the World Bank's Health Project.

A special seminar on Communication for Behavioral Change for 15 senior officers from various ministries, Vietnam, under the World bank sponsorship.

A special lecture on Nutrition Communication for Behavior Change for 40 U.S. volunteers.

A special seminar on School Nutrition for 160 school teachers in the Northeast.

A special training on Nutrition Education and Communication for two medical related officers from Sri Lanka.

1996 A special training on Social Marketing Interventions for nine senior officers from India under UNICEF sponsorship.

A special training on Food-based Interventions for two senior NGOs from Nepal under Helen Keller International/USAID sponsorship.

A workshop on Food-based Participatory Interventions for 40 government officers from various ministries and selected community leaders.

A special training on School Nutrition for a medical research from Monglolia.

A special training on Food-based Interventions for a medical officer from Ministry of Health and a senior lecturer from India under an international collaboration.

A special training on Leadership for Food-based Interventions for 400 government officers and selected community leaders in two Northeastern provinces, Thailand.

A special training on Community Nutrition Interventions for 35 college students in a Northeastern province, Thailand.

A participatory training for 40 Thai women leaders for the improvement of micronutrient status in the community.

1997 A training for 13 Asian program managers on Developing Applied Food and Nutrition Project.

A training for five participants from Bangladesh on Nutrition Policy and

Programs (with the focus on communication).

A training for six public health officers from Cambodia on IEC in Health Promotion.

A training for ten public health dentists on Social Marketing.

1998 A training on Nutrition Communication for 14 Vietnamese medical doctors from the Nutrition Information and Education Center (NIEC) in collaboration with International Agriculture Center under the initial support of the Netherlands Government.

1999 A training program for agricultural officers from Bangladesh on Household Food Security through Nutrition Gardening (I), 27 June-11 July.

1999 A training program for agricultural officers from Bangladesh on Household Food Security through Nutrition Gardening (II), 23 November-5 December.

2000 An international training program for researchers, physicians, nutritionists, and social workers from five countries on Documenting Traditional Food Systems.

2001 A training program for public health workers from Bhutan on Nutrition communication for Promotion and Oral Health Program, Si-Sa-Ket province.

A training program for public health workers from Cambodia and France on Nutrition communication for Promotion and Oral Health Program, Si-Sa-Ket province.

An international training program on Documenting Traditional Food Systems for 20 participants including researchers, physicians and sociologists.

A training on Communication for Nutrition Behavior Modification to ten executives and managers of Mother and Child Health Care Development Program from Vietnam.

A training on Communication and Interpersonal Communication to five health care workers from Bhutan.

A training on Women in the Development of Community-based Nutrition Intervention Program in Thailand to five international scholars and

executives.

A training on Engaging Communities in a Sustainable Dietary Approach: a Thai Perspective to 20 international researchers.

A training on Communication for Nutritional Behavior Modification to 18 BIDANI Network Program Directorates from Philippines.

A training on Nutrition Development with the Emphasis in Communication and Behavioral Development Project to two students from Wageningen University, Netherland.

2002 A seminar aimed to determine Si-Sa-Ket's strategy of child and youth development with sustainable food and nutrition for 30 provincial and district officers.

A seminar on School and Community Nutrition for 900 teachers of Si-Sa-Ket Provincial Primary Education Office.

A seminar on Over-nutrition Prevention Strategies in Thailand for 30 experts and practitioners.

A seminar on Strategy for Over-nutrition Control and Prevention in School Children for 150 kindergarten teachers.

A seminar on National Food Strategy for 20 scholars from government and private sectors.

A seminar on Sustainability on Children Food Development in Thailand for 150 female leaders and district officers.

2003 A seminar on Engaging Suburb Community and School in Food Safety and Consumer protection for teachers and students in Salaya, Nakhon-Pathom.

Other Technical Services:

1980-present Development of communication materials and nutrition education programs.

1989-present	Provision of information and policy advocacy for nutrition and health development through newspapers, magazines, newsletters, radio and television.
1993-present	Consultation and advice on communication, behavioral development and social marketing for nutrition and health development programs.

Publications in English:

Smitasiri S. 2003. Enhancing Community-based Horticulture Development and Home Gardening to improve Micronutrient Nutrition in Thailand: a Communication Perspective. A paper to be presented at a symposium on "Horticulture Development and Home Gardening for Combating Malnutrition", IX Asian Congress of Nutrition, New Delhi, India, 23-27 February 2003.

Smitasiri S. 2002. *6th Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian Government and World Health Organization.

Smitasiri S. 2002. *5th Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian Government and World Health Organization.

Smitasiri S. and Chotiboriboon, S. 2002. Experience with Programs to Increase Animal Source Food Intake in Thailand. A paper presented at the Animal Source Foods and Nutrition in Development Countries Meeting, Washington D.C., U.S.A, 22-28 June 2002.

Smitasiri S. 2001. Translating Nutritional Science into Consumer Action: Developing and Multiplying Meaningful Nutrition Messages. A paper presented at a nutrition seminar and workshop on Food-Based Dietary Guidelines, Hanoi, Vietnam, 14-17 November 2001.

Smitasiri S. 2001. Nutrition Communication: from theory to practice. A paper presented at the 17th International Congress of Nutrition 2001,Vienna, Austria, 25 August-1 September 2001.

Smitasiri S. 2001. *4th Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian Government and World Health Organization.

Smitasiri S. 2001. *3rd Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian Government and World Health Organization.

Smitasiri S. 2001. *2nd Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian and World Health Organization.

Smitasiri S. 2001. *1st Report on Cambodia Weekly Iron/folate Supplementation Programme.* Report to the Cambodian Government and World Health Organization.

Smitasiri S, Dhanamitta S, et al. 2000. Women in the development of a community-based nutrition intervention program in Thailand. A paper presented at the 1st Asia Congress of Pediatric Nutrition, Chiangmai, Thailand, 28 November-1 December 2000.

Smitairi S. 2000. *Communication and Community Participation in Micronutrient Interventions.* http://www.mocronutrient.org/

James P, Norum K, Smitasiri S, et al. 2000. *Ending Malnutrition by 2020: An Agenda for Change in the Millennium.* Final Report to ACC/SCN by the Commission on the Nutrition Challenges of the 21st Century. Food Nutr Bull. 21:3 (Supplement).

Smitasiri S. 2000. A Comment on how the nutritional impact of agricultural innovations can be enhanced. Food Nut Bull. 21:44:503-506.

Smitasiri S. 2000. *Engaging communities in a sustainable dietary approach : a Thai perspective.* Food Nutr Bull. 21.2:149-156.

Smitasiri S. 2000. *A Report on Integrated Nutrition Behavioral Change Communication (BCC)): National Nutrition Program.* Report to the Bangladeshi Government and UNICEF/Dhaka.

Underwood B. and Smitasiri S. 1999. *Micronutrient Malnutrition Policies and Programs for Control and Their Implications.* Annu. Rev.Nutr. 19:303-24.

Smitasiri S,Dhanamitta S, Sa-ngobwarchar K, Kongpanya P, Subsuwan J, etal. 1999. *Sustaining Behavior Change to Enhance Micronutrient Status through Community and Woman-based Interventions in Thailand.* ICRW/OMNI Research Report Series2. Washington. D.C.: International Center for Research on Women.

Smitasiri S. 1999. *A Report on Behavioral Change Communication (INBCC)): National Nutrition Program.* Report to the Bangladeshi Government and UNICEF/Dhaka.

Smitasiri S. 1999. *A Report on Training Program for BINP I "Household Food Security through Nutrition Gardening".* Report to the Bangladeshi Government and World Bank/Dhaka.

Smitasiri S. 1999. *A Report on Training Program for BINP II "Household Food Security through Nutrition Gardening".* Report to the Bangladeshi Government and World Bank/Dhaka.

Smitasiri S. 1998. Nutrition Challenges and Gender in Asia. In *Challenges for the 21st Century: A Gender Perspective on Nutrition through the Life Cycle.* Papers from the ACC/SCN 25th Session Symposium, Oslo, Norway, 30 March and 1 April 1998. ACC/SCN Symposium Report Nutrition Policy #17. Geneva: ACC/SCN Secretariat, pp.45-54.

Smitasiri S. 1997. Communicating nutritional knowledge with the poor to improve health in a developing country context. In Fitzpatrick, D.W., Anderson, J.E. and L'Abbe, M.L. (Eds.).*From Nutrition Science to Nutrition Practice for Better Global Health: The Proceeding of the 16th*

International Congress of Nutrition - Nutrition Montreal 97. Ottawa: Canadian Federation of Biological Societies. pp. 54-6.

Smith B. and Smitasiri S. 1997. A framework for nutrition education programmes. In FAO Food and Nutrition Paper #62. *Nutrition education for the public: Discussion papers of the FAO Expert Consultation*. Rome: Food and Agriculture Organization.

Smitasiri S. 1997. Working toward a simple multidimensional evaluation model for community-based nutrition development programs. A paper presented at the 16th International Congress on Nutrition, Montreal, Canada, 27 July - 1 August, 1997.

Smitasiri S. 1996. On Planning and Implementing Vitamin A Intervention:Linking Scientific Knowledge to Effective Action. In Garza C., Hass J.D., Habicht J.P. and Pelletier D.L. (Eds.). *Beyond Nutritional Recommendations: Implementing Science for Healthier Populations.* Proceedings of the Fourteenth Annual Bristal-Myers Squibb/Mead Johnson Nutrition Research Symposium, Washington, D.C. 5-7 June, 1995. New York: The Division of Nutritional Science, Cornell University.

Smitasiri S, Dhanamitta S. 1996. Nutri-action Analysis as a Research Strategy to Improve Nutrition Information, Education and Communication Interventions in Asia. *Biomedical and Environmental Sciences 9*, 290-295.

Smitasiri S. 1995. Part II of Chapter 3: A framework for nutrition education programmes. *Nutrition education for the public: Report of an FAO Expert Consultation*, Rome, 18-22 September 1995, FAO Food and Nutrition Paper 59, Rome: FAO, p. 14-17 & 51.

Smitasiri S. 1994. *Nutri-Action Analysis: Going Beyond Good People and Adequate Resources.* A Joint publication of the UNICEF South Asia Regional Office and the Institute of Nutrition, Mahidol University.

Smitasiri S. 1994. *Advocating a Multidimensional Evaluation Approach for Comprehensive Nutrition Communication Programs.* INMU Special Publication Series No. 1. A joint publication of the UNICEF East Asia & Pacific Regional Office and the Institute of Nutrition, Mahidol University.

Attig G, Smitasiri S, Ittikom K. 1994. *Beyond Behavior Change: Institutionalizing Nutrition Communication Programs.* INMU Special Publication Series No. 3. A joint publication of the UNICEF East Asia & Pacific Regional Office and the Institute of Nutrition, Mahidol University.

Smitasiri S. 1994. A proposed strategy to promote oral healthy lifestyles: An action-oriented approach. *Proceedings of International Seminar on the promotion of Lifestyles Conducive to Oral Health*, Sukhothai, 6-9 September, 1994, p. 101-109.

Smitasiri S, Heywood P, Western J. Effective nutrition education/communication: a challenge for the 90's. *VITAL News* 4(2):1-2.

Smitasiri S, Attig G, Valyasevi A, Dhanamitta S, Tontisirin K. 1993. *Social Marketing Vitamin A-*

Rich Foods in Thailand. Second Edition. USAID, Bureau for Research and Development, Office of Nutrition, Washington, D.C. and the Institute of Nutrition, Mahidol University.

Smitasiri S, Attig G, Valyasevi A, Dhanamitta S, Tontisirin K. 1993. *Social Marketing Vitamin A-Rich Foods in Thailand.* First Edition. UNICEF East Asia & Pacific Regional Office and the Institute of Nutrition, Mahidol University.

Attig G, Smitasiri S, Ittikom K, Dhanamitta S. 1993. Promoting home gardening for controlling vitamin A deficiency in Northeast Thailand. *Food, Nutrition and Agriculture 7*, 18-25.

Smitasiri S. 1993. Toward effective nutrition education/communication in Asia. A paper presented at the International Nutrition Planners Forum (INPF) workshop, at the Fifteenth International Congress of Nutrition, Adelaide, Australia, 26 September - 1 October, 1993.

Smitasiri S, Attig G, Dhanamitta S. 1992. Participatory action for nutrition education: social marketing vitamin A-rich foods in Thailand. *Ecology of Food and Nutrition 28*(3):199-210.

Smitasiri S, Attig G. 1992. Encouraging the production and consumption of vitamin A-rich foods. *Xerophthalmia Club Bulletin 49* (March):3.

Attig G, Kachondham Y, Smitasiri S, Yoddumnern-Attig B. 1992. Nutrition communication research-cum-action and the role of qualitative research. In Winichagoon P, Kachondham Y, Attig G, Tontisirin K, eds. *Integrating Food and Nutrition into Development: Thailand's Experiences and Future Visions.* A joint publication of the UNICEF East Asia & Pacific Regional Office and Institute of Nutrition, Mahidol University.

Yoddumnern-Attig B, Attig G, Smitasiri S, Vong-ek P, Tangchonlatip K, Leuvananonchai M. 1992. Assessing nutrition communication through effective practice reviews. In Yoddumnern-Attig B, et al.(eds). *Qualitative Methods for Population and Health Research.* Mahidol University: Institute for Population and Social Research.

Smitasiri S. 1991. Encouraging production and consumption of micronutrient rich foods: the Thai experience in participatory dietary diversification. In *Proceedings of ENDING HIDDEN HUNGER: A WHO, UNICEF, FAO, UNDP, World Bank, CIDA, USAID Policy Conference on Micronutrient Malnutrition*, Montreal, Canada, 10-12 October, 1991.

Smitasiri S. 1991. Participatory action for integrated nutrition communication programs: the Thai experience in changing dietary behavior through social marketing. In *Proceedings of the Sixth International Conference of the International Nutrition Planners Forum(INPF),* Paris, France, September, 4-6, 1991.

Smitasiri S. 1991. Social marketing vitamin A-rich foods. In *Report of the XIV International Vitamin A Consultative Group(IVACG) Meeting,* Guayaquil, Ecuador, June, 18-20, 1991.

Smitasiri S. 1991. Participatory social marketing of home gardens. A paper presented at the AVRDC/UPWARD International Workshop on Household Garden Projects, Bangkok, May, 13-15,

1 9 9 1 .

Smitasiri S. 1989. Multi-media approach to modify food related habits. In *Proceedings of the Seventh Asian Workshop on Food Habits,* Penang, Malaysia, 19-21 June, 1989.

Smitasiri S, 1989. Evaluation nutrition education programme: The Thai experience. A paper presented at the International Symposium on Childhood Nutrition Education, Tokyo, Japan, 29-30 A u g u s t , 1 9 8 9 .

Dhanamitta S, Winichagoon P, Kotchabhakdi N, Smitasiri S, Valyasevi A. 1988. Communication for Behavioral Change in Thailand: Radio VS Video Van. In Andersen J, Valyasevi A, eds, *Effective Communications for Nutrition in Primary Health Care,* UNU publication, p. 190-197.

Kotchabhadi N, Winichagoon P, Smitasiri S, Dhanamitta S, Valyasevi A. 1987. The integration of psychosocial components in nutrition education in northestern Thai villages. *Asia-Pacific Journal of P u b l i c H e a l t h 1* (2) : 1 6 - 2 5 .

Tontisirin K, Vuthipongse P, Smitasiri S, et al. 1986. Alternative approaches to supervision of community health workers in Thailand. A project report submitted to PRICOR by Institute of Nutrition, Mahidol University and the Office of Primary Health Care, Ministry of Public Health.

Dhanamitta S, Winichagoon P, Kotchabhadi N, Smitasiri S, Valyasevi, A. 1983. Communications for behavioral change: radio VS video van. In *Proceedings of the Fourth Asian Congress on N u t r i t i o n ,* B a n g k o k , 1 - 4 N o v e m b e r , 1 9 8 3 , p . 2 1 7 - 2 2 1 .

Descriptors of Principal Areas of Interest and Future Actions

Communication and behavior development for nutrition and health

Social marketing for nutrition and health development

Community-based interventions for nutrition and health

School-based interventions for nutrition and health

Evaluation of nutrition programs at community and national development in developing countries

Area-based research for comprehensive development

Transdisciplinary research

Knowledge management and implementation for the public

Current as of January 27, 2003

1 9 9 1 .

Smitasiri S. 1989. Multi-media approach to modify food related habits. In *Proceedings of the Seventh Asian Workshop on Food Habits,* Penang, Malaysia, 19-21 June, 1989.

Smitasiri S, 1989. Evaluation nutrition education programme: The Thai experience. A paper presented at the International Symposium on Childhood Nutrition Education, Tokyo, Japan, 29-30 A u g u s t , 1 9 8 9 .

Dhanamitta S, Winichagoon P, Kotchabhakdi N, Smitasiri S, Valyasevi A. 1988. Communication for Behavioral Change in Thailand: Radio VS Video Van. In Andersen J, Valyasevi A, eds, *Effective Communications for Nutrition in Primary Health Care,* UNU publication, p. 190-197.

Kotchabhadi N, Winichagoon P, Smitasiri S, Dhanamitta S, Valyasevi A. 1987. The integration of psychosocial components in nutrition education in northestern Thai villages. *Asia-Pacific Journal of P u b l i c H e a l t h 1* (2) : 1 6 - 2 5 .

Tontisirin K, Vuthipongse P, Smitasiri S, et al. 1986. Alternative approaches to supervision of community health workers in Thailand. A project report submitted to PRICOR by Institute of Nutrition, Mahidol University and the Office of Primary Health Care, Ministry of Public Health.

Dhanamitta S, Winichagoon P, Kotchabhadi N, Smitasiri S, Valyasevi, A. 1983. Communications for behavioral change: radio VS video van. In *Proceedings of the Fourth Asian Congress on N u t r i t i o n ,* B a n g k o k , 1 - 4 N o v e m b e r , 1 9 8 3 , p . 2 1 7 - 2 2 1 .

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Community-based interventions for nutrition and health

School-based interventions for nutrition and health

Evaluation of nutrition programs at community and national development in developing countries

Area-based research for comprehensive development

Transdisciplinary research

Knowledge management and implementation for the public

Current as of January 27, 2003

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

4 June 2003

Dr. Siripen Supakankunti
Director
Chulalongkorn University
Centre for Health Economics
Faculty of Economics
Phayathai Road, Patumwan
Bangkok 10330
Thailand

Dear Dr. Supakankunti:

Our Board of Trustees met on June 1-3 in Dhaka and from the nominations received have appointed Dr. Halima Mwenesi from South Africa as a member of the Board. We would however like to retain your CV for further vacancies that arise from time to time when Trustees leave at the end of their terms.

I sincerely hope that you will continue to remain interested in the Centre and agree to let us retain your CV.

With best wishes,

Sincerely,

David A Sack, MD
Director

c.c.: Ricardo Uauy Dagach, Chairperson, ICDDR,B Board of Trustees

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For Director's information.
2/5/03

30 January 2003

Dr. Barkat-e-Khuda
Acting Director
ICDDR,B:Centre for Health and Population Research
GPO Box 128, Dhaka-1000
Bangladesh

Subject: Members of the Board of Trustees of ICDDR,B

Dear Dr. Barkat-e-Khuda,

In relation of your letter dated 16 January 2003 regarding the above subject, I am pleased to serve in the Board. I would like also to thank you for inviting me and sending me the Annual Report 2001. Enclosed please find my CV and our Annual Report 2000-01 for your information about the Centre for Health Economics, WHO collaboration.

With best wishes,

Yours sincerely,

(Dr. Siripen Supakankunti)
Director

c.c.: Dr. Ricarda Uauy Dagach, Chair, ICDDR,B BOT

CHULALONGKORN UNIVERSITY
CENTRE FOR HEALTH ECONOMICS
FACULTY OF ECONOMICS, BANGKOK 10330 THAILAND
Telephone (662) 218-6280-81
Fax : (662) 218-6279, 251-3967

30 January 2003

Dr. Barkat-e-Khuda
Acting Director
ICDDR,B:Centre for Health and Population Research
GPO Box 128, Dhaka-1000
Bangladesh

Subject: Members of the Board of Trustees of ICDDR,B

Dear Dr. Barkat-e-Khuda,

In relation of your letter dated 16 January 2003 regarding the above subject, I am pleased to serve in the Board. I would like also to thank you for inviting me and sending me the Annual Report 2001. Enclosed please find my CV and our Annual Report 2000-01 for your information about the Centre for Health Economics, WHO collaboration.

With best wishes,

Yours sincerely,

(Dr. Siripen Supakankunti)
Director

c.c.: Dr. Ricarda Uauy Dagach, Chair, ICDDR,B BOT

CURRICULUM VITAE

I. PERSONAL DATA:

NAME: SIRIPEN SUPAKANKUNTI, M.S., M.A., Ph.D.
DATE OF BIRTH: 12 JANUARY 1957
OFFICE ADDRESS: Centre for Health Economics,
Faculty of Economics, Chulalongkorn University
Phayathai Road, Patumwan, Bangkok 10330.
THAILAND
Telephone: (662) 2186278, 218-6280-1
Fax: (662) 218-6279, 251-3967
E-mail: ssiripen@chula.ac.th. or siripen.s@chula.ac.th

II. CURRENT POSITION:

1.**Administrative Work:** Director, Centre for Health Economics,
Faculty of Economics (1998-present).

2.**Associate Professor of Economics**, Faculty of Economics, Chulalongkorn University.

3.**Vice President:** Federation for International Cooperation of Health Services and Systems Research Centers (FICOSSER)

III. EDUCATION & TRAINING:

DEGREE	INSTITUTION	DATE
B.Sc. (Statistics)	Chiangmai University, Thailand	1980
M.S. (Statistics)	Chulalongkorn University, Thailand	1983
M.A. (Economics)	University of the Philippines, Philippines (Ford foundation Scholarship)	1988
Ph.D. (Economics)	University of the Philippines, Philippines (Ford foundation Scholarship and Presidential Scholarship)	1991
Visiting Scholarship and Grant	London School of Hygiene and Tropical Medicine, University of Leeds (British Council Fellowship)	1992
Certificate in Research & Advanced Training in International Health	Harvard School of Public Health, Harvard University	1996-97
Certificate in Flagship Course on Health Sector Reform And Sustainable Financing	World Bank Institute (WBI) of the World Bank	1998, 1999, 2000,2001

Certificate in Training Course on Evidence for Health Policy: Burden of Disease, Cost Effectiveness and Health Systems	WHO and Burden of Disease Unit Harvard Centre for Population and Development Studies	2000

IV. ADMINISTRATION:

1991 - present	Committee Member Centre for Health Economics, Faculty of Economics	Chulalongkorn University
1992 - present	Executive Board Member, Graduate Study in Health Economics	Chulalongkorn University
1993 - 1995	Committee Member and Secretary, the Curriculum Committee, College of Public Health	Chulalongkorn University
1993 - 1996	Director, Faculty Computer Centre, Faculty of Economics	Chulalongkorn University
1998-present	Committee Member, Faculty Computer Centre, Faculty of Economics	Chulalongkorn University
1994 - 1996	Committee Member, Information Centre,	Chulalongkorn University
1994 - 1996	Deputy Director, Centre for Health Economics	Chulalongkorn University
1995 - 1996	Committee Member, Graduate Study in Economics	Chulalongkorn University
1997-present	Committee Member, Economics Evaluation Working Group	National Center Genetic Engineering and Biotechnology
1997-present	Committee Member, Course Material Development Working Group for Master Degree in Economics	Sukhothaithamatirach University
1998-present	Committee Member, Health Care Financing Reform	Health Care Reform Project, Ministry of Public Health

2001-present	Committee Member, Information Base for Universal Health Insurance Program Development	Health Insurance Office, Ministry of Public Health
2001-present	Steering Committee Member, National Health Account	Health System Research Institute Ministry of Public Health

V. CONDUCTING SURVEY:

1983	Conducting national survey of educational project for primary Education at Northern and Northeastern region of Thailand, Ministry of Education.
1984 - 1985	Conducting national survey of wage rate, salary and income of employee at Central region of Thailand, Ministry of Labour and Social Welfare.
1994 - 1995	Organizing and conducting survey of health seeking behaviour at Northern region of Thailand, Chiangmai Province.
2002	Organizing and conducting survey of the Evaluation of the Universal Coverage: 30 Baht for All Disease Financing Scheme Project. MOPH.

VI. WORK RELATED TO ECONOMICS:

1993-present	Course Coordinator and Lecture on Organization Management and Decision Making in Health Sector for the International Masters Program in Health Economics, Chulalongkorn University.
1993-present	Lecture on Health Care Financing, Economics Evaluation, Research Methods modules for the International Master Program in Health Economics, Chulalongkorn University.
1992-present	Lecture on Urban and Regional Economics, Mathematics and Statistics for Economist, Econometrics, Health Policy and Planning for Economics Program, Faculty of Economics, Chulalongkorn University.
1994	Participate in the Intercountry Seminar on "Health Care Financing at the Glass root level", Vietnam, 1994.
1994	"Health Economics", in Thai, A paper presented in the Training Programme for Health Personnel, Office of Health Insurance, Ministry of Public Health, May-June1994.
1995	Participant in the Intercountry Consultation on "Health Care Financing Reform", an International Workshop organized by WHO, October 1995.

1997	Participate in the 75th anniversary symposium on "Gateway to World Health: New Science and Strategies in Public Health". Organized by Harvard School of Public Health. April 27-29.
1998	Participant in the First Asia-Pacific Health Economics Forum & Network, Bangkok, March 1998.
1998	Participate in the HEU 3rd Annual Conference on " Health Economics and its Role in Health Sector Reform". The conference organized by Health Economics Project, MOHFW & DFID. Dhaka, Bangladesh, June 4-5.
1998	Participate and Special Lecture in the 42nd All India Annual Conference of the Indian Public Health Association on " Impact of Public Health on National Economy". Chennai, India, June 26-28.
1998	WHO Consultancy Work on Community Cost Sharing in Myanmar. July-October. Myanmar.
1998	Consultant of Health Economics Workshop for the Health Policy, Planning and Management Project, India. National Institute of Health and Family Welfare, Delhi. 27 August – 5 September.
1998	Consultant of Community Cost Sharing Workshop for the HDI-E PHC project, UNDP, Yangon, Myanmar. 14-19 October 1998.
1999	Participate in the Interregional Workshop on Hospital Cost Analysis, Cairo, Egypt. 1-4 February 1999.
1999	Advice on the Cost-Effectiveness of the Two Intervention Measures of the TDR Project, Yangon, Myanmar. January-February, 1999.
2000	Get invitation as the expert from Federation for International Cooperation of Health Service and Systems Research Centers (FICOSSER) to chair and present in the " Session II: Health Services Expenditures ", 15-18 June 2000, Vouliagmeni , Athens.
2000	Congregate in Symposium on International Health and Medicine Ethics Harvard SPH Takemi Symposium Main Theme " International Health and Medicine Ethics in The 21 Century", Japan. November 29,2000 - December 7, 2000
2000	Get invitation as the expert from WHO-SEARO to do the panel discussion and present the country paper in: Intercountry expert group meeting on globalization, trade & public health: tool & training for national action, 12-14 December 2000, New Delhi, India

2001	Organize and participate in the WHO meeting on "Harmonized Criteria for the Monitoring of the Impact of Globalization/TRIPS on Access to Drugs", Faculty of Economics, Chulalongkorn University, Bangkok, 19-21 February 2001.
2001	Get invitation as the expert from WHO-SEARO to chair and present in the session on vaccine development research and lead the discussions in the 2nd Core Group Meeting on development of SEAR Vaccine Policy, 3&4 April 2001, Jakarta, Indonesia.
2001	Get invitation as the technical expert from WHO-SEARO in: Regional Consultation on Health Systems Performance Assessment, 18-21 June 2001, WHO/SEARO, New Delhi, India.
2001	Get invitation from Health Economics Unit Policy and Research Unit. Ministry of Health and Family Welfare, Bangladesh to address this conference as a speaker on the subject of the regulation of health care providers in Thailand in the third conference on the theme of the role of the state in the financing and regulation of the health sector, 4-5 July 2001, Dhaka, Bangladesh.
2001	Get invitation as the technical expert from WHO-SEARO to present in the session on Financing Immunization Programs in SEAR Task Force on Development of a Regional Vaccine Policy, 22-25 October 2001, WHO/SEARO, New Delhi, India.
2001	Get invitation from The Initiative on Public-Private Partnerships for Health to present the study results and experiences on evolution of IP protection and strategies for accommodating WHO/TRIPS in Thailand in Global Forum for Health Research - Forum 5, 8-12 October 2001, Geneva, Switzerland
2001	Get invitation from the Medical Division, MOPH to present on CEA for National Forum on CPG. 31 October 2001.
2002	Get invitation from GAVI Financing Task Force to participate the GAVI Financing Task Force Forum, 23-24 January 2002, Kellogg Conference Center, Gallaudet University, Washington, D.C.
2002	Get invitation as a WHO Temporary Adviser from WHO Headquarters, Geneva to discuss issues relating to the framework and operationalization of generalized cost-effectiveness analysis, 28-29 January 2002, WHO, Geneva, Switzerland
2002	Get invitation as a WHO Temporary Adviser from WHO Geneva to attend the Third Meeting of The Network for Monitoring the Impact of Globalization and TRIPS on Access to Medicines, 5-7 February 2002, Rio de Janeiro, Brazil.

2002 Get invitation as the expert from Federation for International Cooperation of Health Service and Systems Research Centers (FICOSSER) to chair and present in the " Session 9: Health Care Financing in the Developing and Newly Industrializing Countries:Achievements and Shortcomings ", 12-14 June 2002, Chersonissos, Heraklion, Crete, Greece.

VI. RESEARCHES (recently):

1983 **A Statistical Analysis in Selecting Factors Affecting the Attitudes of the Northeastern Rural People in Out-Migration for work,** Master thesis, Chulalongkorn University, 1983.

1991 **Development, Technological Change and the Process of Urbanization in Thailand: An Applied General Equilibrium Approach,** Faculty of Economics, Chulalongkorn University.

1992 **Implications of VAT on Prices, Income Distribution, Exports and Export Taxes and Incentives.** Monograph.
(Charit Tingsabadh, Somchai Ratanakomut, Kitti Limskul, Siripen Supakankunti)

1994 **Structural Change: Impact on Urbanization Process in Thailand.** Research Report funded by Chulalongkorn University.

1995 **An Evaluation of the Major Cities Development Plan under the National Economics and Social Development Plan,** Social Research Institute, Chulalongkorn University.

1994 **Characteristics and Medical Expenses of Car Injuries.** Research Report funded by MOPH. (Wattana S. Janjaroen, Siripen Supakankunti and Nantawan Vijitwatakarn)

1995-1996 **Economic Analysis of Health Card Project in Thailand: Chiang Mai Province** Research report funded by Health Insurance Office, MOPH (Siripen Supakankunti and Wattana S. Janjaroen)

1995-1996 **Economic Analysis of Voluntary Health Insurance Schemes in Khon-Kaen Province.** Research report funded by Health Insurance Office, MOPH.
(Siripen Supakankunti, Wattana S. Janjaroen and Supan Sritamma)

1998	**Framework for the Fifth Bangkok Development Plan (Economic Section),** Bangkok Metropolitan Authority.
1999	**Study of the Implications of the WTO TRIPS Agreement for the Pharmaceutical Industry in Thailand.** Research report funded by WHO SEARO (Siripen Supakankunti, Wattana S. Janjaroen, Oranee Tangphao, Sauwakon Ratanawijitrasin, Paitoon Kraipornsak and Pirus Pradithavanij)
1999	*"Preliminary Study on Trade Liberalization in Health Services Sector: Its Consequences on Social and Health Care System in Thailand"*, a research report submit to Thai Research Fund, Bangkok, Thailand, October 1999. (Janjaroen, Wattana S., Chitr Sitthi-amorn, Siripen Supakankunti, Sauwakon Ratanawijitrasin, Kamalinne Pinitpuvadol, Sathirakorn Pongpanich, Ratana Samrongthong).
2000	**General Agreement on Trade in Services (GATS) and the Effects on Health System and Services in Thailand.** (Wattana S. Janjaroen and Siripen Supakankunti).
1999-2000	**Impact of Capitation Payment: the Social Security System of Thailand** in collaboration with Harvard School of Public Health, Research report funded by USAID (Winnie C. Yip, Siripen Supakankunti, Jiruth Sriratanaban, Wattana S. Janjaroen and Sathirakorn Pongpannich).
2001	**Economic Analysis of Strategies for Better Improvement of Milk and Related Products Industries,** Research report funded by BIOTECH, Ministry of Industry, March, 2001.
2001	**Valuing Health and Economic Costs of Water Pollution in Thailand,** Study report funded by the World Bank. (Siripen Supakankunti, Pirus Pradithavanij and Tanawat Likitkererat)
2002	**The 30 Baht Scheme: Can Thailand Have It All? The Challenge of Concurrent Implementation of Universal Coverage, Decentralization and Health Reform.** (Siripen Supakankunti, Agnes Soucat, and Wim Van Lerberghe)
2002	**Review of the Vaccine and Immunization Financing Mechanisms of The SEAR Countries.** Research report funded by WHO SEARO.
2002	**"Implications of Foreign Hospital Operations on Health Sector - a case study of Thailand".** (Wattana S. Janjaroen and Siripen Supakankunti) Research report funded by WHO-SEARO, August, 2002.
2002	**Analysis of the Attitudes of the Thai People towards the Universal Health Insurance Program.** (Siripen Supakankunti, et al.) Research report funded by Asia Foundation.

2002 **Economics Analysis of the Hospital Expenditures for the Inpatient Care and the Hospital Financial Status under the Universal Health Insurance Program: Phase I.** Health System Research Institute, MOPH. (Siripen Supakankunti and Pirus Pradithavanij).

2002 **Evaluation of the Universal Coverage: 30 Baht for All Disease Financing Scheme.** Health System Research Institute, MOPH. With others.

2002 **Quality indicators for contracted hospitals under the social security scheme project: Phase 1 development of quality indicators.** (Jiruth Sriratanaban, Siripen Supakankunti, Sunthorn Supapong, Yupin Aungsuroj, and Mayuri Jiravisit)

2002 **The Priority Setting in Health Economics Research in Thailand.** A paper in Strategic Planning Project for Health Research under the Medical Science Area, Medical Research Division, The National Research Council of Thailand (NRCT), The Ministry of ScienceTechnology and Environment.
(Pirom Kamolratanakul, Siripen Supakankunti, Somsak Shunharas, Viroj Tangjaroensatien, Tossaporn Vimolkej and Jiruth Sriratanaban)

VIII. ON-GOING RESEARCHES:

1998-2002 **Quantitative Approaches to Analysis and Redefinition of Market Roles in Changing Options for Health Services.** Research funded by WHO SEARO.

1999-2002 **Health Insurance Program Development, Roi-Ed Province,** Research funded by Roi-Ed Provincial Health Office, Thailand.

2001-2002 **Developing and Formulating the Quality Indicators for Social Security Scheme in Thailand.** Research funded by Social Security Office.

2001-2003 **Harmonized Criteria for the Monitoring of the Impact of Globalization/TRIPS on Access to Drugs.** Research funded by WHO Geneva.

2002-2003 **An Evaluation of Economic Impacts of "Improving Access to Care to Highly Active Antiretroviral Therapy (HAART) Program" for HIV/AIDS Patients in Thailand.** Research funded by WHO Thailand. (Siripen Supakankunti and Keiko Tsunekawa)

IX. WRITTEN WORK RELATED TO HEALTH ECONOMICS:

1995 **Structural change and urbanization in Thailand: What implications for health services?** Faculty of Economics, Chulalongkorn University.

1995 **Characteristics and Costs of Traffic Accident Injuries.** Faculty of Economics, Chulalongkorn University.

1997 **Future Prospects of Voluntary Health Insurance in Thailand,** Takemi Paper No. 130, Harvard School of Public Health.

1998 **"Development And Sustainability of Voluntary Health Insurance Scheme in Thailand "**, Chulalongkorn Journal of Economics 10 (2), Faculty of Economics Chulalongkorn University, 1998. 125 – 147 Pages.

1998 **"Priority Setting in Health Economics Research in Thailand : Present and Future"**, A paper in Strategic Planning Project for Health Research under the Medical Science Area, Medical Research Division, The National Research Council of Thailand (NRCT), The Ministry of ScienceTechnology and Environment.
(Wattana S. Janjaroen, Siripen Supakankunti and others).

1998 **"Health Economics and its Role in Health Sector Reform: Thai Experience"**. Paper presented to the Health Economics Unit 3rd Annual Conference. Dhaka, Bangladesh. 4-5 June 1998.

1998 **"Comparative Analysis of Various Community Cost Sharing Implemented in Myanmar".** Paper presented to the Workshop on Community Cost Sharing in Myanmar under the HDI-E, PHC project, UNDP, Yangon, Myanmar. 13-19 October 1998.

1998 **"A Proposed Model for the Improvement of Community Cost Sharing in Myanmar".** Paper presented to the Workshop on Community Cost Sharing in Myanmar under the HDI-E, PHC project, UNDP, Yangon, Myanmar. 13-19 October 1998.

1998 **"Health Services Systems and the Consequences from the General Agreement on Trade in Services (GATS)"**, with Wattana S. Janjaroen, A paper presented at the conference on : *A Macroeconomic Core of Open Economy for progressive Industrialization and Development in Asia in the new Millenium*, organized jointly by Chulalongkorn University and American Committee on Asian Economics Studies, Bangkok, Thailand, 16-18 December, 1998.

1999 **"Future Prospects of Voluntary Health Insurance in Thailand"**, Health Policy and Planning; 15(1): 85-94, Oxford University Press.

1999 **"Study of the Implications of the TRIPS Agreement of WTO on the Pharmaceutical Industry in Thailand"** Siripen Supakankunti with others, paper presented at The Regional Consultation on WTO Multilateral Trade Agreements and their Implications on Health – TRIPS ", organized by World Health Organization, Ministry of Public Health and Chulalongkorn Universty at Siam City Hotel, Bangkok, 16-18 August 1999.

2000 **"Community Health Insurance in Thailand"**, 2000. 28 Pages. (Paper presented to Joint International Conference : APHEN (Asia-Pacific Health Economics Network) Forum 2000 and 5 th Annual of The Bangladeah Health Economics Unit (HEU), Health Sector Reform: Equity Efficiency, Sustainability?, 4 – 6 June 2000, Dhaka , Bangladesh)

2000 **"Health Economics and Its Role in Health Research Development: Lessons Learned from the Asian Economic Crisis"** 12 pages. Paper presented to the International Conference on Health Research Development at Shangri-La Hotel, Bangkok, Thailand 10-13 October 2000.

2001 **"Development and Sustainability of Community Health Insurance in Thailand"** in "Health Economics in the New ERA", EXANDAS, National School of Public Health, Athens, Greece.

2001 **"Determinants of Demand for Health Card in Thailand"**, Health, Nutrition and Population Discussion Paper, the World Bank's Human Development Network, the World Bank, Washington D.C., USA, September 2001.

2001 **"A case study of the WTO TRIPS agreement impact on the pharmaceutical industry in Thailand: lessons learned for developing countries"**. Siripen Supakankunti with others, WHO Bulletin, 2001.

2001 **"The 30 Baht Scheme: Can Thailand Have It All? The Challenge of Concurrent Implementation of Universal Coverage, Decentralization and Health Reform"**, Draft, Siripen Supakankunti, Agnes Soucat and Wim Van Lerberghe.

2002 **Thai Health System in Transition: Challenges for the Future in "Key Economic Issues for the Future of Asia"**. Presented at Chulalongkorn University Academic Affair organized by the Faculty of Economics, Chulalongkorn University and Department of Economics, National University of Singapore and The International Institute for Trade and Development (ITD). 6 December 2002.

2002 **Impact of Payment and Regulation: Case of Thailand.** Paper presented to the 5th FICOSSER General Conference: session 9 Health Care Financing in the Developing and Newly Industrialised Countries: Achievements and Shortcomings. Crete Island, Greece.

2003 **Thai Universal Health Insurance Scheme in Transition: Challenges for the Future.** iHEA 2003, USA.

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

4 June 2003

Dr. Nafsiah Mboi
Jln. Gatot Subroto
Kompleks, A.D. No. G 11
Jakarta 12950
INDONESIA

Dear Dr. Mboi:

Our Board of Trustees met on June 1-3 in Dhaka and from the nominations received have appointed Dr. Halima Mwenesi from South Africa as a member of the Board. We would however like to retain your CV for further vacancies that arise from time to time when Trustees leave at the end of their terms.

I sincerely hope that you will continue to remain interested in the Centre and agree to let us retain your CV.

With best wishes,

Sincerely,

David A Sack, MD
Director

c.c.: Ricardo Uauy Dagach, Chairperson, ICDDR,B Board of Trustees

(3)

Dr Tikki Pang

Dr David A. Sack
Director, ICDDR,B

Jakarta, 22 January 2003

Dear Dr.David A. Sack:

Thank you for your recent letter, kindly sent to me by Dr Barkat-e-Khuda. I apologize for the delay in replying, I have been travelling to the Provinces.

I have known of and admired the work of ICDDR, B for many years. I would be honored to serve on the Board, should I be selected by the Committee. I am pleased if my experience can be useful to the Centre and am sure that I will benefit from the opportunity to know the institution and its programmes better. I look forward very much to working with the Board, I know and highly respect several of the Board Members.

I look forward to hearing more about meeting arrangements as the time draws nearer
With warm regards.

Sincerely,

Nafsiah Mboi, MD. Pediatrician, MPH
Jln. Gatot Subroto
Kompleks A.D. No. G 11
Jakarta 12950
INDONESIA

Cc: Dr Barkat-e-Khuda, Acting Director
Dr Ricarda Uauy Dagach, Chair, ICDDR,B BOT
Dr Tikki Pang, Director, RPC WHO

Tel : (62 21) 525-0552 e-mail : nmboi@attglobal.net Fax : (62 21) 522-8452

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CURRICULUM VITAE

PERSONAL INFORMATION

Name : Nafsiah Mboi, MD, Pediatrician, MPH.

Profession : Pediatrician

: Retired (August 2002) Director, Department of Gender and Women's Health, World Health Organization, Geneva, Switzerland

Nationality : Indonesian

EDUCATION

1994 : **Study tour** : One month study of HIV/AIDS management in Australia as a Fellow of the Australia-Indonesia Institute

1990-1991 : **Research Fellow**, Harvard University. Takemi Program in International Health, Harvard School of Public Health. Training/ Seminars/ Study visits etc.

1989-1990 : Prince Leopold Institute of Tropical Medicine, Antwerp, Belgium. International Course for Health Development (**Master of Public Health**)

1989 : **Summer Course** : "Epidemiologi en gezondheidsbeleid" organized PAOG - Erasmus University. Rotterdam

1981 : Senior Staff College. Department of Health, Gov. of Indonesia. Senior Management training

1972 : **Post graduate course** : social pediatrics, Amsterdam, Holland.

1971-1972 : **Post graduate course** : Pediatrics, Rijks Universiteit, Gent, Belgium.

1968-1971 : University of Indonesia, Jakarta. Faculty of Medicine. Specialization in Pediatrics. (**Pediatrician** 1971)

1958-1964 : University of Indonesia, Jakarta. Faculty of Medicine. (MD 1964)

PROFESSIONAL EXPERIENCE

A. Civil Service

1992 to Oct : Senior researcher, National Institute of Health Research and Development, Min of Health, RI

1988-1992 : Staff, Secretary General, Ministry of Health, Rep. of Indonesia.

1985-1988 : Senior specialist (Pediatrics), General Hospital, Kupang, NTT

1978-1985 : Head, Community Health Services Division, Dept. of Prov. Health, NTT

1973-1974 : 1. Staff, Provincial Health Service, Prov. NTT

2. Deputy Director, General Hospital, Kupang, NTT

1968-1971 : Assistant in Pediatrics, Cipto Mangunkusumo General Hospital, Jakarta.

1964-1968 : Director, General Hospital, Ende, Flores.

B. **Private practice of medicine**

1964-1972 : General practice

1972-1978 : Pediatric practice including establishment of two private maternity clinics

C. Other health related assignments

1999-2002 : Director, Department of Gender and Women's Health, WHO. Geneva, Switzerland.

1978-1986 : Director, Blood Transfusion Service, Indonesian Red Cross, Province of NTT

1975-1978 : Seconded full time to the Indonesian Red Cross : Director, Blood Transfusion Service of the Red Cross for Metropolitan Jakarta.

1973-1974 : Director, Blood Transfusion Service, Indonesian Red Cross, Kupang, NTT

1971-1972 : Asst. in pediatrics, Academisch Ziekenhuis. Gent, Belgium

D. Legislative Experience

1992-1997 : Member of Parliament RI, DPR RI

1982-1997 : Member of People's Consultative Assembly, MPR RI, Highest Indonesian representative body. (Three terms)

E. Selected Consultancies, advisory assignments and other projects

1999 : **Speaker/ resource person** : "Reflections on Violence Against Girls and Women : A call for action by the Health Sector". Prepared for Regional Consultation on Violence Against Women organized by WHO-SEARO, Yangon, Myanmar. 12-15 January 1999.

1997 : **Team leader** : Case study of child labour in Indonesia and efforts towards its elimination carried out in context of **ILO** International Programme on the Elimination of Child Labour (IPEC).

1996-1997 : **Advisor/ facilitator** : Pilot project for HIV/AIDS testing and counseling in context of Safe Blood Transfusion by the Indone-

sian Red Cross, a program of the Government of Indonesia and the Red Cross.

1996 : **Speaker/ resource person** : Regional Workshop on AIDS Policy in South Asia. Organized by The Economic Development Institute of the World Bank in collaboration with the UNDP regional project on HIV/AIDS Kathmandu, Nepal. February 5-9, 1996.

1996 : **Designer/ facilitator** : Gender workshop for all members of provincial legislature (Province of Nusa Tenggara Timur) including introduction to gender analysis, gender analysis of selected NTT development indicators (education, labor force participation, etc), gender as influence in work of the legislature, gender analysis as a tool in field visits of member of legislature.

1996-1997 : **Team leader/ principal speaker/ training facilitator** : provincial AIDS advocacy, education, and planning program reaching provincial AIDS Commissions, community and religious leaders, the NGO community, professional health care providers, and sex workers as well as promoters and workers in recreation/ hospitality industry. Organized by World Vision Indonesia. 18 multiple day programs in 7 provinces. (Riau, Jakarta, Central and North Sulawesi, Irian Jaya, Timor Timur, Nusa Tenggara Timur)

1996 : Similar multi-day programs in two additional provinces sponsored by AusAID (Australian ODA) in Province of Nusa Tenggara Timur and an Indonesian Fishing Company in Province of Maluku.

1995 : **Resource person** : Seminar of Female Indochinese Parliamentarians on Women's Status and Reproductive Health. Ho Chi Minh City, 25-26 June 1995

: **Speaker/ Resource Person** : European Parliamentary Forum for Action Implementing the Cairo 1994 Programme for Population, Reproductive Health and Development. 26-27 May 1995, Brussels, Belgium

: **Speaker/ Resource person** : "Women and AIDS in SE Asia" at WHO SEARO Regional Consultation on "Action for Women's Health and Development. 19-22 February, New Delhi, India.

: **Facilitator** : Needs assessment workshop for women members of provincial legislature and district council (DPRD Tk I &II), Province of Nusa Tenggara Timur. Output : design for three year program of capacity building in "women in politics."

1993 : **Training team member** : "AIDS Advocacy and Education Basic AIDS training for "Kancil", a public service group of advertising professionals. (May-June 1993)

1992-1997 : **Project leader** : Multi-country study of health of poor urban women working in the informal sector

1992 : **Organizer/participant/speaker/regional coordinator** : SE Asia Regional "Workshop on Urban Research in the Developing World : Towards a research Agenda for the 1990s". Sponsored by the Ford Foundation through the Centre for Urban and Community Studies, University of Toronto. Meeting in Jakarta, Indonesia. September 1992. (*)

1992 : **Resource person/ participant** : "First Asian Regional Human Resource Development Meeting". Organized by UNDP/ World Bank Water and Sanitation Program. Puerto Azul, Philippines. 13-16 July 1992.

: **Project Advisor** : World Bank study of community management of household water supply in rural settings with particular attention to roles of women in management systems.

: **SE Asia Regional Coordinator** : "Urban Research in the Developing World : Towards a Research Agenda for the 1990s" and author of research paper on urban research in Indonesia. World project managed by the University of Toronto. Funded by the Ford Foundation.

1991 : **Program review** of the Comprehensive and Integrated Reproductive Health Care Program (WKBT) of the Indonesian Planned Parenthood Association (PI). Commissioned by the International Women's Health Coalition (IWHC), New York and carried out in Indonesia, January 1991.

1988-1989 : **Training design-Trainer** : Participatory approaches to Nutrition/ Health planning for Department of Public Works, RI. Led training for Indonesian officials in Indonesia and Belgium.

1988 : Women's participation in urban planning. **Substantive review and proposal of program revisions** to improve community management aspects, including women's participation in Medan multi-year urban water and sanitation development scheme. Department of Public Works, RI.

: Regional Consultation on International Drinking Water Supply and Sanitation Decade, New Delhi, July 1988. **Representing UNDP** programme for Promotion of the Role of Women in Water Supply and Environmental Sanitation Services (PROWESS).

1987 : **Guest lecturer and resource person** in Regional and Area Development training for Indonesian officials in 9 month training programme of West Flankers Development Institute, Burgee, Belgium.

1986 : **Speaker-Resource person** : Workshop on "Health Programmes for Family Development", a three country broadcast media workshop. Organized by the Asia Pacific Institute for Broadcasting Development (AIBD), Kuala Lumpur, Malaysia.

MEMBERSHIPS AND VOLUNTEER COMMUNITY SERVICE

International

1997-1999	:	**Member, subsequently Chair,** UN Committee on the Rights of the Child.
1996-2000	:	**Member** : Board of Directors, International Women's Health Coalition
1994-1999	:	**Member** : Board of Trustees of US-Indonesia Society.
1992-1997	:	**Vice Chair** : Global Commission on Women's Health established by World Health Assembly (1992)
1992-1996	:	**Member** : International Advisory Board, Project on International Mental and Behavioral Health. Harvard Medical School, Department of Social Medicine.
1989-1999	:	**Associate** : The Synergos Institute, New York.

Indonesian

1998-1999	:	**Member** : National Commission on Human Rights
1998-1999	:	**Founding Vice-Chair, Member** : Community Recovery Program (Pemulihan Keberdayaan Masyarakat)
1998-1999	:	**Founding Board Member and Secretary General** : National Commission for Child Protection (*Lembaga Perlindungan Anak)*
1996-1999	:	**Member** : Board of Atmajaya University Foundation
1996-1998	:	**Vice Chair** : Communication Forum of Non Governmental AIDS Organizations
1994-1999	:	**Member** : National Working Group on AIDS
1993-1999	:	**Member** : Advisory Committee for World Vision International/ Indonesia and subsequently Board Member of World Vision Indonesia
1983-1993	:	**Vice Chair** : Indonesian National Council of Handicrafts.
1978-1988	:	**Chair**, Board of Advisors for Coordinating Board of Provincial Women's Organizations, Kupang.
	:	**Chair**, Koperasi Serba Usaha "Wanita Cendana" (Women's Cooperative), Kupang.
	:	**Chair**, NTT branch of Indonesian Planned Parenthood Association
	:	**Chair**, BK., Provincial Board for Coordination and Development of Non Governmental Social Development Activity

1978-1988 : **Chair**, Action Team of PKK in NTT (Family Welfare Movement).

: **Chair**, Dharma Wanita, Province of NTT (Organization of Wives of Indonesian Civil Servants)

1971-present : **Member** : Indonesian Pediatric Association.

1964-present : **Member** : Indonesian Medical Association.

INTERNATIONAL MEETINGS AS SPEAKER/ RESOURCE PERSON:

(indicates paper was prepared and presented)*

1974 : **Seminar** : "Re-hydration", Jakarta. Organized by the Medical Faculty of the University of Indonesia. (*)

1983 : **Speaker** : "Second Asian Media Seminar on Women, Children, and Population in Asia", Jakarta. Organized by UNICEF, the Press Foundation of Asia and the Indonesian Planned Parenthood Association.(*)

: **Speaker**: Seminar on "Development in Dry Land Agricultural Areas". Organized by Nusa Cendana University, Kupang, NTT.

1984 : **Speaker** : Seminar/Training on Development in Dryland Agricultural Areas (Aeroki). Organized by UNICEF. Bali.

1985 : **Speaker** : "Second National Working Meeting of Provincial Coordinating Boards of Social Development Activity". Organized by the National Council on Social Welfare. Jakarta.

: **Inter country workshop** : "Methodology for case studies on women's participation in community water supply and sanitation", Bangkok, Thailand. Organized by WHO-SEARO and UNDP.

: **Member**, Indonesian delegation to Third Turkish National Immunization week and International Seminar : "Universal Child Immunization by 1990 -- Country Perspectives." (*)

: **Principal speaker** : "Third Media Workshop on Child Survival and Development", Hong Kong. Organized by the Press Foundation of Asia. (*)

1986 : **Participant/ speaker** : "Second Inter country workshop on women's participation in community water supply and sanitation", Kathmandu, Nepal. Organized by WHO/ SEARO and UNDP. (*)

1987 : **Participant and chair**, plenary session: Asia and Western Pacific "Regional Conference of the International on Social Welfare," Jakarta. Organized by the International Council of Social Welfare.

: **Participant** in Magsaysay Awardees Assembly and **Moderator** for Assembly Symposium on Rural Development, Bangkok, Thailand. Organized by the Ramon Magsaysay Award Foundation and the Rockefeller Brothers Fund.

1988 : **Organizer/participant/speaker/workshop Chair**: "Third Intercountry workshop on women's participation in community water supply and sanitation", Kupang, Nusa Tenggara Timur, Indonesia. Organized by WHO/ SEARO and PKK NTT(*)

1989 : **Speaker** : UNICEF Nairobi "Symposium on National Capacity Building for Child Survival and Development" in Africa. Organized by UNICEF International Child Development Center (Florence, Italy) and the University of Nairobi. (*)

: **Speaker** : The "International Conference on Research for Healthy Cities". The Hague, The Netherlands. Organized by the Netherlands Society of Public Health and Science in collaboration with WHO/ Europe. (*)

1990 : **Speaker** : "Women, water and sanitation, an action-research program of PKK in the Province of NTT, Indonesia" : Presentation for the United Board for Christian Higher Education in Asia, 9 November 1990 in New York.

: **Speaker** : "Closing the gap between policy and implementation: the food sufficiency policy in NTT, Indonesia" : Guest lecture at the Kennedy School of Government, 21 Nov. 1990 in Cambridge.

: **Participant** : "Conference on Outpatient Hospitals in Developing Countries". 26-27 November 1990 in Boston, Ma. organized by Harvard School of Public Health (HSPH), the Rockefeller Foundation, World Health Organization (WHO).

1991 : **Speaker** "Posyandu and Dasa Wisma : grassroots action to improve accessibility to Health Care" : for the Student Conference on Grassroots Development organized by the Overseas Development Network. 16 March 1991. Wellesley College.

: **Speaker** "Women's reproductive health care in Indonesia" : for Harvard School of Public Health, Dept of Population Sciences seminar series on reproductive health care. 1 April 1991, Boston.

: **Speaker** : "Policies and Programs for Healthy Women and Children : lessons learned from Indonesia". The Woodrow Wilson School of Public and International Affairs, University of Princeton. 16 April 1991 in Princeton, New Jersey.

: **Speaker** : "Towards Self Sustaining Family Planning in Indonesia: Priorities for 1990s". Presentation for Pathfinder International. 3 June 1991 in Watertown, Massachusetts.

: **Speaker** "Empowerment of women through economic activity" : Presentation for Women and International Development (WID) seminar, 15 March 1991 at the Kennedy School of Government, Cambridge.

: **Participant** : International Conference on Women's Health : "Action Agenda for the 1990s". 24-27 June 1991 in Washington D.C. Organized by National Council for International Health.

1991 : **Participant** : World Health Assembly. 6 - 11 May 1991 in Geneva. Organized by WHO.

: **Participant** : "Consultation on Advanced Urban Health Care Unit". 2-4 May 1991 in Geneva. Organized by WHO.

: **Participant** : "Building Health through Community : An International Dialogue." April 24-26, 1991 in Boston, Ma. organized by Commissioners' Office, Boston, Department of Health and Hospitals.

1992 : **Keynote speaker/ participant** : "SE Asian Regional Consultation on Health Rights and AIDS Prevention Among Street Youth". Organized by CHILDHOPE, Manila, Philippines. 15-21 November 1992.(*)

1993 : **Speaker/participant** : "UN Expert's Meeting on Women in Urban Areas". Organized by UNDP Division for Advancement of Women. Santo Domingo, Dominican Republic, 22-25 November 1993.(*)

: **Speaker/ workshop Chair** : ILO-IPEC "Workshop on the Elimination of Child Labour in Hazardous Industries" at the Occupational Safety and Health Congress for Asia and Pacific Region, 19-20 August 1993, Singapore.(*)

: **Speaker/ participant** : Global seminar, "Urban Research in the Developing World" coordinated by The Centre for Urban and Community Studies, University of Toronto. Meetings 14 - 18 February 1993, American University in Cairo. (*)

1994 : **Speaker** : "Towards a " New" Public Health : Partnerships, the key to change". **Moderator** : Women's Health in Indonesia. Denpasar, Bali, 4-7 December 1994. (*)

: **Resource person**: UNFPA, "Regional Consultative Meeting on the Operationalization of the Programme of Action of the International Conference on Population and Development". New York. 29 Nov - 1 Dec. 1994

: **Speaker** : "Gender and Women's Health in Urban Indonesia : New Priorities for the 21st Century". Prepared for the Takemi Program in International Health, Harvard School of Public Health. 26 September 1994. (*)

: **Moderator** : "The risks of exposure : The Challenge of Urban Air Pollution" a panel in the World Bank's second annual conference on environmentally sustainable development. Washington, D.C. September 1994.

: **Speaker/Resource Person** : International Conference of Parliamentarians on Population and Development. "Gender Equality and Empowerment of Women". Cairo, Egypt. 3 Sep 1994 (*)

: **Speaker** : Mary Johnston Memorial Lecture : "Community Participation and Public Health in Indonesia : The Challenge of Women and AIDS". Organized by Mary Johnston Foundation, Overseas Bureau, Melbourne, Australia. 26 July 1994.(*)

1944 : **Speaker/ participant** : 10th Asian Parliamentarians Meeting on Population and Development. "Women in the 21st Century : The Indonesian Family and Housewife in the Social, Economic and Demographic Context". Organized by The Asian Population and Development Association. Beijing, China 3-4 March 1994.(*)

1995 : **Moderator** : panel discussion "Women, Drug Abuse, and Addiction" organized by the UN Drug Control Program. Beijing, China, 5 September 1995.

: **Moderator** : panel discussion "Women and AIDS". Discussion organized by the World Health Organization. Beijing, China, 5 September 1995.

1995 : **Speaker** : workshop "Women in Partnership for Survival and Humanity" organized by the International Council of Women, at the NGO Forum, Huairou, China, 5 September 1995.(*)

: **Speaker** : "Colloquium on Women and Health Security", organized by the World Health Organization at Fourth World Conference on Women. Beijing, China, 5 September 1995. (*)

: **Speaker** : "Indonesian Update 1995", A seminar of the Australian National University. Canberra, Australia, August 25-26 1995. (*)

: **Participant** : UNICEF-Harvard Workshop : "The Children's Summit Goals -- the Challenge of Sustainability". Florence, Italy. 1-2 June 1995

: **Speaker** : 11th Asian Parliamentarians' Meeting on Population and Development with theme Women in the 21st Century -- Strategy for Prosperity and Peace. 14-15 March 1995. Tokyo, Japan.(*)

: **Chair** : WHO "Global Consultation for Policy Makers on Women and AIDS". Geneva, Switzerland. 1-10 Feb 1995

: **Speaker** : "Women and AIDS : The need for special attention". Senior seminar at the Indian Institute for Management, Ahmedabad, India.

: **Speaker** : "Women's Health : Indonesian Experience in the Past and Challenges in the Future". The Tata Institute of Social Sciences, Bombay, India.

1996 : **Speaker/ Resource-Person** : "Women's Health and Development : Motherhood and More" Southeast Asia Regional Meeting of the International Medical Parliamentarians Organization. July 1996, Bangkok, Thailand.(*)

: **Speaker** : speaking tour in the US organized by the US-Indonesia Society. Focused on a variety of topics related to women's health in Indonesia, AIDS in Indonesia and the impact of gender on both. Audiences included staff and graduate students of Schools of Public Health at Tulane and Emory Universities, Howard University Center for International Affairs and the Medical School, invited members of the US Congress and the international development/donor community. 10-24 April 1996.

1996 : **Participant, member of drafting committee** : 12th Asian Parliamentarians' Meeting on Population and Development with theme Women in the 21st Century -- Strategy for Prosperity and Peace. February, 1996 Manila.

1997 : **Speaker :** "The Rights of Children with Disabilities". Remarks on the occasion of Theme Day Discussion organized by the UN Committee on the Rights of the Child, 6 October 1997, Geneva, Switzerland.

: **Speaker/ resource person :** "Healthy Cities, Health Communities : a woman's perspective". Asia Regional Meeting of the International Medical Parliamentarians Organization. August 1997, Bangkok, Thailand.(*)

: **Speaker/ Resource person :** "University for a Night". Round table (1) "World Challenges" with Henry Kissinger, Richard Parsons, Rajesh Tandon and others; (2) "Conflict or Collaboration" cases from Brazil, Indonesia and South Africa. May 1997

: **Speaker :** "Global Leadership through Conventions". A symposium talk at WHO's 4th International Conference on Health Promotion. July 1997.(*)

: **Speaker :** "The UN Convention on the Rights of the Child (CRC) : A tool to advance "the best interest" of the child". Harvard School of Public Health, April 1997.(*)

1998 : **Speaker/ resource person :** "Ensuring Justice for Children and Youth in the 21st Century", Closing remarks at World Forum '98 - Justice for Children organized by the International Forum for Child Welfare, 8 November 1998, Manila, Philippines.(*)

: **Speaker :** "Children : their Rights and Life in the World with AIDS". Remarks on the occasion of Them Day Discussion organized by the UN Committee on the Rights of the Child, 5 October 1998, Geneva, Switzerland.

: **Speaker/ resource person :** "Global Experience Implementing the Convention on the Rights of the Child : Achievements, issues, and prospects." Regional Meeting of National Coordinating Bodies for the Convention on the Rights of the Child organized by UNICEF Regional Office for East Asia and the Pacific. May 1998, Bangkok, Thailand.(*)

1999 : **Speaker/ resource person :** "Promotion and Protection of Child Rights : An Obligation to Our Children on the Verge of the 21st Century". Remarks at an international seminar organized by the Tunisian Association for the Rights of the Child. Tunis, 19 September 1999. (*)

: **Speaker/ resource person :** "Keep Children Smiling in the New Millennium". Opening remarks at a conference to mark the 10th anniversary of the adoption by the General Assembly of the United Nations of the Convention on the Rights of the Child. Warsaw, Poland. 27-28 September 1999. (*)

1999 : **Speaker/ resource person** : "Remarks of the Chairperson of the Committee on the Rights of the Child on the occasion of the 8th anniversary of Sri Lanka's ratification of the Convention on the Rights of the Child". 12 July 1999, Colombo, Sri Lanka. (*)

: **Speaker** : "Remarks of the Chairperson of the Committee on the Rights of the Child on the occasion of ECOSOC's Commemoration of the 10th anniversary of the Convention on the Rights of the Child". 6 July 1999, Geneva, Switzerland. (*)

: **Speaker/ resource person** : "Reflections on Violence Against Girls and Women : A call for action by the Health Sector". Prepared for Regional Consultation on Violence Against Women organized by WHO SEARO. Yangon, Myanmar. 12-15 January 1999.

SELECTED LECTURES/ SPEAKING as Director, Department of Gender, Women, and Health, WHO (In most cases also acted as resource person. Unless otherwise indicated papers were prepared.)

2000 : **Speaker** : Statement at the 44th meeting of the Commission on the Status of Women. 29 Feb 2000. UN, New York

: **Speaker** : Remarks at panel discussion organized by American Autoimmune Related Diseases Association and the Global Alliance for Women's Health. UN, New York. 2 March 2000

: **Speaker** : "Women's Access to Health Care and Delivery". Focus on Women's Health Around the World. Forum sponsored by the Beijing Plus Five Women's Health Planning Committee. 7 June 2000. Hunter College, New York..

: **Speaker** : "Gender, Health, and Poverty : Some comments on the Beijing+5 Outcome Document". Prepared for WHO/SID workshop "Asymmetry of Globalization : Gender, Health and Poverty", 27 June 2000. Geneva, Switzerland.

: **Speaker** : "Female Genital Mutilation : the challenge and the response". Conference on Prevention and Elimination of Female Genital Mutilation. 31 October 2000. Vienna, Austria.

: **Speaker** : Remarks on the occasion of the opening of WHO's South East Asia Regional Technical Consultation on Gender Mainstreaming in Health. 6 November 2000. New Delhi, India.

: **Speaker** : "Female Genital Mutilation : Responding to the challenge." Prepared for the International Day on Female Genital Mutilation (FGM) organized by the European Parliament. 29 November 2000. Brussels, Belgium.

2001 : **Speaker** : "Strategic Issues in Women's Health". Prepared for meeting of focal points for reproductive health and gender mainstreaming organized by the WHO Regional Office for Europe. 5-7 February 2001. Copenhagen, Denmark.

2001 : **Speaker** : Statement at the 45th Meeting of the Commission on the Status of Women meeting. 6 March 2001. UN Headquarters, New York.

: **Speaker** : "Women's and Girl's Right to Health - HIV/ AIDS and Tobacco". Remarks at a panel discussion organized by the NGO Committee on the Status of Women and the Campaign for Tobacco Free Kids. 7 March 2001, UN, New York.

: **Speaker:** "The Impact of the HIV/AIDS Epidemic on Women and Girls in Africa". Keynote for Briefing on HIV/AIDS in Africa. The World Health Organization (WHO) and the International Health Awareness Network (IHAN) in Conjunction with the Commission on the status of Women. 9 March 2001. UN, New York.

: **Speaker** : "Generating Evidence to Promote Empowerment of Women in Public Health" Prepared for *Second International Meeting on Women's Health : Maximizing Women's Capacities and Leadership* organized by WHO Centre for Health Development and hosted by the University of Canberra, Australia. 4-6 April 2001.

: **Speakers** : "The Medical Women's International Association & WHO : Partners in advancement of women in health and women's health". Prepared for the International Congress of the Medical Women's International Association. Remarks read by President of MWIA. Sydney, Australia. 19 April 2001.

: **Speaker** : "The Impact of HIV/AIDS on children and women : a challenge to the witness and work of WVI". Presentation for Triennial Council of World Vision International. Riverside, California. 27-31 August 2001

: **Speaker** : "Prevention, Care, and Stigma Reduction in the field of HIV/ AIDS". Presentation at an International Workshop for Red Cross/ Red Crescent Women Leaders. 6-7 September 2001. Oslo, Norway

: **Speaker** : "Female Genital Mutilation : Action to Accelerate It's Elimination." Remarks at Global Dissemination Workshop on Training Materials for Nurses and Midwives". Harare, Zimbabwe. 3-7 December 2001.

2002 : **Speaker** : Remarks on the occasion of the 2nd Workshop on CEDAW Guidelines organized by the Jordan National Committee on Women (JNWC) and Rights and Humanity. Amman, Jordan. 19 March 2002.

: **Speaker** : "Gender Mainstreaming and the Work of WHO". Keynote speech at WHO gender workshops Amman, Jordan and Cairo, Egypt. March 2002.

: **Speaker** : "Gender, Health and Ageing". Presentation at the Valencia Forum, an international scientific congress on ageing preceding the Second UN World Assembly on Ageing. Valencia, Spain. 1-4 April 2002.

: **Speaker** : Statement at the 27th session of the Committee on the Elimination of Discrimination Against Women. New York. 3 June 2002.

WRITING : numerous titles (in English and Indonesian) including 20 published papers, articles and chapters. (full list of titles available on request)

HONORS/ AWARDS

1993 : Chosen 1993 Fellow of the Australia-Indonesia Institute

1989 : Satya Lencana Bhakti Sosial. Awarded by President of Indonesia.

1986 : Magsaysay Award for Government Service. Awarded by the Ramon Magsaysay Foundation, Manila, Philippines.

1984 : Honored by Minister of Education (Indonesia) for distinguished service in field of non formal education.

1982 : Indonesian Red Cross : silver medal for 10 voluntary blood donations.

LANGUAGES : Indonesian, English, Dutch, and several local Indonesian languages

Nafsiah Mboi, MD, Ped, MPH.

Printed, 23 January 2003

Full Board, Sunday 28 Nov 2004
02:00-04:00 pm: Selection of new Trustees

Md. Shah Alam

From: David A Sack MD [dsack@icddrb.org]
Sent: Wednesday, November 03, 2004 3:23 PM
To: shahalam@icddrb.org
Subject: Fw: Nomination - ICDDR,B Board of Trustees

----- Original Message -----
From: Raj KARIM
To: David A Sack MD
Sent: Wednesday, November 03, 2004 2:08 PM
Subject: RE: Nomination - ICDDR,B Board of Trustees

Dear Mr David Sack,

Thank you for your note. I am sending you my CV as requested for your files. I apologize for the delay. Our system has been down for over a month and it has been a long process to retrieve our mails.

With best wishes,
Dr Raj Karim

Reply-To: "David A Sack MD" <dsack@icddrb.org>
From: "David A Sack MD" <dsack@icddrb.org>
To: <rkarim@ippfeseaor.org>
Cc: "Terry Hull" <Terry.Hull@anu.edu.au>, <ruauy@hotmail.com>
Subject: Nomination - ICDDR,B Board of Trustees
Date: Sun, 26 Sep 2004 08:48:18 +0600

Dear Dr. Karim:

Terry Hull has forwarded to me your willingness to serve on our Board of Trustees. Thank you. I am hoping you could now send a copy of your CV for our files. The current Board will be reviewing potential new Board members at the meeting to be held in Dhaka in November.

With best wishes,

David
David A. Sack, M.D.
Executive Director
ICDDRB: Centre for Health and Population Research
GPO Box 128
Mohakhali, Dhaka 1000, Bangladesh
880-2-882-3031 (office telephone)
880-2- 882-3116 (fax in Dhaka)
1-208-955-4437 (fax in the USA, read in Dhaka)
dsack@icddrb.org

CV OF DR RAJ KARIM

Name: **DATUK DR. RAJ BTE. ABDUL KARIM**

Address: International Planned Parenthood Federation
246, Jalan Ampang
50450 Kuala Lumpur

Telephone: 603-42566122

Fax: 603-42570697

E-mail: rkarim@ippfeseaor.org

Nationality: Malaysian

Date of Birth: 24th Oct. 1944

Sex: Female

Marital Status: Married with 5 children

QUALIFICATION:

Date	*Institution*	*Qualification Obtained*
1990, 1994	National Institute of Public Administration, Kuala Lumpur.	Certificate, Leadership and Management for Senior Management Personnel
1974	Institute of Mother and Child, Warsaw, Poland.	Post Graduate Certificate in Advanced Maternal and Child Health and Family Planning
1971	Royal Institute of Public Health and Hygiene, London.	Diploma in Public Health
1971 - 1972	Family Planning Association, Margaret Pyke House, London	Certificate in Family Planning, Instructors in IUD.
1968	Fatimah Jinnah Medical College, Univesity of Punjab, Lahore, Pakistan.	MBBS

POSITIONS HELD

Date	*Position Held*
1968	Housemanship, General Hospital Kuala Lumpur, Malaysia.
1969	Medical Officer, General Hospital Kuala Lumpur, Malaysia.
1971 – 1972	Medical Officer, London Borough of Hammersmith, Ealing, London. (Sessional Doctor for Maternal and Child Health, School Health and Family Planning Clinics).
1972 – 1974	Medical Officer, (MCH/FP) Ministry of Health, Malaysia. (Volunteer Medical Officer, Family Planning Association 1973 – 1976)
1974 – 1989	Assistant Director of Health Services (Maternal and Child Health) Ministry of Health, Malaysia.
1978 – 1988	Part time (sessional) lecturer, in Maternal and Child Health, National University, Medical School, Kuala Lumpur, Malaysia, And Masters in Public Health, University Malaya, Kuala Lumpur, Malaysia.
1989 – 1992	Director, Public Health Institute, Ministry of Health , Malaysia.
1990 – 1994	Invited Lecturer (Maternal Health Module) Masters in Tropical Health, Queensland University, Brisbane, Australia.
Apr. 1992 - Oct. 1999	Director General National Population and Family Development Board

PRESENT POSITION

From Oct. 1999	Regional Director International Planned Parenthood Federation (IPPF) East and South East Asia and Oceania Region Kuala Lumpur, Malaysia
From Apr. 2002	Appointed by His Majesty the Yang Di Pertuan Agong as a Commissioner of National Human Rights Commission (SUHAKAM)

AWARDS AND HONORS:

Date	*Awarding Body*	*Name of Award*
1999	Government of Malaysia awarded by His Majesty the Yang DiPertuan Agong (King)	Panglima Jasa Negara (P.J.N.) Title: Datuk
1997	Government of Malaysia awarded by His Majesty the Yang DiPertuan Agong (King)	Johan Setia Mahkota (J.S.M.)
1993	Government of Malaysia awarded by His Majesty the Yang DiPertuan Agong (King)	Kesatria Mangku Negara (K.M.N.)
1995	Joanne Drew International	Total Woman Award
1990	Government of United States of America.	Hubert Humphrey Fellowship Award

ASSOCIATION MEMBERSHIP

1.	Malaysian Association of Maternal and Neonatal Health (MAMANEH)	President 1992-1996 Appointed Adviser in 1996 up to present.
2.	Malaysian Menopause Society (MMS)	Vice President 1998 - 1999
3.	Pan Pacific & South East Asia Women Association (PPSEAWA)	Vice President 1995 – 1997
4,	International Association of Maternal and Neonatal Health (IAMANEH)	EXCO Member since 1996
5.	International Council on Management of Population Programme (ICOMP)	Vice President 1997 - 1999 Adviser 1994 - 1997
6.	National Council of Child Welfare Malaysia	Expert Representative since 1992 Vice President since 2000
7.	Global Partnership for Maternal and Maternal and Newborn Health (Secretariat WHO Geneva)	Representing IPPF since 2004

CAREER DEVELOPMENTS

- Her pioneering efforts in Family Health in Malaysia in advocating for and development of policies, strategies, programmes and new initiatives are recognised not only in the country, but also in the region and internationally. Over a span of a 20 years period, she has been the prime mover of many of the strategies and programmes that are in place today to improve the health and wellbeing of women, children and families.

- During the period from mid 70's and 80's, she was involved with the major changes in the institutional structure for family development – the upgrading of rural health services, upgrading of midwives to multipurpose community nurses; institutionalizing of the Primary Health Care and strategies for expansion of coverage to underserved and unserved areas; the Functional Analysis Review of MCH/FP services; and the MCH/FP component of the 1st. National Health and Morbidity Survey. She was also responsible for the integration of family planning into MCH services, nutrition services, and the School Health Programme. In 1985, she proposed for the development of a Family Health programme.

  During the same period, she also developed and integrated Child Survival Strategies into the Family Health Programme – the promotion of breast feeding and Code of Ethics on Marketing of Infant Formula; the Expanded Programme of Immunization with introduction of oral polio vaccine (1974), tetanus toxoid for pregnant women (1975), measles (1986), Rubella (1987), hepatitis B for newborns (1989); the Oral Rehydration Strategy for Diarrheal Disease and the screening of newborns for G6PD deficiency.

  With support of WHO, UNICEF and the Prime Minister's Implementation Coordination Unit, she worked on a system for National Nutrition Surveillance for Children under 7 years from 1982 to 1986. The report presented to the Prime Minister, resulted in the birth of a special budget and programme for identification and rehabilitation of children with moderate and severe malnutrition. This programme today is an integral part of the family health programme and of the Poverty Eradication Programme for the poorest of the poor.

  Her involvement in promoting intersectoral initiatives led to her being appointed as the National Coordinator for the World Summit for Children in 1990 and the convening of high level meetings chaired by the Prime Minister's wife to develop a National Plan of Action for Children. The document, Caring for the Children of Malaysia 1990-2000 approved by the Cabinet in 1994 is the first blue print for Child Health, Protection and Development. She continued this role to explore newer areas of child development, protection and participation, monitor the mid decade goals, and represented the Government at the Ministerial Meetings for Review of Mid Decade Goals. She was appointed Adviser to the Minister of National Unity and Social Development for the Ministerial Meeting for Review of End Decade Goals for Children in May 2001. For her work on Child Survival and Development, she was named in UNICEF State of Children 2000 Report as the key person in Malaysia.

- She has pioneered work on the Risk Strategy in MCH Care and of evolving it into a Systems Approach to reduce maternal mortality. The outcomes of the Risk Approach e.g. Training and utilization of TBA's based on a Partnership Approach; Colour Coding for Prenatal Assessment; Referral and Management; Confidential Enquiry of Maternal Mortality; Quality Assurance Programme (Maternal Health Indicator Approach); system for referral and feedback; and standardized case management protocols are now in place nationwide. She also worked on Safe Motherhood Initiatives to make programmes safer by promoting district initiatives through the district team problem solving approach. These initiatives were initially planned with cooperation from WHO.

  In spite of the International debate on the Risk Approach, Malaysia's system has been recognised as pragmatic and operational and Dr. Raj Karim has been invited to present this case study at several international meetings, the recent ones being the WHO Regional Workshop on Reproductive Health for the Western Pacific Region in 1995; the South-South Initiative – Partners in Population and Development in Dacca (1998) and Harare (1998), the Inter Regional Meeting on Lessons Learnt in Safe Motherhood in Colombo (1997) and Experience of Low Maternal Mortality Country in Tunisia (2000). Many developing countries have recognised Malaysia's efforts in Maternal Health and Mortality and Safe Motherhood and have expressed interest in sharing experiences. A project for South-South Cooperation with the Partners in Population and Development was developed in 2002 using Malaysia's Safe Motherhood experiences .

- Her special interest in Family and Reproductive Health transcends the positions she has held. As Director of the Public Health Institute from 1989-1992, she pursued her interest in developing projects on Safe Motherhood Research; District Team Problem Solving; Strengthening of District Health Systems; Health Services Research and Health Management. In 1993, in conjunction with 70 years midwifery in Malaysia, she founded the Safe Motherhood Research Fund and the Red Carnation Safe Motherhood Award. This award given every 3 years, is to recognise health and medical professionals including TBA's who have dedicated their lives to maternal health.

- She has also pursued the more sensitive areas of Reproductive Health. She initiated the first National Study on Adolescent Reproductive Health and Sexuality (1996-1998) and presented its findings to the Cabinet which resulted in the adolescent health development policy and programme. She chaired the Inter Sectoral Technical Committee on Reproductive Health and Adolescent Reproductive Health, and has written experiences on the adolescent sexuality study for inclusion into the WHO Guidelines on Situational Analysis of Adolescent Health and for IPPF.

- Dr. Raj Karim led the country's delegation in the preparatory meetings for the International Conference on Population and Development (ICPD) and was alternate leader to the Minister for the ICPD in Cairo in 1994. Her interventions on the issues of Reproductive Health and Rights, Maternal Health and Mortality, Abortion, Family Planning and Family Formation was noted by "Earth Times" who identified her as one of the 100 persons that made a difference at the Cairo Conference. She has served as a Consultant or Temporary Advisor to WHO and UNFPA for policy and technical meetings on Reproductive Health. She was an invited member of the panel of the Commission on Quality of Life in Population and Development (1995) and Advisory Panel to the Executive Director of UNFPA to discuss ICPD+5 (1997). She also served as an invited 'developing country partner' for the Panel on Health

(Reproductive Health and Maternal Mortality) for the OECD Development Progress Indicators in Paris in 1997, 1998 and 2000. She represented Malaysia as a member of the UN Commission on Population and Development, was elected Vice Chairperson and Rapporteur of the 30th. Session in 1997 and Chairman of the 31st. Session (Feb. 1997 to March 1998) as a representative of Asia. In September 1998, she chaired and hosted the Inter-Sessional Bureau Meeting in Kuala Lumpur to prepare for the ICPD+5. Preparatory Meeting in March 1999 and the Special Session of the UN General Assembly in June/July 1999. The Executive Director UNFPA and Director UN Population Division attended the meeting.

- Dr. Raj Karim has organized, attended and presented papers at conferences and workshops on various aspects of Family Health, Safe Motherhood and Reproductive Health. She was a WHO Consultant for the Regional Workshop on Reproductive Health for Western Pacific Region in 1995. As President of Maternal and Neonatal Health Association Malaysia, she organized the First National Conference on Safe Motherhood in 1996 with participation of lesser developed countries in the region and invited speakers from WHO, UNICEF, UNFPA and Executive Board of the International Association of Maternal and Neonatal Health. She has served as a Consultant to Myanmar, Pakistan, Indonesia, Iran (for the ECO Region), Iraq and North Korea for their country programmes, and for international organisations such as WHO, UNICEF and UNFPA.

- Dr. Raj Karim has been a member of several Task Forces and Steering Committee in WHO since 1979, having participated in the Risk Approach Project, Safe Motherhood Research, Global Advisory Group on EPI, Prevention and Control of Diarhoeal Diseases in Children and Technical Consultations on MCH/FP, Nutrition and Reproductive Health. She has been a member of the WHO Expert Advisory Committee on MCH since 1985 and represented Malaysia in the WHO Policy and Coordinating Committee of the Human Reproduction Programme. She was a member of the Regional Advisory Panel on Reproductive Health (Western Pacific Region 1996, 1997) and the WHO Steering Committee on Introduction of Fertility Regulation Methods of the HRP Programme.

  She also advocates for and disseminates issues on Family MCH and Reproductive Health to local and international NGO's. She was the Vice Chairperson of ICOMP (International Council on Management of Population Programmes), and member of the Executive Board member of International Association of Maternal and Neonatal Health. As a member of the Executive Council of the Pan Pacific and South East Asia Women's Association (Malaysia Chapter), she has organized national, regional and international workshops.

- In April 1998 she was chosen to represent Malaysia as the Technical Resource to Dr. Siti Hasmah, wife of the Hon. Prime Minister of Malaysia, who was invited as a Special Guest Speaker at the World Bank Special Event on Safe Motherhood. For this event, Dr. Raj Karim compiled country experiences on Safe Motherhood Initiatives and the speech for Dr. Siti Hasmah entitled "Empowering our Women to Live".

- In April 2002, she was appointed by His Majesty the Yang Pertuan Agong as a Commissioner of National Human Rights Commission of Malaysia (SUHAKAM) and continues for work on issues of women and children including rights of women and children. Presently she is focusing on Trafficking of Women and Children and MDGs.

- As Vice President of Malaysian Child Welfare Council (MKKM), she advocates for issues and rights of children and is currently focusing on training of care givers home) for children with disability and promotion of child protection and safety.

- Since assuming the post of Regional Director of IPPF East and South East Asia and Oceania Region in October 1999, she continues work on Safe Motherhood and Reproductive Health in the region and in transferring experiences through South to South collaboration and technical assistance.

  Among her recent initiatives are:

  - Prepared/coordinated Documentation for Transfer of Experiences to Partner Countries in collaboration with Partners in Population and Development – a South to South Initiative (completed December 2000) and presented at Workshop on Transfer of Experience to South-South Initiative for India, Pakistan, Gambia, Kenya, Uganda and Zimbabwe, in Kuala Lumpur using the Malaysian model.

  - Country Report of Malaysia's Safe Motherhood Experience (Malaysia selected as an example of a Low Mortality Country) for International Conference of Interagency Group on Safe Motherhood in Tunisia in October 2000.

  - Coordinated workshop for Futures Group International and presented a paper on Malaysia's Experience in Safe Motherhood to ADB/UNICEF RETA Workshop on Safe Motherhood Asia in Kuala Lumpur in August 2000.

  - Invited to speak on Malaysia's Safe Motherhood Experience at Global leadership Training on Health organised by Partners in Population and Development in February 2001 in Dhaka.

  - Invited to speak at the SARC Conference in Bali on Quality Improvements in Safe Motherhood (Malaysia) and "From Family Planning to Reproductive Health" in February 2001.

  - Developing Reproductive health Guidelines for integrated Reproductive Health Services including HIV/AIDS, Gender and Women, and developing projects/mobilising resources for countries in the region especially least developed countries.

  - Invited as one of the 11 members of the NGO team led by Hon. Wife of Prime Minister, Datin Seri Dr Siti Hasmah bte Hj Mohd Ali for the mission to Iraq in March 2000 and for the Government humanitarian mission to Iraq in June 2001.

  - Invited for Minister of Foreign Affair's delegation to Iraq and North Korea in 2001 and a task force member of Malaysia's bilateral humanitarian assistance to Cambodia.

  - Selected to participate in the Transition Group Meeting on Global Safe Motherhood in London in February 2002 to discuss global strategies for the improvement of maternal and newborn health care and currently represents IPPF in the Partnership for Maternal and Newborn Health (Inter Agency Group).

- In her capacity as Regional Director, East and South East Asia and Oceania Region (ESEAOR) she is responsible for the development and overseeing of the Reproductive Health (women, family, children's health and welfare) in 25 countries; identifies and develops needy projects for funding on priority issues of women's health, HIV/AIDS, Adolescent and Youth, Reproductive Health, etc. She represents IPPF at Regional Intergovernmental and International Meetings of UN Agencies and NGOs such as WHO, UNFPA, UNICEF, ESCAP, Asian Forum on Parliamentarians for Population and Development, and others.

  - Was resource person for ESCAP and invited to write and present the review paper on Reproductive Health and Family Planning for the 5th Asian Population and Development Conference in December 2000 at UNESCAP Bangkok.

  - She also convened the NGO Forum in conjunction with this conference on the theme of Population, Reproductive Health and Poverty.

  - Represented IPPF at the Global Round Table on ICPD at 10 in London (September 2004), High Level Meeting on ICPD+10 in Wuhan, China (October 2004) and Asian Parliamentarians Conference on ICPD+10 in Almaty, Kazakhstan (October 2004).

  - Convened and organized two workshops on Trafficking of Women and Children in Malaysia in April and October 2004 with participation of South East Asia countries and regional organizations (IOM, ECPAT, UNICEF, etc).

  - Wrote monograph for UNDP Malaysia for Malaysia's achievements in MDG 4 and 5 for Maternal and Child Health (in draft) (2004)

Date for next BoT meetings

2005 – June	-	**Executive Committee (EC)**
3, 4, 5 June	-	Fri, Sat, Sunday
Arrival:	-	Thursday
(31 May-3 June	-	Global Health Conference 2005 Washington)
2005 – November	-	**Full Board**
11, 12, 13 November	-	Fri, Sat, Sunday
Arrival:	-	Thursday
2006 – June	-	**Executive Committee (EC)**
2, 3, 4 June	-	Fri, Sat, Sunday
Arrival:	-	Thursday
2006 – November	-	**Full Board**
3, 4, 5 November	-	Fri, Sat, Sunday
Arrival:	-	Thursday

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 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 Reviewers: Dr. C.E. Gordon Smith, Dr. David J. Sencer.
December 1990	Diarrhoeal Diseases Information Services Centre (DISC) Reviewer: Paul Osborn
June 1991	Scientific Advisory Council (Health) Committee Members: Yoshifumi Takeda, MD & D.Med Sci (Japan) Dr. Betty Kirkwood (London) Dr. J. Tulloch (Switzerland) Professor J.R. Hamilton (Canada) Dr. Jon E. Rohde (India) Professor M.K. Bhan (India) Dr. A.S. Muller (The Netherlands) Dr. Norbert Hirschhorn (USA)
November 1991 (7-9 Nov)	Population Science and Extension Division 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 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 Response to the June 1993 BOT Meeting. 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 Reviewer: Dr. Larry Marlow (Australia).
November 1993	Community Health Division 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 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 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 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 (1-14 Sep)	Integrated Institutional Review of the Centre Reviewers: Dr. David Sencer (USA) – Team Leader, 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 Consultant: Jackie Reeves
June 1998	Public Health Sciences Division Reviewers: Prof. C. Victora (from BOT), Prof. Margaret Bentley, Dr. Halida Hanum Akhter.
August 1998	ICDDR,B Human Resources Report Human Resources Consultant: Jackie Reeves
November 1998	ICDDR,B Human Resources Report Human Resources Consultant: Jackie Reeves

November 1998	Business Plan and restructuring of the Centre Consultants: Messrs Jurg Frick and Matthias Scherler.
November 1998 3-6 Nov	Health & Population Extension Division 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 (No review because of Nutrition Programme Review)
November 1999	BoT Retreat
January 2000 (24-27)	Nutrition Programme Review Reviewers: Prof. Andrew Tomkins, Mr. Rolf Carriere, Prof. Nazmul Hassan, INFS, Mr. Charles Lusthaus
June 2000	Laboratory Sciences Division No review
August 23-30	ORP Review 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 No review
June 2002 (June 4-5)	Laboratory Sciences Division Reviewers: Dr. I K Wachsmuth, Dr. Tikki Pang (from BoT), Dr. Wanpen Chaicumpa (Thailand), Major General (Dr) ASM Matiur Rahman (Bangladesh).
November 2003 (28-30 Oct 03)	Clinical Sciences Division 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)
May 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)

External Programme Review

May 2005: Information Sciences Division (ISD)

Following agreement by the Board to conduct a review of the ISD, in 2005, and selection of Dr Terence Hull as Chair of the Review team, the following individual were contacted regarding their availability to assist with the review.

Name of the recommended/suggested reviewers for the ISD Review:

Recommended by: Dr Charles P Larson

1. Dr Joyce L. Pickering - CV attached
   Division of General Internal Medicine
   Royal Victoria Hospital, Rm. A4.21
   687 Pine Avenue West
   Montreal, Quebec H3A 1A1
   Canada
   Tel: (514) 843-1515
   Fax: (514) 843-1676
   Email: joyce.pickering@muhc.mcgill.ca

Recommended by: Dr Kul Gautam

2. Nóra Godwin - CV attached
   Deputy Director
   Division of Communication
   UNICEF New York, USA
   Tel: 1 212 326 7513
   Fax: 1 212 326 7518
   Email: ngodwin@unicef.org

Recommended by: Dr Terence H Hull

3. Mr Tommy Hor - CV attached
   Director
   Computer Centre
   National University of Singapore
   Singapore
   Email: tommyhor@nus.edu.sg

Suggested by: Mr Peter Thorpe
(Individuals not contacted)

4. M. Shafiqur Rahman - CV not available
Managing Director
Knowvision Consulting
House 44 (5th floor), Road 15
Banani, Dhaka 1213
Bangladesh
Tel: (o) 880-2-882 4548,
(r) 880-2-881 4548
Mob: 0189-9212364
Email: shafdmr@citechco.net

5. Dr Hooman Momen - CV not available
Editor, Bulletin of WHO
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
Email: momenh@who

6. Md. Shahjahan - CV not available
Bangladesh Center for Communication Programs (BCCP)
House # 3A, Road # 74
Gulshan 2, Dhaka
Bangladesh
Email: bccp@citechco.net

CURRICULUM VITAE

JOYCE L. PICKERING

Place of Birth:	**Tokyo, Japan**
Citizenship:	**Canadian**
Languages:	**English, French, Japanese**
Address:	**Division of General Internal Medicine** **Royal Victoria Hospital, Rm. A4.21** **687 Pine Avenue West** **Montreal, Quebec H3A 1A1** **Canada** **Tel: (514) 843-1515** **FAX: (514) 843-1676** **Email: joyce.pickering@muhc.mcgill.ca**

EDUCATION

UNDERGRADUATE

1975	B.A.(Hons) Mathematics/Political Science York University Toronto, Canada

MEDICAL

1980	M.D.C.M. McGill University Montreal, Canada

GRADUATE

1988	M.Sc. Epidemiology and Biostatistics McGill University Montreal

POSTGRADUATE MEDICAL TRAINING

1985-87	Resident in Community Medicine, Montreal General Hospital and the Royal Victoria Hospital, Montreal
1983-85 1981-82	Resident in Internal Medicine, Montreal General Hospital and the Royal Victoria Hospital, Montreal
1980-81	Mixed Internship, St. Michael's Hospital, Toronto, Canada

PROFESSIONAL CERTIFICATION

1991	Fellow of the American College of Physicians
1986	Fellow of the Royal College of Physicians and Surgeons of Canada (Internal Medicine)
1986	Certificat de Specialité, Médecine Interne, Province de Québec
1986	Diplomate, American Board of Internal Medicine
1982	National Board of Medical Examiners (USA)
1981	Licentiate of the Medical Council of Canada

APPOINTMENTS

Royal Victoria Hospital

1998 - Associate Physician, Royal Victoria Hospital

1998 - 2002	Site Director, Internal Medicine Residency Program, Royal Victoria Hospital
1997 - 98	Director of Undergraduate Medical Education, Dept. of Medicine, Royal Victoria Hospital
1996 - 2000	Director, Residents' Group Practice, Royal Victoria Hospital

1993 - Attending Physician, Internal Medicine Unit, Royal Victoria Hospital

1993 - 98	Assistant Physician, Royal Victoria Hospital

Montreal General Hospital

1992 - 97 88 - 90	Consulting Physician, Department of Community Health, Montreal General Hospital, Northern Quebec Module

1988 - Consulting Physician, Tropical Disease Centre, Montreal General Hospital, Montreal

Other Hospitals

1982-88	Consulting Physician. (Intensive Care Unit and Emergency Room) Reddy Memorial Hospital, Montreal
1982-83	Consulting Physician, Lachine General Hospital (Emergency Room Coverage)

Other

1982-83 General Practice, Clinique St. Georges, Montreal

University

2004 - Associate Dean, Undergraduate Medical Education (to start 1 November 2004)

2002 - Director, International Health Office, McGill University

1999 - 2004 Associate Program Director, Summer Programme in Epidemiology, Department of Epidemiology and Biostatistics, McGill University

1999-2004 Associate Professor, Departments of Medicine and Epidemiology and Biostatistics, Faculty of Medicine, McGill University

1994-98 Assistant Professor, Department of Medicine, Faculty of Medicine, McGill University

1994-98 Assistant Professor, Department of Epidemiology and Biostatistics
Faculty of Medicine, McGill University

1989-92 Assistant Professor, Department of Community Medicine, Faculty of Medicine
Addis Ababa University, Addis Ababa, Ethiopia

1988-94 Part-time Assistant Professor, Department of Epidemiology and Biostatistics Faculty of Medicine, McGill University

1991-92 Project Director, McGill Ethiopia Community Health Project, Addis Ababa, Ethiopia

1988-89
1990-92 Staff member, McGill Ethiopia Community Health Project, Addis Ababa, Ethiopia

AWARDS

2003 Canadian Association for Medical Education Certificate of Merit Award

2003 Faculty Honour List for Excellence in Teaching, McGill University

2003 Phillip Hill Award for Excellence in Clinical Teaching, Royal Victoria Hospital

TEACHING

2003- Tutor: Evidence Based Medicine (for 2nd year medical students)

2002-2004 Unit Chair: Clinical Epidemiology's Core Epidemiology course for 2nd year medical students (Unit 8)

May 2001 Special Topics in International Health : 1 credit course, McGill University

April 2002 Lecturer: Clinical Epidemiology. Course taught over 2 weeks in Chelyabinsk, Russia

March 2000 Lecturer: Clinical Epidemiology. Course taught over 3 weeks in Chelyabinsk, Russia

May 1999 Co-teacher: Clinical Epidemiology. 3-credit course, McGill University

1998-1999, 2001,2003 2004 Guest lectures in Back to Basics course for 4th year medical students, McGill University. Basic Concepts in Tropical Medicine/International Health

1997 Course Co-director: Health Research for Development. A one-week workshop on health research for health professionals involved in public health research. Kampala, Uganda (60 hours)

1995 - OMAF (Osler Medical Aid Foundation) - a McGill Medical student foundation for health in developing countries. Faculty sponsor. 10 hours/year

1995 - Medical ward attending physician, Royal Victoria Hospital 1-2 months/year. Approx. 70 hours/year teaching medical students, junior and senior residents in internal medicine.

1994-95 Course Director: Health Research Methods for Developing Countries. Developed and co-ordinated one-week intensive pilot course on the applications of health research methods for developing countries. Funded by the International Development Research Centre (Canada) via the Canadian University Consortium for Health in Development. Attended by 50 public health researchers from across Canada and internationally, 400 hours.

1994 - Residents' Group Practice, Royal Victoria Hospital, with four to seven R1 to R3 residents 120 hours/year

1994 - Attending Physician, Consulting Service in General Internal Medicine, Royal Victoria Hospital 1-2 months/year, teaching senior residents in Internal Medicine, 50 hours/year

1994-1998, 2001, 2003, 2004 Link (or ICMB) Medical Student ward teaching in Internal Medicine, Royal Victoria Hospital, 100 - 240 hours/year

1994 - Course director, Health in Developing Countries, 3 credit graduate course Dept. of Epidemiology and Biostatistics, McGill University,

(Given once in 1994, twice in 1995, twice in 1996, once in 1997, 1998, 2000, 2002, 2004)

1994 - Examiner for R2 and R3 Internal Medicine exams and preparation for Royal College exams, 15 hours/year

2001, 1995 Introduction to Clinical Sciences (2nd year medical students), Royal Victoria Hospital,
1994 20 hours/year

1994 Guest Lecturer, Infectious and Parasitic Diseases, Graduate Course in the Department of Epidemiology and Biostatistics, McGill University, 3 hours

1994 Guest Lecturer, The Power to Heal, A Historical Survey - 2nd yr medical students, McGill University, 3 hours

1993 Physical Diagnosis for Nurses working in Cree clinics, Montreal General Hospital (1 week course)

1993 Guest Lecturer, Thursday Evening Lecture Series, McGill University, Continuing Medical Education: Health Problems in Immigrants

1993 Guest Lecturer, Undergraduate Course in Epidemiology, Department of Epidemiology & Biostatistics

1993 Guest Lecturer, Tropical and Parasitic Diseases, Department of Epidemiology & Biostatistics

1993 Guest Lecturer, Health in Developing Countries, Department of Epidemiology & Biostatistics

1992-96
1989-90
1986-88 Tutor, Undergraduate courses in Epidemiology, McGill Faculty of Medicine (Med I, Med IV) 14 hours/year

1989-1992 Instructor in Epidemiology I and II, Masters of Public Health Program, Department of Community Health, Addis Ababa University, Addis Ababa, Ethiopia

1988-89 Instructor in Epidemiology, Ministry of Health: Accelerated District Health Manager's Training Program, Addis Ababa, Ethiopia

Thesis Supervision

Principal supervisor for Masters of Public Health Theses at Addis Ababa University:

1992 Mismay Gebre/Hiwot: The Prevalence of Hypertension and its Determinants in Wonchi Awraja, Ethiopia.

1992 Yemane Berhane: Are Reminder Stickers Effective in Reducing Immunization Dropout Rates?

1992 Filimona Bisrat: KAP Study in Harar Town High School Students on Family Planning.

1991 Solomon Demanu: A Community Based Study of Childhood Injuries in Adamitulu District, Ethiopia.

1989 Damen Hailemariam: Determinants of Community Health Agent Functionality in Arsi Region, Ethiopia.

1989 Fikreab Kebede: Characteristics Influencing Usage of Modern Contraception.

1989 Assefa Amenu: Factors Affecting Utilization of Health Stations in Yerenu Na Kereyu Awraja.

Thesis Committee Member:

1995 Ian Schokking: Effectiveness of Outreach Community Health Worker Visits in the Aga Khan University Primary Health Care Program, Targeting Squatter Settlements of Karachi, Pakistan. MSc Thesis, Department of Epidemiology and Biostatistics, McGill University.

Supervision:

Undergraduate Medical Students/Residents International Health Projects

1997 Andrea Low: Impact of a direct recording scale on mothers' understanding of growth curves in Haiti.

1995-96 Christine Zakhary: Study on the Health Impact of a Developmental Project in the Volta Region of Ghana, West Africa

1993-94 Ralph Buhrmann: Ophthalmic Practice Among Traditional Healers in Manicaland, Zimbabwe.

Natasha Dastoor, Patricia Moussette: The Benefits of Traditional Weaning Methods in Ghana.

Karl Kabesele, Heidi Carlson: Missed Opportunities for Primary Health Care in Ghana.

1993-94 Stephen Freedman, Irina Ghenea: Assessment of the Knowledge, Attitudes and

Practices of Women in Sao Paulo, Brazil with Regards to Family Planning.

1992-93 Steven Miller: The Effectiveness of Health Information Dissemination: Knowledge-Attitudes-Practices of AIDS/HIV Infection in Two High Risk Populations in Ghana, West Africa.

Maya Marc, Lorraine Natho, Clark Parris: Organizations Serving the Disabled in Addis Ababa, Ethiopia and its Rural Regions

Anaar Sajoo: Handicapped Children and Family Burden by Class of Disability in Ethiopia.

OTHER CONTRIBUTIONS

REVIEWS

Journals and Periodicals

1996 - Reviewer, Canadian Medical Association Journal

1996 - Reviewer, Canadian Journal of Public Health

1993 - 94 Reviewer, the Ethiopian Medical Journal

Grants

1998 External Reviewer of grant application to the British Columbia Health Research Foundation

SHORT-TERM CONSULTANCY

Methodology and questionnaire development for Indian Child Health study. Madras, India, Feb. 14-21, 1993 (IDRC).

COMMITTEES

National

1993-95 Canadian Universities Consortium for Health in Development, Education Committee

McGill

1997 - Member, Judges' Committee, McGill Medical Student Research Day

1995 - International Health Committee, Department of Epidemiology, McGill University

1995 - Faculty Scholarships Committee (OMAF Scholarships), Faculty of Medicine, McGill University

1994 - Residency Training Committee, Department of Medicine, Royal Victoria Hospital

1994 Human Subjects Committee, Department of Epidemiology and Biostatistics, McGill University, (replacement member)

1993-95 Working Group on Aboriginal Partnerships at McGill

1992-97 Department of Epidemiology, Summer Program Committee

1992-98 McGill Ethiopia Community Health Project, Steering Committee

PROFESSIONAL SOCIETY MEMBERSHIP

Fellow, American College of Physicians

Member, Canadian Public Health Association

Member, Canadian Society for International Health

Member, Canadian Society for Internal Medicine

Member, Canadian Medical Protective Association

EXAMINATION BOARDS

2001 - External examiner, MPH theses defence, University of Addis Ababa, Ethiopia

2001 External examiner, PhD thesis, Dept. de médecine sociale et préventive, University of Montreal

1999 - Examiner, Royal College of Physicians and Surgeons of Canada (Internal Medicine)

1995-97 Examiner, Collège des Médecins du Québec Internal Medicine Specialty Certification

1994 - Internal examiner, Masters and/or PhD theses, Dept. of Epidemiology and Biostatistics, McGill University

RESEARCH ACTIVITIES

1988 - Public health issues in developing countries

1988 - 95 Health issues in Canadian aboriginals

RESEARCH GRANTS

1992-1995 Strengthening Community Health Research (Ethiopia) Phase II extension and Phase III, from the International Development Research Centre (IDRC) Canada, for the McGill Ethiopian Community Health Project, under the Department of Epidemiology and Biostatistics, McGill University. Sole author of the proposals. Total: $750,000

PUBLICATIONS

1. EJ Robinson, Y Gebre, JL Pickering, B Petawabano, B Superville, C Lavallee. Effect of bush living on aboriginal Canadians of the Eastern James Bay Region with non-insulin-dependent diabetes mellitus. Chronic Diseases in Canada 1995:16(4); 144-148.

2. A Loutfi, APH McLean, J Pickering. Training general practitioners in surgical and obstetrical emergencies in Ethiopia. Tropical Doctor 1995: 25 (suppl 1); 22-26.

3. F Bisrat, J Pickering. High school students' knowledge, attitude and practice on contraception in Harar Town, Eastern Ethiopia. Ethiopian Medical Journal 1994:32;151-159.

4. B Wolde, J Pickering, K Wotton. Chloroquine Chemoprophylaxis in children during peak transmission period in Ethiopia. Journal of Tropical Medicine and Hygiene 1994: 97(4) 215-218.

5. H Yeneneh, TW Gyorkos, L Joseph, J Pickering, T Shibru. Antimalarial drug utilization in women in Ethiopia: a knowledge-attitudes-practice study. Bull WHO 71(6) 763-72, 1993.

6. A Loutfi, JL Pickering. The spectrum of surgery in Ethiopia. Canadian Journal of Surgery 1993: 36;91-95.

7. Y Berhanu, J Pickering. Are reminder stickers effective in reducing immunization drop out rates in Addis Ababa, Ethiopia? Journal of Tropical Medicine and Hygiene 1993:96(3);139-145.

8. A Loutfi, JL Pickering. The distribution of cancer specimens from two pathology centres in Ethiopia. Ethiopian Medical Journal 1992:30;13-17.

9. D Hailemariam, J Pickering. Determinants of community health agent functionality in Arsi Region. The Ethiopian Journal of Health Development 1991:5(1);11-15.

10. Y Kebede, J Pickering, JC McDonald, K Wotton, D Zewde. HIV infection in an Ethiopian prison. American Journal of Public Health 1991:81(5);625-7.

11. J Pickering, C Lavallee, J Hanley. Cigarette smoking in Cree Indian school children of the James Bay Region. Arctic Medical Research 1989:48; 6-11.

12. EKL Lo, MB Coukell, AS Tsang, J Pickering. Physiological and biochemical characterization of aggregation deficient mutants of Dictyostelium discoideum: detection and response to exogenous cyclic AMP. Canadian Journal of Microbiology 1978:24(4);455-465.

ABSTRACTS

A Loutfi, R Lisbona, JL Pickering, SH Meterissian, V Derbekian. Scintimammography (SMM) in breast masses, La Société Canadienne d'Oncologie Chirurgicale, Montreal, April 1997.

E Robinson, R Imrie, C Boulin, J Pickering, A Bobbish. Smoke-free health care facilities in the Far North: dream or reality. 10th International Congress on Circumpolar Health, Anchorage, Alaska, USA, May 1996.

BOOKS

Health Research for Development: A Manual. ed. Joyce L. Pickering, Canadian University Consortium for Health In Development, McGill University Printing Services. 1st printing April 1997, 3rd printing March 1998.

BOOKLET

The S.T.D. Germ Family, Dept. of Community Health, Montreal General Hospital for the Cree Board of Health and Social Services of James Bay. Joyce L. Pickering, with Conway Jocks and Elizabeth Robinson.

CONFERENCE PRESENTATIONS

McGill

Invited Guest Speaker. Clinical Vignette: Secondary Syphillis. Tropical and Parasitic Diseases, Montreal, May 2004

Invited Guest Speaker. Tobacco in Developing Coutnries. Tropical and Parasitic Diseases, Montreal, May 2004

Invited Guest Speaker. Childhood Vaccinations in Developing Countries. Student University Network for Social and International Health (SUNSIH) Conference, Ottawa, Oct. 2002

Invited Guest Speaker. Maternal Mortality. Tropical and Parasitic Diseases, Montreal, May 2002

Invited Guest Speaker. Clinical Vignette: Cutaneous Leishmaniasis. Tropical and Parasitic Diseases, Montreal, May 2002

Invited Guest Speaker. Infectious Disease Eradication Progress. Tropical and Parasitic Diseases, Montreal, May 2000

Invited Guest Speaker. The Global Program on Vaccines, Tropical and Parasitic Diseases: A Clinical and Laboratory Update, May 1998

Invited Guest Speaker. Therapeutic Challenges in Cardiovascular Disease: Should the Whole World be on a Lipid Lowering Drug? 29th Annual Course in Drug Therapy, May 1997

Invited Guest Speaker. Global Eradication of Diseases, Tropical and Parasitic Diseases: A Clinical and Laboratory Update, May 1996

Invited Guest Speaker. Understanding Breast Cancer Statistics, Breast Cancer Information Evening, October 1995

Invited Guest Speaker. The Geographic Diseases of Immigrants, Tropical Medicine for the Clinician, May 1994

Invited Guest Speaker. The Expanded Program of Immunization and the Eradication of Diseases by Vaccination, Tropical Medicine for the Clinician, May 1994

Invited Guest Speaker. Filaria Prophylaxis, Tropical Medicine for the Clinician, May 30 - June 1, 1990

Invited Guest Speaker. Primary Health Care in Developing Countries, Tropical Medicine for the Clinician, May 30 - June 1, 1990

Invited Guest Speaker. Update on Vaccines (Japanese B, Meningococcal, oral typhoid), Tropical Medicine for the Clinician, May 11-13, 1988

National, International

Invited Guest Speaker. Vaccination Programs in Developing Countries. Student University Network for Social and International Health (SUNSIH) - Canadian Society for International Health (CSIH) Conference, Ottawa, Canada, Oct. 2002.

Presenter. Reproductive Health in Developing Countries: More than a Matter of Choice, 4th Canadian Conference on International Health Ottawa, Canada, Nov. 1997

Invited Guest Speaker. Childhood Vaccinations Volunteering in the Developing World, Duke University School of Medicine, Durham, North Carolina, USA, March 1997.

Invited Guest Speaker. Women's Health, Volunteering in the Developing World, Duke University School of Medicine, Durham, North Carolina, USA, March 1997.

Invited Guest Speaker. Personal Logistics, Surgery Forum, 3rd Canadian Conference on International Health, Ottawa, Canada, Nov 1996

Invited Guest Speaker. Childhood Vaccinations Volunteering in the Developing World, Duke University School of Medicine, Durham, North Carolina, USA, March 1996.

Invited Guest Speaker. Women's Health, Volunteering in the Developing World, Duke University School of Medicine, Durham, North Carolina, USA, March 1996.

Invited Guest Speaker. L'immigrant qui retourne dans sons pays, Colloque sur la santé des voyageurs internationaux, Montreal, Canada, November, 1995

Presenter. Le diabete chez les Cris de la Baie James, Colloque Nord-Laval en Sciences Humaines 1994 April 1994

Invited Guest Speaker. An Evaluation of the McGill University Model in International Health. Scientific and Pedagogic Fora on International Health, Annual Meeting of the Canadian Society for International Health and the Canadian Universities Consortium for Health in Development. Ottawa, Canada, Dec. 1993

Presenter. The Determinants of Community Health Agent Functionality in Arsi Region, Ethiopia. Canadian Public Health Association Conference, Toronto, Canada, June 1990

REPORTS - PUBLIC HEALTH MODULE - CREE REGION, MONTREAL GENERAL HOSPITAL

1994 Use of Outpatient Health Services in the Cree Communities of Region 18 (April 1992 to March 1993)
Also available in French:
Utilisation des services ambulatoires de santé dans les communautés cries de la région 18 (avril 1992 à mars 1993)

REPORTS - NORTHERN QUEBEC MODULE

1993 Dental Health in James Bay Cree Children - 1991. Northern Quebec Module

1991 Attitudes and Knowledge of James Bay Cree with Respect to the Prevention of Sexually Transmitted Diseases and Teenage Pregnancies. Northern Quebec Module

1988 Sexually Transmitted Diseases: A Manual for Clinicians in Cree Communities of Northern Quebec. Northern Quebec Module

September 2004

NÓRA GODWIN

Nóra Godwin is currently Deputy Director of the Division of Communication in UNICEF's New York Headquarters. This division is responsible for UNICEF's outreach to the public – through the media and the Internet, through its publications (including the flagship publication "State of the World's Children"), through the intervention of Goodwill Ambassadors and through its worldwide partnerships to people everywhere.

Before taking up this post, she was head of the Organisational Learning and Development Section in UNICEF, with responsibility for helping staff around the world develop the skills and competencies they need to carry out UNICEF's mandate for children everywhere.

In her thirteen years with the Organisation, she has held a variety of pivotal positions, including UNICEF Representative for Romania and Moldova in Eastern Europe, and as HQ Chief for Communication for Development (developing communication tools to encourage people in communities to change their behaviour for more healthy lifestyles and for rights-based child-rearing practices), and for Education for Development (working with young people and schools in donor countries to help broaden their understanding of peace, human rights and global development issues).

Prior to joining UNICEF, Ms. Godwin was faculty member of the Curriculum Development Unit in the School of Education at Trinity College, University of Dublin, in her native Ireland. She was involved for many years in teacher training and curriculum innovation, and acted as special advisor to the Ministry of Education on the development of new national curricula in social and political studies. She also worked closely with cross-border educators and schools as part of the all-Ireland peace-building process.

At international level, she has been an important contributor to and participant in seminars, discussion fora and think-tanks on current global issues, including peace, girls' and women's rights and education for global solidarity.

She has published - both as editor and author - a number of books and articles in the field of curriculum development and education for global awareness.

NATIONAL UNIVERSITY OF SINGAPORE
Curriculum Vitae
(Private and Confidential)

Name: Tommy Hor (Mr.)

Present Appointment and Date: Director, 15.11.2002

Department: Computer Centre

Date of Birth: 04.06.1958

Academic/Professional Qualifications:

- M.Phil (1985), University of Hong Kong
- B.Sc Honours (1982), University of London

Awards/Honours:

- Senior Certified IT Project Manager, Singapore Computer Society (2004)
- Teaching Excellence Award, use of IT in teaching, National University of Singapore (1998)

Career History:

- Director, Office of Communications & IT, Singapore Management University (2000-2002)
- Deputy Director (last position held), Computer Centre, National University of Singapore (1989-2000)
- Analyst Programmer, City Polytechnic of Hong Kong (1985-1989)

Main Areas of Responsibility in Past 3 Years:

- To spearhead the development and exploitation of information technology (IT) to facilitate teaching, research and administration.

- To develop a robust and secure communication infrastructure with rich global connections ensuring a connected community for online learning.

- To optimize use of scattered institutional IT resources and integrate distributed applications across the campus for cost saving and improved user services.

- To develop staff core competency and expertise for operation excellence.

- To align the University with the e-Government Action Plan, meeting the key performance indicators as defined by the Ministries.

Major Achievements/Projects Undertaken Since Joining NUS:

- Reduced IT manpower and system cost through optimized use of scattered institutional resources across the campus.

- Successful commissioning of the first-ever online bidding system for course registration for over 22,000 students.

- Much enhanced IT security with successful prevention of malicious attacks and containment of computer virus infections across the campus.

- Undertake to transform the department and IT support model for improved staff morale, competencies, team spirit, operation transparency and user accountability.

- Undertake to plan and erect a Data Centre outside of campus for disaster recovery for the critical IT services.

Updated: 06.09.2004

International Centre for Diarrhoeal Disease Research, Bangladesh
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Web : http://www.icddrb.org

1 November 2004

Guest Lecture

TITLE	:	**DOTS expansion and Operational Research**
GUEST SPEAKER	:	**Dr. Nobukatsu Ishikawa** **Vice Director** **The Research Institute of Tuberculosis** **Japan Anti-Tuberculosis Association** **3-1-24 Matsuyama, Kiyose-shi** **Tokyo 204-0022, Japan**
DIVISION/PROGRAMME	:	**Member** **ICDDR,B Board of Trustees**
DATE	:	**Monday, 29 November 2004**
TIME	:	**09:00 am**
VENUE	:	**Sasakawa Auditorium** **ICDDR,B, Mohakhali** **Dhaka**
TEA	:	**10:00 am**

Executive Director
ICDDR,B

RSVP
Tel: 882 3031

15 Oct 2004

Names and addresses of current ICDDR,B BOT members

(as of October 2004)

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Dr. Kul Gautam (from July 2003 replaced Mr Rolf Carriere)
Dr. Halima R A Mwensei (from July 2003 replaced Prof. Marian E Jacobs)
Mr Mirza Tasadduq Hussain Beg (from Aug 2003 replaced Mr Anisul Huq Chowdhury)
Mr AFM Sarwar Kamal (from Sept 2003 replaced Mr M Fazlur Rahman)
Dr Maimunah Bte Abdul Hamid (resigned June 2004)
Dr. Peter Tugwell (from July 2004 replaced Prof. Carol Vlassoff).

7/BT/NOV 2004

BoT Retreat
25-26 Nov 2004

Board Retreat Documents

Prepackage

25-26 November 2004

Rajendrapur CDM, Dhaka

Prepackage Documents

#1: Board Survey

#2: Roles and Responsibilities ICDDR,B Ordinance

#3: Conflicts of Interest

- Boards and Trustees can ....
- Draft Conflict of Interest Policy
- Draft Annual Conflict of Interest Disclosure Statement

#4: Resource Development Update

#5: Centre Funding Profile

#6: ORDINANCE

#7: BY-LAWS

CENTRE
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POPULATION RESEARCH

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To: ICDDR,B Board of Trustees
From: Executive Director
Date: 31 October 2004
Subject: **Feedback to the Board of Trustees from the Staff of ICDDRB**

At the request of the Board, and in preparation for the Board's retreat, the management was requested to carry out a "survey" of the staff to learn their impressions of the performance of the board. This request from the Board stimulated considerable discussion among the senior staff at the Centre as to how to carry out such a "survey." At first the thought was to carry out a true survey of all staff, and referring to the Ordinance's description of the Board's functions, ask all staff members to rate the Board on each of these functions. The survey would have expanded or explained each of these functions and asked more detailed questions.

As Executive Director, I rejected this approach for several reasons. I did not believe ranking these functions on a scale of 1 to 5 would provide useful information to the Board. Secondly, such a survey would have to be anonymous, and we do not allow anonymous letters in the Centre. I felt that this would be similar to a kind of "anonymous letter" and I did not want to encourage this form of "communication."

A social scientist might have developed some focus groups but this method went beyond the scope or the time availability at the Centre.

Finally, we employed a method suggested by Marcel Tanner which, I believe, worked rather well. Each of the Divisions selected a group of ten to 15 relatively senior staff, not all scientists, to participate in a 60 to 90 minute discussion on the Board's performance. The Division Director was the leader of the session and each person in turn was asked to list a characteristic that they felt the Board was carrying out well and another that needed improvement. By going around the room, the group was queried until their were no additional items to add to the list. Overlapping items were consolidated into single items whenever possible. With this method, a list was created of possible good and bad attributes. Then the group was asked to vote on which of these they agreed with most. Each person was given two votes. After the first round of voting, they were given one more vote. These lists, with their votes tallied, were then sent to me. Since the group was discussing this in the open, this is not an anonymous feedback, but I do not know the identities of the individuals, but it does represent the feelings of the group.

As far as I can determine, the groups were independent; that is, there was no discussion between the groups that would have influenced the results between the groups.

In addition to the interesting feedback contained in the list, it was also interesting to learn about the relative lack of understanding many of the staff have of the board and its functions. Many were not able to name the number of Board members, their country of origin or their expertise. All knew the Chair, but the others were not so clear. Also, they were not aware of the duties as described in the ordinance, and after learning of the ordinance's description of the Board, continued to assume that the Board's functions were more expanded than the ordinance.

I believe the reports from the different divisions will provide some interesting food for discussion during the Board retreat. I do not find many surprises in the results of this exercise, but I do believe you will find it interesting.

In addition to providing results, I believe the methodology used here was a useful one to know opinions of the staff in an efficient and representative manner. I do very much thank Marcel for suggesting this method. My understanding is that the Divisions also found it a useful and a relatively painless method of providing the type of information needed for the Board.

Some notes about the reports: If an item is listed but receives no votes, it means that someone mentioned it for the list, but no one in the group voted for it, suggesting it may be considered, but is not strongly felt. The tallies are not entirely uniform, since each Division provide their own report based on their session.

Division 1

In response to the Executive Director's memo on Board's performance, the Director of Division 1 called a meeting at 8:30 am today to review the Board's functioning and performance. Fifteen staff participated; all were national officer level or higher grade.

The meeting began with a general orientation and a short quiz about BoT membership make-up and backgrounds. There was an incomplete understanding of the number of board members or their names. This was followed by a round- robin exercise during which each participant identified one strength and one weakness of the board. By the time one round was completed, no new/additional inputs were identified. They were then asked to vote as to which qualities (strength or weakness) with which they agreed. After one round of voting, they were given a second vote. Thus, this list represents those items mentioned along with their votes indicating their agreement with this assessment. The items with zero votes indicated that this was included on the list, but when the voting occurred, there were none who felt that this is a high priority, relative to the others.

Board doing well		Requires improvement	
Strategic Plan Development Review	14	**Communication with Centre staff - Feedback/ Interest in Divisional activities**	8
Review of Centre's activities	9	**Governance vs. management**	7
Gender equity	7	**Board mix**	7
Supportive of the thematic approach	4	Employee benefits monitoring staffs' rights in line with Centre regulations/UN structure, Mechanism for exchange of ideas with staff	4
Support for treatment/hospital facility	2	Fundraising , Interest in sustainability, Donors' priorities	5
Field visit consultation	2	Within BoT communication throughout the year	2
Personal interest on individual staff	0	Dialogue with and supportive for the Staff Welfare Association	2
Participation in the meeting	0	Interaction with staff (beyond HR and Finance staff)	2
		Programme needs	1
		Financial support to the Centre's organizational structure, monitoring distribution of funds.	1
		Staff development	1
		Centre's promotion	0

The strengths are generally self-explanatory. The reported weaknesses probably need more explanation to be fully understood, though perhaps this is best left to the board to discuss. The "Board mix" apparently indicated a feeling that the board was too homogeneous in background from a disciplinary standpoint and might benefit from more variety of backgrounds.

Division 2.

Thirteen scientific and administrative staff from Division 2 participated in a workshop to identify Strength and Weaknesses of ICDDR,B Board of Trustee members. The results are shown below:

Sl	***Strengths***	1st Vote	2nd Vote
1	Geographic representation	4	
2	Established professionals	10	9
3	Management experience	9	
4	Diversity of field experience	11	4
5	Diverse cultural back ground (developing & developed)	1	
6	Share scientific ideas with some staff in Centre		
7	Scientific presentation by staff at one time		
8	Some members come from UN organizations		
9	Scientific presentation by BoT members		

Sl	***Weaknesses***	1st Vote	2nd Vote
1	Gender imbalance		
2*	Lack of communication with staff (general and scientific)	13	7
3*	Staff lack knowledge of BoT		
4*	Lack of contact with staff		
5	After BoT term some joined as staff		
6	Don't raise funds for the Centre	5	
7*	Lack of interaction with staff		
8	Lacks social science strength		
9	Arrogance / lack of modesty		
10	Lacks representation from China		
11	Staff lack interest in BoT and also lack confidence	1	
12	Lack of transparency (i.e.BoT Agenda setting)	1	
13	Lack of management expertise		
14	Created class sense through formal networking with select staff		
15	Not clear of their understanding of ordinance/ functions		
16	No document regarding BoT functions available to staff	2	
17	Big money spent on BoT meetings		
18	Self perpetuation of BoT		
19	Transparency on BoT Agenda		
20	In recruiting senior staff (both management and scientific) BoT aren't consistently involved	4	6
21	Lack of general understanding of how ICDDR,B functions	1	
22	Failure to ensure job security		

* In 2nd vote, we combined 2,3,4 &7 and labeled it as sl #2.

Division 3

We held two sessions (one hour each on two consecutive days) for the survey involving 16 staff from Division 3, all with supervisory role.

I introduced the topic using a few power point slides, and had asked a couple of questions to the participants. Interestingly, as has also been observed by another division, none could tell how many members constitute Centre's BoT! I then used the guidelines (ten in number) Venessa had prepared to describe the role/functions of the BoT to ease the survey process and provide an idea to the staff the type of response expected of them.

Each participant identified three functions of BoT that are well done, and another three that need improvement. We thus ended having a total of 16 x 3 = 48 responses for each of these two categories. We eliminated the duplications, and based on discussion considered some of the responses as inappropriate and thus eliminated them. Finally, we identified 28 functions considered done well (Table 1), and 18 functions (Table 2), which could be improved.

We then asked them to give two votes, for each category (well done, and need improvement), and the numbers of votes for each of them are shown in the first column of the tables. Next, we asked them to give one more vote for each category, and the votes are indicated in the second column. The total of these two columns are shown in the right most (third) column.

Please note that the responses (in both categories) had been much greater than ten functions of the BoT described in Venessa's guidelines, and that some of the responses might not be considered appropriate given defined functions of the Board. Some of the responses need to be rephrased to relate them better with the BoT functions

Does Well, Division 3: Functions/activities considered done well	Number of Votes		
	1st Round*	2nd Round*	Total
1. Good Overall Guidance	2	2	4
2. Supervision of Centre's Activities	1	0	1
3. Good Financial Management	0	0	0
4. Good Organisational Management	3	1	4
5. Respecting/Following Ordinance	0	0	0
6. Remains Sensitive to Centre's Interest	1	0	1
7. Closer supervision of Centre's Management	1	1	2
8. Participating in and Approval of Centre's Policy Guidelines	2	0	2
9. Marketing of Centre's Achievements	0	1	1
10. Review and Approval of Budget	6	0	6
11. Authorizing Centre in Fund Raising	0	0	0
12. Maintaining good liaison with GoB	0	0	0
13. Maintaining Good Relationship with Development Partners	1	2	3
14. Good Working Relationship with Sr. Management	4	0	4
15. Playing Key Role in Scientific Growth of Centre	1	0	1
16. Taking Active Interest in Centre's Activities	1	1	2
17. Deciding Research and Service Strategies	0	2	2
18. Interaction with Centre Staff	0	0	0
19. Management of emergencies/ unusual situations (crisis management)	1	1	2
20. Development of Strategic Plan	1	1	2
21. Closer Review of Research and Training Activities	0	0	0
22. Selection/termination of Executive Director	3	2	5
23. Consider Staff Salary Increase on a Yearly Basis	1	1	2
24. Not Terminating Job of Staff	1	1	2
25. Limiting number of programs when some programs are suffering from lack of fund	1	0	1
26. Determine Employment Policies	0	0	0
27. Promotion of Non-clinical Science	1	0	1
28. Interest in Staff Development	0	0	0

Note: * Two (2) votes in the 1st and one (1) vote in the 2nd round

Need Improvement Division 3: Functions/activities needing improvement	*Number of Votes*		
	1st Round*	2nd Round*	Total
1. Review of the need for and the recruitment process of International Staff (Quality and Number)	2	0	2
2. More Closer Guidance of Research Activities	2	0	2
3. Promote/help (exploring opportunities) in Staff Development	0	0	0
4. Help Centre Get More Fund	4	4	8
5. Greater Interaction with Local Scientist and Staff	1	0	1
6. Help Individual Scientist (provide scientific guidance and in exploring research fund)	2	0	2
7. Explore fund to improve physical facilities of the hospitals	1	1	2
8. Ensure equitable distribution of research funds	1	3	4
9. Equitable distribution of resources across the divisions	4	3	7
10. Improve salary structure of local staff	5	2	7
11. Greater salary increase every year	0	2	2
12. Consider Application of UN Salary Scale	6	0	6
13. Active help in developing Scientific Leadership	0	1	1
14. Establish mechanism to improve interaction between management and staff	1	0	1
15. Relate salary (in BDT) to market rate of US Dollar	2	0	2
16. More closer supervision of Centre's management	1	0	1
17. More support for hospital–not leaving the responsibility solely to CSD	0	0	0
18. More closer contact with Centre's activities	0	0	0

Note: * Two (2) votes in the 1st and one (1) vote in the 2nd round

Things the Board does well Division 4	Votes
Provides good oversight of the Centre's activities, finances and administration.	6 + extra vote
Provides valuable feedback when the Centre is developing new policies and practices, such as the Strategic Plan.	5
Promoting the continuation and expansion of the Staff Development Programme	3

Ways in which the Board's performance could be improved:	Votes
Board Members should be goodwill ambassadors, fostering the interests of the Centre, in areas such as fundraising, promoting joint research between home institutions and the Centre, and in promoting the Centre as a training and education institution. This responsibility should be made clear to potential members on recruitment to the Board.	6 + extra vote
Board Members should not be eligible for Centre employment, though conversely ex-staff (alumni) should remain eligible for election to the Board.	3
The Board should seek to expand the professional background of members, so as to provide a more rounded approach, including expertise in management, fundraising, advocacy, etc.	1
The Board should examine their conflict of interest policy to ensure that any hidden agendas are brought into the open.	1
The Board should involve itself more in ensuring that the Centre's salary structure is maintained at a similar level to that of other international organisations.	1
The Board should devote more time to promoting a promotions policy for non-scientific staff.	1
The interaction between Board Members and Centre's staff should be strengthened, maybe by Board Members spending longer at the Centre during meetings and/or by continuing the series of project and unit visits initiated two years ago.	
Local salaries should be notionally in dollars, even though paid in taka.	

A meeting on Performance Review of the Board of Trustee by Division 5 was held on October 28, 2004

A short quiz session on the Board of Trustee and related issues was conducted before the main session. It was also instructed how the review would be done. The major observations have been noted down on priority basis in which areas the BOT has been doing well and which areas need improvement.

Sl #	Does well	Vote	
1	Strong science/give parameters research vision - Roadmap.	4	4
2	Gender Equality	3	1
3	With fund constraint the Centre runs effectively and efficiently	2	1
4	Effective at appointing strong Leadership/Executive Director	2	
5	Assist in fund raising for the Centre	2	
6	Policy development	1	
7	Recognition of staff quality		
8	Good Financial overview		
9	Transparent		
Sl #	Need Improvement	Vote	
1	Time constraint – not enough time in the Centre to oversee the broad base activities of the Centre		4
2	Need to interact more with the Centre staff		2
3	Need to conduct a more detailed analysis of the Centre's finance		1
4	Need to bring in more funds to alleviate fear of job loss		
5	Fund raising		
6	BOT decisions are not communicated to all staff		
7	BOT members are not known to staff		
8	Need to interact more with Centre staff		
9	All BOT members to contribute financially to the Centre		

Board of Trustees
Powers & Functions Under the Ordinance

According to the governing Ordinance that provides for the establishment of ICDDR,B, (Ordinance LI, 1978. Government of Bangladesh) the Board is vested with the power to determine the general direction, management and administration of the affairs of Centre and has full authority to determine and execute the policies and undertakings of the Centre.

The Powers and Functions are enumerated in Section 7(2) of the Ordinance as follows:

(a) To exercise general supervision of the Centre;
(b) To approve courses of studies and research work and related activities in broad outlines
(c) To approve the plan, programme and organisation of the Centre
(d) To authorize the Centre to request and receive grants in aid
(e) To authorize the Centre to borrow money and request loans
(f) To select and appoint the Director and terminate his services
(g) To approve establishment of all international level positions in the Centre and approve appointment to persons in these positions and delegate to the Director the approval to appoint other positions
(h) To determine employment policies and practices of the Centre
(i) To examine and approve the budget
(j) Perform all other acts as deemed necessary, suitable and proper for the attainment of the Centre's activities and objectives for which the Centre is established.

CONFLICTS OF INTEREST

Trustees tend to be active, involved and influential people. It is not unusual that they have loyalties that may complete with each other and with ICDDRB. The Board and individual trustees can take steps to ensure that all of them fulfill their obligation to separate personal interests from those of the Centre. For trustees ICDDRB must come first.

Boards Can:

- ✓ Adopt a conflict of interest policy that enjoins trustees or their family members from gaining financial or personal advantage from their board service. This policy needs to be reviewed by legal counsel and then adopted by the board.
- ✓ Ask every trustee to sign an annual statement that acknowledges that they understand the conflicts of interest policy and to list any current or potential conflicts they have involving their board service.
- ✓ Orient new trustees to the conflict of interest policy and how it plays out in practice. Give examples of the types of conflicts typically found at ICDDRB.
- ✓ Have periodic discussions at board meetings on why the conflict of interest policy protects the Centre and all trustees from being involved improperly in board decisions. These discussions can also protect the Centre from being perceived as an institution whose trustees can better their personal and financial situations by their board service.
- ✓ Establish a tradition that the board will deal openly with all matters that come before it.
- ✓ Hire an outside investment manager for the endowment funds; have a yearly financial audit by an independent auditor; and require an independent appraisal of any property given to the Centre.
- ✓ Establish a policy that all major contracts for goods and services will be put out to bid.

Trustees Can:

- ✓ Sign the annual statement that they understand the conflict of interest policy and list all current and potential conflicts. If they are sure what constitutes a conflict, they should consult the chair, who may put them in touch with the Centre's legal counsel.
- ✓ Be conscious of any conflicts that may arise after making the list and bring them to the attention of the chair.
- ✓ If a conflict does arise, make sure that the board knows what the situation is and then recuse themselves from the discussion and the vote. Make sure that the minutes reflect this action.
- ✓ Always keep board discussion and decisions confidential, including those whose disclosure might benefit a relative, friend, professional colleague or business associate.

- ✓ Whenever they are not sure if one of their biases or connections is coloring their approach to a problem or decision, ask themselves, "What must the board do that is in the best interest of ICDDRB?" Not every trustee will agree on the specific answer to that question, but it will keep all board members focused on their trustee role as keeper of the mission of ICDDRB.

Trustees' success at avoiding conflicts of interest depends upon the board's willingness to develop policies, follow them rigorously, and encourage open discussion on all issues. Such success also depends on the ability of individual trustees to govern themselves with integrity and hold the Centre in trust. Failing to do so can open the board and individual members up to lawsuits alleging that their self-interest has harmed ICDDRB. Above all, the abrogation of the duty of loyalty can create distrust and ruin the morale of the board, the executive director and all of the staff – not to mention its clients, funders and the like.

ICDDR,B Board of Trustees

Conflict of Interest Policy

General Policy Statement

Members of the ICDDR,B: Centre for Health & Population Research (hereinafter, "ICDDR,B" or "the Centre") Board of Trustees (hereinafter, "the Trustees" or individually, "Trustee") are charged to act on behalf of the Centre and in support of its mission. In their capacity as the Trustees, they are expected to hold the interests of the Centre paramount. An apparent conflict of interest arises when a Trustee is in a position to influence the Centre's decisions in ways that could lead to personal financial gain, personal scientific achievement or other advantage for the trustee or his/her immediate family or associates. A potential conflict of interest occurs when an individual's personal or private interests might lead an independent observer reasonably to question whether the individual's professional actions or decisions are influenced by considerations of significant personal interest, financial or otherwise.

Trustees are expected to disclose potential conflicts of interest. They should identify in writing any such conflicts to the chairperson of the board prior to engaging in the activity that poses the potential conflict. If the Board concludes that a conflict of interest exists, the trustee involved should recuse himself/herself from participation in decisions on behalf of the Centre that affect his/her personal interests.

I. Conflict of Interests Situations

Potentially conflicting involvements include but are not limited to the following:

A. A Centre Trustee, or the immediate family members of a Centre Trustee, serves as a board member, faculty or senior staff of:
   a. Institutions or bilateral governmental agencies providing direct financial support for the Centre's sponsored research and activities; or
   b. Institutions or bilateral governmental agencies with authority to make decisions regarding Centre's Sponsored Research and Activities, intellectual property rights; or
   c. collaborating institutions engaged in sponsored research and activities; or
   d. other organizations, corporations or institutions that have significant financial interests or business relationship with the Centre.

B. A Centre Trustee, or the immediate family members of a Centre Trustee:
   a. Is directly seeking funding from institutions or bilateral governmental agencies , where the Trustee (or his /her immediate family member) are competing with ICDDR,B for such funding; or
   b. Is directly seeking funding from or otherwise doing business with an organizations, corporations or institutions that have significant financial

interests, contractual obligations or business relationships with the Centre, or

c. Has a scientific interest as an investigator, a funding partner or as a business associate in a particular topic or project in which the Centre must decide whether to invests its resources, or
d. Is also a trustee, owner or has financial interest in another organization with a product or service that directly competes for funding or market share with the Centre's products or services.

II. Board Action

A. In the event that a Trustee, shall have a significant financial interest, personal or professional commitment that could potentially create a conflict of interest or perception of one in any transaction involving the Centre or being considered by the Board of Trustees (including any committee of the Board), such person shall, as soon as he or she has knowledge of the transaction, take the following actions:
   a. *Disclosure*. Disclose fully in writing the precise nature of his or her interest in such transaction to those the Centre involved with the transaction, or;
   b. *Non-Participation*. Refrain from participation (including acting individually or as a member of a committee or other group) in the Board's decision(s) related to the proposed transaction unless expressly permitted to do so by the Director, or in the case where the conflict arises involving the Director, by the Chairperson of the Board.

B. Board Record of the Action. In cases where the Board takes a vote on a Resolution or otherwise makes a decision and one or more of the Trustees has abstained from voting or otherwise approving a Board decision as the result of a conflict or the appearance thereof, such abstentions and the Trustee(s)shall be identified in the Board minutes.

III. Disclosure Forms

The trustees shall also disclose in writing to the Director on a continuing basis on disclosure forms provided by the Director's Office the following:

A. All significant financial relationships, scientific or business interests with collaborating institutions, corporations or individuals, and
B. All relationships where the Trustee serves as an officer, director, trustee, partner, employee, faculty, consultant, or agent of an organization or institution that provides funding to or engages in sponsored research and activities with ICDDR,B.

IV. DEFINITIONS

For purposes of this policy:

A. " *ICDDR,B or the Centre*" shall mean ICDDR, B: Centre for Health and Population Research situated in Dhaka, Bangladesh
B. "*Trustee*" shall include any current trustee, and any nominee for the Board of Trustees and any former trustee serving on any committee of the Board of Trustees.
C. "*immediate family members*" shall include spouses, siblings, parents or children of the Trustee.

D. *"Sponsored research and activities"* shall mean all research, training and service activities that are administered through the Centre and are funded by bilateral or multilateral donor agencies, governments and government-supported institutions, UN agencies, foundations, corporations or individuals.

E. *"Significant financial interest"* shall mean any direct or indirect interest with monetary value, including but not limited to:
   a. salary, other payments for services (e.g., consulting fees or honoraria), royalties or other payments that, when aggregated for the individual and the individual's spouse and dependent children over the next twelve months, are expected to exceed $25,000
   b. equity interests (e.g. stocks, stock options or other ownership interests) that, when aggregated for the individual and the individual's spouse and dependent children, either exceeds $10,000 in value (as determined through reference to public prices) or represents more than five percent (5%) ownership interest in any single entity;

F. The term "intellectual property rights" includes, patents, copyrights and royalties from such rights.

G. The term "significant financial interest" does *not* include:
   a. Executive Director's compensation,
   b. honoraria, or reimbursement of expenses/per diem from the Centre;
   c. income from seminars, lectures, or teaching engagements at the Centre sponsored by donors or collaborating institutions;

H. The term "significant Business Relationship" includes any ongoing relationship, negotiation or direct investment in an enterprise or corporation that may result in a significant financial interest as described in Section E (above).

ANNUAL CONFLICT OF INTEREST DISCLOSURE STATEMENT

I, _____, have read and understand the ICDDR,B: Centre for Health and Population Research ("ICDDR,B") Conflict of Interest Policy, and I will conduct myself so as to avoid any conflicts or potential conflicts of interest relating to my position as a trustee of ICDDR,B.

I, and the members of my family (spouse, parents, siblings, children, their spouses, etc.), now have the following affiliations or interests and have taken part in the following transactions, that when considered in conjunction with my position as a trustee of ICDDR,B, might constitute a conflict of interest. (Check "None" where applicable. If additional space is needed, please make disclosure and sign on reverse side.)

1. **Outside Employment or Service:** Identify any employment, provision of consultancy services, current or planned, or services as a member of another board of trustees/governors or a donor or donor government agency which may be in conflict with your position as a trustee of ICDDR,B. (Board membership on the Board of donor organizations, government agencies, foundations or collaborating institutions and universities listed as ICDDR,B donors and collaborating institutions should be reported). None _____

   _____

2. **Outside Interests, Financial:** Identify any interests or positions which you or your family (as defined above), directly or indirectly, hold in any outside concern from which ICDDR,B secures funding, or will secure financial support in excess of $10,000 (such as shares in a pharmaceutical company). Identify any interests or positions which you or your family (as defined above), directly or indirectly, hold in any outside concern for which ICDDR,B conducts research; from which ICDDR,B receives financial support, resources or services; or for which ICDDR,B competes for funding resources. None _____

   _____

3. **Outside Interests Non-Financial:** Identify any interests or positions which you will directly benefit as a scientist from research conducted at ICDDR,B (i.e., Principal Investigator on a protocol, publications, etc.) or you or your family (as defined above), directly or indirectly, hold in any outside concern from which ICDDR,B secures goods or services, or that provides research, training and/or services competitive with ICDDR,B.

   None _____

   _____

4. **Gifts, Gratuities, Services and Entertainment:** Identify any support, gifts, gratuities, services or entertainment that you or your family (as defined above) have accepted that might influence your judgment or actions concerning ICDDR,B's policies and business decisions. None _____

   _____

5. **Other:** Identify any other activities in which you or your family (as defined above) are engaged that might be regarded as constituting a conflict of interest. None _____

   _____

I hereby agree to promptly file a further Disclosure Statement regarding any situation that may develop before the scheduled completion of my next Annual Disclosure Statement.

_____

Signature

_____

Date:_____

RESOURCE DEVELOPMENT UPDATE

Prepared by Hannah Lemon, Senior Associate, ER&ID

Ms Mary de Kuyper's 1999 observations:

- **I applaud each and every trustee 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 commencing to work in this area certainly set the climate for such agreement.**

Although there have been gifts from both ex- and current Board members since the review, the general feeling among Trustees is one of resistance to engage in the fundraising activities of the Centre, except in an 'ambassadorial' role. The subject of fundraising was discussed in a small break-out group at the meeting of the Board of Trustees in November 2003, prompting mention of it at the closing meeting of the full Board. Details of these discussions are given below.

- **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.**
    - **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?**

The Centre has contacted a variety of consultants, both in the States and in the UK since 1999 and has taken the following steps:

- The Child Health Foundation (CHF), a registered US charitable agency, was contracted to receive and solicit funds in the USA for the Centre. This work is ongoing and has proved both profitable and efficient.
- The International Health Solutions Trust (IHST), registered in the UK to receive donations from the UK and Europe and to enable the Centre to receive maximum tax benefits on these gifts, was utilized for the first time to undertake a fundraising initiative for the Centre. IHST is governed by a volunteer Board who campaign and conduct activities where directed, on the Centre's behalf.
- Two experienced fundraisers were hired, in-country, to work in the Centre's External Relations and Institutional Development (ER&ID) office. Julia Ackley, a US national, with significant experience of public health funding mechanisms, responsible for

North American fundraising and Hannah Lemon, a UK national with a background in institutional fundraising for Oxford University and extensive major gift experience, responsible for UK and European fundraising. (Ms Ackley has since returned to the US following the completion of her husband's tour with the US Embassy and pending the birth of their first child. Her replacement is currently being sought.)

- To maintain the oversight of an important aspect of the Centre's fundraising, grant management, the ED recently approved the appointment of Ms Armana Ahmed, a Bangladeshi national, to the ER&ID office to oversee all aspects of grant management including the management and long-term cultivation of major project and core donors.

- **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?**

The Fund Development Committee was established under the revised By-Laws as a Standing Committee of the BoT. In developing the By-Laws of the Fund Development Committee the BoT decided that geographic distribution of the Fund Development Committee should reflect the BoT as a whole and not be weighted in favour of members from North America, Europe, Japan and Australia, i.e. the more likely countries to contribute such resources. The Committee convened for the first time at the full Board meeting in November 2003. The Chaired by Dr Kul Gautham of UNICEF, the Committee met for 45 minutes in conjunction with ER&ID staff to discuss the Centre's fundraising activities. The discussion focused on the role of the Board of Trustees in the Centre's fund development strategy.

Trustees were uncomfortable with the idea of soliciting potential donors on behalf of the Centre, although most suggested that they would be willing to refer prospects for follow-up. There was consensus among the Committee members that the Trustees could assume an 'ambassadorial' role by identifying potential donors and engaging them on the Centre's behalf. In the event that these individuals, groups or organisations were interested in making a financial contribution to the Centre, then the actual 'ask' would be made by the Centre's directorate and fundraising staff. This suggestion was approved by the remaining Trustees at the closing meeting of the Board. Trustees requested fact sheets and presentation materials to assist them in their role as ambassadors for the Centre. The concept of 100% Board giving was not universally approved; Trustees cited inability, disinclination and existing commitments among their reasons.

- **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 fundraising calls etc., but he/she should not be seen as *the* person that raises the funds.**

At present, the Centre's fundraising staff does not have direct access to the Board of Trustees. All communication between the Centre and the Board of Trustees is conducted through the Executive Director's office, thus the fundraisers' ability to assist the Trustees on an ad hoc basis is limited. The fundraising staff does however work extensively with other Centre staff to develop grant proposals, arrange meetings and liaise with donors, as per Ms De Kuyper's recommendations.

TRUSTEES FUNDRAISING ROLE: AN IDEAL MODEL

The board of trustees is a vitally important part of every nonprofit organisation's fundraising effort. A board that is enthusiastic about fundraising and determined to succeed virtually guarantees the nonprofit's long-term fiscal health. A board that is hostile or indifferent to fundraising, on the other hand, risks the organisation's ability to continue to attract investors. Board members have three main fundraising responsibilities:

1) To make their own financial contributions to the extent of their capacity. Some board members can only give $5; others may be able to give $5 million. Each board member should make a "stretch" gift every year, regardless of specific amount. Other funders - particularly foundations and major donors - will not consider making contributions if the board's own giving is less than 100 percent.

2) To solicit contributions from friends, relatives, colleagues and associates. The most important reason that a person makes a contribution to a nonprofit organisation is that the right person asks. Board members should be prepared to approach the men and women on their personal and professional address lists on behalf of the nonprofit. These approaches may be for anything from small direct mail contributions, to major, planned or corporate gifts.

3) To identify and recruit new members of the board of trustees with the influence and connections to ensure the success of the fundraising effort. Volunteers other than board members can also play valuable fundraising roles and may bring a particular kind of expertise to the organisation's fund development activities. These individuals should be engaged and enthused by the existing Trustees.

CONTRIBUTIONS 2002 - 2005

(Amount in US$ '000)

Donors	2002 ACTUAL Amount	%	2003 ACTUAL Amount	%	2004 Jun. FORECAST Amount	%	2004 Nov. FORECAST Amount	%	2005 BUDGET Amount	%
Australia - AusAID	214	1.4	292	1.8	267	1.7	285	1.5	220	1.5
Bangladesh	766	5.0	970	5.9	860	5.5	1,115	5.9	434	3.0
Belgium - BADC/BTC	128	0.8	111	0.7	72	0.5	43	0.2		
Canada - CIDA	94	0.6	892	5.4	1,067	6.8	1,175	6.2	1,216	8.4
Centre for Disease Control & Prevn. (CDC)	117	0.8	281	1.7	317	2.0	488	2.6	335	2.3
Centre Endowment Fund	71	0.5	46	0.3	1	-	5	-		
European Union - BHARP	293	1.9	(9)	(0.1)			39	0.2		
Ford Foundation	243	1.6								
Gates Foundation			311	1.9	2,299	14.6	2,248	12.0	2,647	18.3
Gates - GoB Award	413	2.7	729	4.4	442	2.8	507	2.7	82	0.6
Hospital Endowment Fund			400	2.4	200	1.3	200	1.1	200	1.4
International Vaccine Institute (IVI)	352	2.3	545	3.3	286	1.8	291	1.5	21	0.1
Japan	410	2.7					1	-		
Netherlands	1,856	12.1	2,312	14.0	1,243	7.9	1,508	8.0	1,481	10.3
New England Medical Center (NEMC)	147	1.0	137	0.8	106	0.7	86	0.5		
Saudi Arabia	53	0.3	50	0.3	50	0.3	50	0.3		
Sri Lanka			4	-			4	-	4	-
Sweden - Sida/SAREC	711	4.7	937	5.7	968	6.1	1,185	6.3	715	4.9
Switzerland - SDC	500	3.3	750	4.5	1,000	6.3	1,000	5.3	1,000	6.9
Swiss Red Cross (SRC)	162	1.1	161	1.0	82	0.5	97	0.5	15	0.1
Thrasher Research Fund	226	1.5	93	0.6	95	0.6	117	0.6	13	0.1
United Kingdom - DFID	1,507	9.9	1,712	10.4	2,287	14.5	2,384	12.7	2,165	15.0
UNDP/UNOPS - Japan	149	1.0	89	0.5						
UNICEF	230	1.5	118	0.7			32	0.2	57	0.4
USAID - Dhaka	2,291	15.0	2,445	14.8	1,520	9.6	1,716	9.1	997	6.9
USAID - Washington	1,875	12.3	525	3.2						
USA - National Institute of Health (NIH)	442	2.9	470	2.8	964	6.1	1,239	6.6	1,038	7.2
USA - Other Sources	289	1.9	560	3.4	583	3.7	933	5.0	501	3.5
Wyeth Pharmaceuticals, Inc.	186	1.2	124	0.7			3	-		
WHO	439	2.9	163	1.0	184	1.2	267	1.4	190	1.3
Self Sustaining	82	0.5	64	0.4	136	0.9	92	0.5	214	1.5
Others	1,031	6.8	1,229	7.4	746	4.7	1,700	9.0	900	6.2
Total Contributions	**15,276**	**100**	**16,511**	**100**	**15,776**	**100**	**18,810**	**100**	**14,445**	**100**

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

CONTRIBUTIONS BY UNRESTRICTED AND RESTRICTED FUNDS 2002 - 2005

(Amount in US$ '000)

Donors	2002 Actual		2003 Actual				2004 Jun Forecast				2004 Nov Forecast				2005 Budget			
	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%	Unrestricted	Restricted	Amount	%
Unrestricted Funds																		
Australia - AusAID	163	1.1	219		219	1.3	201		201	1.3	220		220	1.2	220		220	1.5
Bangladesh	174	1.1	335		335	2.0	339		339	2.1	334		334	1.8	339		339	2.3
Belgium - BADC/BTC	59	0.4				-				-				-				-
Canada - CIDA	48	0.3	859		859	5.2	1,066		1,066	6.8	1,174		1,174	6.2	1,216		1,216	8.4
Netherlands	1,845	12.1	2,116		2,116	12.8	1,186		1,186	7.5	1,200		1,200	6.4	1,264		1,264	8.8
Saudi Arabia	53	0.3	50		50	0.3	50		50	0.3	50		50	0.3				-
Sri Lanka		-	4		4	-				-	4		4	-	4		4	-
Sweden - Sida/SAREC	269	1.8	305		305	1.8	326		326	2.1	335		335	1.8	549		549	3.8
Switzerland - SDC	500	3.3	750		750	4.5	1,000		1,000	6.3	1,000		1,000	5.3	1,000		1,000	6.9
USAID - Washington	338	2.2				-				-				-				-
Others	38	0.2				-				-	484		484	2.6				-
Total Unrestricted	**3,486**	**22.8**	**4,638**		**4,638**	**28.1**	**4,168**		**4,168**	**26.4**	**4,801**		**4,801**	**25.5**	**4,592**		**4,592**	**31.8**
Restricted Funds																		
Australia - AusAID	51	0.3	14	58	72	0.4	13	53	67	0.4	13	52	65	0.3				-
Bangladesh	592	3.9	94	540	634	3.8	104	417	522	3.3	103	678	781	4.2	19	76	95	0.7
Belgium - BADC/BTC	69	0.4		111	111	0.7		72	72	0.5		43	43	0.2				-
Canada - CIDA	46	0.3	1	32	33	0.2		1	1	0.0		1	1	-				-
Centre for Disease Control & Prevn. (CDC)	117	0.8	47	234	281	1.7	49	269	317	2.0	84	404	488	2.6	79	256	335	2.3
Centre Endowment Fund	71	0.5		46	46	0.3		1	1	-		5	5	-				-
European Union - BHARP	293	1.9		-9	-9	-0.1				-		39	39	0.2				-
Ford Foundation	243	1.6				-				-				-				-
Gates Foundation		-	75	236	311	1.9	557	1,742	2,299	14.6	545	1,703	2,248	12.0	642	2,005	2,647	18.3
Gates - GoB Award	413	2.7	29	700	729	4.4	7	435	442	2.8	7	500	507	2.7	1	81	82	0.6
Hospital Endowment Fund		-		400	400	2.4		200	200	1.3		200	200	1.1		200	200	1.4
International Vaccine Institute (IVI)	352	2.3	103	442	545	3.3	57	229	286	1.8	58	233	291	1.5	4	17	21	0.1
Japan	410	2.7				-				-		1	1	-				-
Netherlands	11	0.1	2	194	196	1.2	7	49	57	0.4	4	304	308	1.6	3	214	217	1.5
New England Medical Center (NEMC)	147	1.0	32	104	137	0.8	25	81	106	0.7	19	67	86	0.5				-
Sweden - Sida/SAREC	442	2.9	112	520	632	3.8	118	524	642	4.1	157	693	850	4.5	23	143	166	1.1
Switzerland - SDC		-				-				-				-				-
Swiss Red Cross (SRC)	162	1.1	21	140	161	1.0	11	71	82	0.5	13	84	97	0.5	2	13	15	0.1
Thrasher Research Fund	226	1.5	6	87	93	0.6	6	89	95	0.6	8	109	117	0.6	1	12	13	0.1
United Kingdom - DFID	1,507	9.9	176	1,537	1,712	10.4	235	2,052	2,287	14.5	236	2,148	2,384	12.7	269	1,896	2,165	15.0
UNDP/UNOPS - Japan	149	1.0		89	89	0.5				-				-				-
UNICEF	230	1.5	-5	123	118	0.7				-	1	31	32	0.2		57	57	0.4
USAID - Dhaka	2,291	15.0	578	1,867	2,445	14.8	302	1,218	1,520	9.6	347	1,369	1,716	9.1	203	794	997	6.9
USAID - Washington	1,537	10.1	105	420	525	3.2				-				-				-
USA - National Institute of Health (NIH)	442	2.9	16	454	470	2.8	27	937	964	6.1	38	1,201	1,239	6.6	25	1,013	1,038	7.2
USA - Other Sources	289	1.9	52	508	560	3.4	68	515	583	3.7	131	802	933	5.0	77	424	501	3.5
Wyeth Pharmaceuticals, Inc.	186	1.2	28	96	124	0.7				-	1	2	3	-				-
WHO	439	2.9		163	163	1.0		184	184	1.2		267	267	1.4		190	190	1.3
Self Sustaining	82	0.5		64	64	0.4		136	136	0.9		92	92	0.5		214	214	1.5
Others	993	6.5	108	1,122	1,229	7.4	73	673	746	4.7	132	1,084	1,216	6.5	132	768	900	6.2
Total Restricted	**11,790**	**77.2**	**1,594**	**10,279**	**11,872**	**71.9**	**1,660**	**9,948**	**11,608**	**73.6**	**1,897**	**12,112**	**14,009**	**74.5**	**1,480**	**8,373**	**9,853**	**68.2**
Total Contributions	**15,276**	**100**	**6,232**	**10,279**	**16,511**	**100**	**5,828**	**9,948**	**15,776**	**100**	**6,698**	**12,112**	**18,810**	**100**	**6,072**	**8,373**	**14,445**	**100**

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

ublished in the Bangladesh Gazette, Extraordinary, dated the 9th December 1978.]

OVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

MINISTRY OF LAW AND PARLIAMENTARY AFFAIRS

NOTIFICATION

Dacca, the 9th December, 1978.

No. 920-Pub.—The following Ordinance made by the President of the ple's Republic of Bangladesh, on the 6th December, 1978, is hereby pub-ed for general information :—

TERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH ORDINANCE, 1978.

Ordinance No. LI of 1978.

AN

ORDINANCE

to provide for the establishment of an International Centre for Diarrhoeal Disease Research, Bangladesh.

WHEREAS it is expedient to provide for the establishment of an international ntre for diarrhoeal research in Bangladesh with multinational scientific colla-ration and financial contributions to conduct research in diarrhoeal diseases d directly related subjects of nutrition and fertility with special relevance to veloping countries and for matters ancillary thereto;

NOW, THEREFORE, in pursuance of the Proclamations of the 20th August, 75, and the 8th November, 1975, and in exercise of all powers enabling him that behalf, the President is pleased to make and promulgate the following rdinance:—

1. **Short title and Duration.**—(*1*) This Ordinance may be called the inter-tional Centre for Diarrhoeal Disease Research, Bangladesh.

(*2*) It shall continue in force for a period of 25 years.

Price: 35 paisa.

2. **Definitions.**—In this Ordinance, unless there is anything repugnant in the subject or context,—

(*a*) "Board" means the Board of Trustees for the Centre constituted under section 8;

(*b*) "Centre" means the International Centre for Diarrhoeal Disease Research, Bangladesh established under section 3;

(*c*) "Chairman" means the Chairman of the Board;

(*d*) "Cholera Research Laboratory" means the Cholera Research Laboratory established in Bangladesh under an agreement executed on 15th May, 1974, between the Government of the People's Republic of Bangladesh and the Government of the United States of America and others;

(*e*) "developing countries" mean those countries who have been put under this classification by the United Nations;

(*f*) "Director" means Director of the Centre;

(*g*) "donor" means an agency, organization, or government which contributes in cash or kind to the Centre;

(*h*) "employee" includes regular, contractual and probationers employed by the Centre;

(*i*) "member" means a member of the Board;

(*j*) "officer" includes advisor, consultant and expert employed by the Centre;

(*k*) "prescribed" means prescribed by by-laws made under this Ordinance.

3. **Establishment and Incorporation of the Centre.**—(*1*) There shall be an international centre to be called the "International Centre for Diarrhoeal Disease Research, Bangladesh" for carrying out the purposes of this Ordinance.

(*2*) The Centre shall be a body corporate having perpetual succession and common seal with power, subject to the provisions of this Ordinance, to acquire, hold and dispose of property, both movable and immovable, and shall by the said name sue and be sued.

(*3*) The Centre shall be an autonomous, international, philanthropic, and non-profit centre for research, education and training as well as clinical service.

4. **Headquarters of the Centre.**—(*1*) The Headquarters of the Centre shall be at Dacca.

(*2*) The Centre may establish such subsidiary offices of research stations as may be decided by the Board as being necessary for effective conduct of its programme subject to the approval of the respective governments.

5. **Aims and objectives of the Centre.**—(*1*) The aims and objectives of the tre shall be:

(*a*) To function as an institution to undertake and promote study, research and dissemination of knowledge in diarrhoeal diseases and directly related subjects of nutrition and fertility with a view to developing improved methods of health care and for the prevention and control of diarrhoeal diseases and improvement of public health programmes with special relevance to developing countries.

(*b*) To provide facilities for training to Bangladeshi and other nationals in areas of the Centre's competence in collaboration with national and international institutions, but not to include conferring of academic degrees.

(*2*) In fulfilling the above aims and objectives, the Centre shall have responsibilities:

(*a*) To conduct clinical research, laboratory and animal experiments, epidemiological and survey research, field investigations, demonstration projects, within the applicable laws and regulations, or concurrence where necessary, of the Government and other countries where it may be appropriate; to hold meetings and to arrange lectures, seminars, discussions and conferences, both international and national, on clinical medicine, epidemiology, basic medical sciences, bio-statistics demography, fertility and other social sciences relating to studies of diarrhoeal disease control and public health, in this section referred to as the studies.

(*b*) To publish books, periodicals, reports and research and working papers on the studies.

(*c*) To establish and maintain contact with scholars and their work on the studies through collaborative studies, seminars, exchange of visits or otherwise.

(*d*) To undertake studies on behalf of or in collaboration with other institutions.

(*e*) To maintain hospitals, clinics, laboratories, animal research facilities, libraries, reading rooms, scientific equipment and instruments, as well as vehicles, boats and other transport for its proper functioning.

(*f*) To ensure the rights and opportunities of Bangladesh scientific personnel to participate in the programme and activities of the Centre.

(*g*) To undertake a systematic staff development programme.

(*h*) To institute fellowships for different categories of professional workers on the studies.

(*i*) To create within itself, from time to time, branches, divisions, sections and other units for proper and efficient conduct of the activities of the Centre in different fields of the studies.

(*j*) To accept endowments, gifts, donations, grants, other funds, payments for services and to earn income.

(*k*) To take such other actions as may further the aims and objectives of the Centre.

6. **Interim International Committee.**—(*1*) There shall be an Interim International Committee for the purpose of assisting in the establishment of the Centre. The Interim Committee shall consist of the United Nations Development Programme which shall be its Chairman and the following initial members, namely:—

(*a*) the Government of Australia;

(*b*) the Government of Bangladesh;

(*c*) the Government of the United Kingdom;

(*d*) the Government of the United States of America;

(*e*) the Ford Foundation;

(*f*) the International Development Research Centre;

(*g*) the United Nations Fund for Population Activities;

(*h*) the United Nations Children Fund; and

(*i*) the World Health Organisation.

(*2*) The Chairman of the Interim Committee may invite any other Government or Organisation to become members of the Interim Committee or to attend its meeting as observers.

(*3*) The Interim Committee shall function through the representatives of its members. It shall meet at the call of the Chairman and shall conduct its business at such meeting. The decision of a meeting shall be taken either by consensus or by a majority of votes of the members present and voting, including the Chairman, each member having one vote. Majority of the members of the Interim Committee including its Chairman shall constitute a quorum. Subject to these provisions, the business of the Interim Committee shall be regulated by the rules of procedure adopted by it.

(*4*) Unless otherwise decided by the Interim Committee the Secretariat of the Interim Committee shall be located in the premises of the Cholera Research Laboratory.

(*5*) The Interim Committee shall take steps for the establishment of the Board. For this purpose it shall elect not less than seven nor more than eleven members for the first Board to be constituted under this Ordinance. It shall also specify the date on which the first Board shall assume its functions under this Ordinance.

(*6*) The Interim Committee shall stand dissolved on the day on which the Board holds its first meeting, unless the Board by a Resolution continues the existence of the Interim Committee for such period and for the purpose as may be specified in the Resolution.

7. **Powers and Functions of the Board.**—(*1*) The general direction, management and administration of the affairs of the Centre shall vest in the Board which shall have full authority to determine and execute the policies and undertakings of the Centre within the framework of this Ordinance.

(2) Without prejudice to the generality of the foregoing provisions, the Board shall, in particular, have power—

(a) to exercise general supervision over the affairs of the Centre;

(b) to approve courses of studies and research work and other related activities to be conducted in the Centre in broad outlines;

(c) to approve the plan, programme and organisation of the Centre;

(d) to authorize the Centre to request and receive grants-in-aid from aid-giving agencies, Governments and other institutions; with intimation of such receipts to appropriate governmental agencies;

(e) to authorize the Centre, if and when necessary, to borrow money or raise loans in accordance with the applicable laws and regulations of the countries in which the funds are being sought;

(f) to select and appoint the Director and terminate his services;

(g) to approve establishment of all international level positions in the Centre and approve the appointments of persons to these positions, and in its description, delegate to the Director authority to appoint persons to other staff positions;

(h) to determine employment policies and practices of the Centre;

(i) to examine and approve the budget for the Centre; and

(j) to do and perform all other acts that may be considered necessary, suitable and proper for the attainment of any or all of the purposes, activities and objectives for which the Centre is established.

8. **Constitution of the Board.**—(1) The Board shall consist of sixteen members who shall serve in their individual capacity as follows:—

(a) three members nominated by the Government;

(b) a member nominated by the Director-General of the World Health Organisation;

(c) the Director of the Centre; and

(d) eleven members at large, who shall be chosen initially by the Interim Committee, comprising as members of the Interim Committee those governments and organizations under sub-sections (1) and (2) of section 6;

(2) At any given time, no country shall have more than two members except for Bangladesh under sub-section (1).

(3) At any given time, the Board shall be so composed that, not counting the members nominated by the World Health Organisation, 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.

(4) The members shall be individuals qulified to serve by reason of scientific, research, administrative or other appropriate experience.

(5) Except for the Director, all members shall be appointed to fill three-year terms, except for members of the initial Board. In the initial Board, all members except the Director shall be divided into three classes of approximately equal numbers, these classes serving terms of one, two and three years respectively. The Board shall decide how many members shall be in each class, and the members of each class shall be chosen by lot.

(6) Vacancies in seats of members at large shall be filled by the Board. A member appointed to a vacancy arising from a cause other than the normal expiration of a term shall serve for the remainder of the term of the member being replaced. No member may serve more than two consecutive three-year terms or portion thereof, except that a member serving a term of less than three years on the initial Board may serve two consecutive three-year terms immediately thereafter.

9. **The Chairman.**—(1) The members shall elect one of them except the Director as Chairman for a term to be determined by the Board.

(2) The Chairman shall preside over the Board meetings.

(3) In the absence of the Chairman, the members present may appoint one of them as the Chairman for that meeting.

10. **Meetings of the Board.**—(1) The meetings of the Board shall be held at such time, place and manner as may be prescribed. A majority of the sitting membership shall constitute a quorum.

(2) Except for the first year, at least two mettings of the Board shall be held in one calendar year.

(3) In the meeting of the Board, each member shall have one vote, but in the event of equality of votes, the Chairman shall have the second or casting vote.

11. **Validity of Proceedings.**—(1) No act or proceedings of the Board shall be invalid merely on the grounds of the existence of any vacancy in or defect in the constitution of the Board. A vacancy in the Board or a temporary absence of a member for any reason shall not impair the right of the remaining members to act.

(2) All acts done by a person acting in good faith as the Chairman or member shall be valid, notwithstanding that it may afterwards be discovered that his appointment was invalid by reason of any defect or disqualification or had terminated by virtue of any provision of law for the same being in force; but nothing in this section shall be deemed to give validity to any act of the Chairman, member or Director after his appointment has been shown to be invalid or to have been terminated.

12. **Committees.**—(1) The Board may designate an Exceutive Committee of its members who shall have the power to act for the Board in the interim between Board meetings on all matters which the Board delegates to it. The Director and at least one of the Bangladeshi members shall serve as members of the Executive Committee.

(2) All interim actions of the Executive Committee shall be reported to the Board at its next subsequent meeting.

(3) The Board shall convene, at least once in two years, an external ientific Review Committee from developing and developed countries of such mbers as the Board may decide for the purpose of carrying out a technical iew of the scientific programmes of the Centre.

(4) The Board shall create a Programme Co-ordination Committee for the rpose of co-ordination of research in Bangladesh and may create such other nding committees or *ad hoc* committees as may be deemed necessary for rying out the responsibilities of the Centre. The Centre shall be supportive and avoid actions prejudical to, the interest of research in similar fields ried out by other organizations in Bangladesh. A standing committee with presentatives from the Government shall be set up for the purpose of co-linating research by the Centre with that of other organizations specifically fertility and related fields in Bangladesh.

(5) The Board shall authorize the creation of an Ethical Review Committee h representation from the Bangladesh Medical Research Council.

(6) The Board may delegate its functions and powers to such committees may be prescribed.

(7) The powers, functions and duties of different committees shall be such may be prescribed.

13. **Director.**—(1) The Centre shall be administered by a Director who all be selected and appointed by the Board for a term of three years which ay be renewable for another term.

(2) The Director shall be the Chief executive of the Centre and subject to provisions of this Ordinance, and the by-laws made thereunder, he shall minister and manage the affairs and funds of the Centre.

(3) The Director shall be responsible for implementation of the decisions the Board in directing, conducting and carrying out research and other acti-ies of the Centre.

(4) The Director may be assisted by a Deputy Director who shall be ected and appointed by the Board, in all matters assigned to him by the rector and shall act as the Director during the Director's absence, serving as member of the Executive Committee but not assuming the seat of the Director the Board.

14. **Salaries, etc.**—(1) Persons including Bangladeshi nationals appointed to international level positions of the Centre by the Board shall receive the ne privileges and salaries for equivalent positions; restrictions on pay and owances imposed by the Government upon its nationals shall not be plicable.

(2) Salaries and emoluments of non-international level positions should be mparable to those paid by the United Nations organizations in Bangladesh.

15. **Indemnity.**—The Chairman, members, Director, officers and employees all be indemnified by the Centre against all losses and expenses incurred by em in or in relation to the discharge of their duties, except such as have been used by their wilful act of default or negligence.

16. **Public Servant.**—The Chairman, members, Director, officers and employees shall while acting or purporting to act in pursuance of any provision of this Ordinance or by-laws made thereunder, be deemed to be a public servant within the meaning of section 21 of the Penal Code (Act XLV of 1860).

17. **Fund.**—(*1*) The Centre shall have its own fund which shall consist of—

(*a*) grants made by the Government;

(*b*) grants and contributions from other governments and their agencies, international organizations and private organizations;

(*c*) gifts and endowments;

(*d*) sale proceeds and royalties of publications;

(*e*) income from research and contractual undertakings; and

(*f*) other sources.

(*2*) All funds of the Centre shall ordinarily be kept in any nationalized Bank or Banks in Bangladesh as approved by the Board.

18. **Accounts of Receipts and Expenditure.**—(*1*) The Director shall maintain the accounts of all receipts and expenditures of the Centre in the manner as may be prescribed and such accounts shall be audited annually by Chartered Accountants as may be appointed by the Board in this behalf, a report of which shall be submitted to the Board.

(*2*) Copies of such audited reports shall be supplied to the donors.

19. **Annual Report and Statement of Accounts.**—The Director shall, as soon after the end of every financial year as may be directed by the Board, prepare for the Board an annual report of the working of the Centre and a statement of receipts and expenditure of the Centre. Following the approval by the Board it shall be circulated to the donors.

20. **Exemption from Labour Laws.**—(*1*) The Centre shall be exempted from the labour laws in force in the country. It shall be governed by its own by-laws as may be prescribed.

(*2*) The Centre shall not be construed as a "shop", "commercial establishment", "industrial establishment", "factory" or "industry" within the meaning of the Shops and Establishment Act, 1965 (VII of 1965), the Factories Act, 1965 (IV of 1965) or the Industrial Relations Ordinance, 1969 (XXIII of 1969).

21. **Exemption from tax, rate and duty.**—(*1*) Notwithstanding anything contained in any law for the time being in force relating to any tax, rate or duty, the Centre shall not be liable to pay any tax, rate or duty other than those paid by any other person in respect of any movable or immovable property which the Centre purchases or otherwise acquires from such person and other than those payable in respect of public utilities like water, gas, electricity, telephone and municipal rates.

(2) All non-Bangladeshi experts, technicians and research scholars employed by the Centre and working in Bangladesh for the furtherance of the objectives of the Centre shall be exempt, notwithstanding the provisions of the Income Tax Act, 1922 (XI of 1922), from payment of income tax in respect of any salary or other remuneration received or deemed to be received by them or accruing or arising, or deemed to accrue or arise in Bangladesh to them; if such salary or other remuneration of the person is also exempt from the payment of tax in the country of his domicile or permanent residence and evidence in respect of the said exemption is produced to the income tax authority concerned in Bangladesh. Such person shall also be accorded privileges for importation of personal and household effects and articles for consumption free of customs duty and sales tax as are accorded, under laws and regulation in force from time to time, to the expatriate experts, technicians and consultants working in Bangladesh under international agreements.

22. **Immunities and privileges of officers and employees.**—The Chairman, Trustee, Director, Officers, and employees—

(*a*) shall be immune from any legal process with respect to any acts performed by them in their official capacity except when the Board or the Director waives their immunity, which should be reported to the Board; and

(*b*) those who are nationals of countries other than Bangladesh, and their spouses and dependents, shall be free from immigration restrictions, other than normal visa requirements, and alien registration requirements in accordance with the laws and regulations of the Government.

23. **Immunities and privileges.**—(*1*) The centre, its property and assets wherever located and by whomsoever held, shall enjoy immunity from every form of judicial process except for criminal offences for which the Board or the Director expressly waives its immunity for the purpose of any proceeding. Such action shall be reported to the Board.

(*2*) All property and assets of the Centre shall be free from any restrictions, regulations, controls and moratoria of any nature to the extent it is necessary to carry out the objectives and functions of the Centre effectively.

(*3*) Subject to national and international laws and regulations, the Centre shall be entitled to movement of biological materials in and out of the country.

24. **Waiver or Immunity, Exemption and Privileges.**—The Board may waive any of the privileges, immunities, and exemptions granted under this Ordinance in any particular case or instance, in such a manner and upon such conditions as it may determine to be appropriate in the best interest of the Centre.

25. **Free publication and dissemination of research.**—(*1*) The Centre shall enjoy the privilege of free publication and dissemination of its research and other scientific work.

(*2*) All research materials and scientific results shall be treated as property of the Centre and shall not be used, published, duplicated or transferred for private advancements or other material gains or used by any other institution without express approval of the Centre.

26. **Patents and Copyrights.**—(*1*) The Centre shall enjoy full rights of patents and copyrights with respect thereto under Bangladesh and foreign laws.

(*2*) It shall be the responsibility of the Board to ensure that appropriate arrangements are made concerning the public availability of patents, licences, copyrights and the like arising from the Centre's scientific results and discoveries.

27. **Benevolent fund.**—The Centre may establish benevolent fund for its officers and employees for the purpose of providing welfare amenities and facilities for their betterment and development, and the same shall be regulated in the manner as may be prescribed.

28. **Power to make by-laws.**—The Board may make by-laws for carrying out the purposes and provisions of this Ordinance.

29. **Government support for facilities.**—The Government may provide facilities and privileges to the Centre for its proper development and expansion including lease of land at nominal or no rent.

30. **Dissolution of the Cholera Research Laboratory.**—On the commencement of this Ordinance, the Cholera Research Laboratory, in this section referred to as the CRL, shall notwithstanding anything contained in any other law for the time being in force, or in any other instrument or in the agreement under which it was established, stand dissolved and upon the such dissolution—

(*a*) all assets and liabilities of the CRL shall stand transferred to, and vested in, the Centre.

Explanation.—(*i*) The term "assets" includes all rights, powers, authorities and privileges, cash and bank balances, grants and all other interests and rights, in or arising out of, such property and all books of accounts, registers, records and all other documents or whatever nature relating thereto; and all properties, movable and immovable which were owned, used and or possessed by the CRL other than land and buildings thereupon wherever they may be situated.

(*ii*) The term "liabilities" shall be limited to all obligations to claims on behalf of *ex*-employees of the CRL at the time of dissolution for compensation or under existing employment agreements or other contractual arrangements and vendors of goods and services to the CRL.

(*b*) all officers, employees, consultants, advisors, and other staff of the CRL shall hold their respective offices on the same terms and conditions and with the same rights and privileges which were enjoyed by them immediately before the commencement of this Ordinance and shall continue to do so until the same are duly altered by the Board.

31. **Valioation, etc.**—Notwithstanding the dissolution of the Cholera Research Laboratory, anything done or action taken in good faith in or in relation to the Cholera Research Laboratory before the commencement of this Ordinance shall be deemed to have been validly done or taken, and shall have and shall be deemed always to have had effect accordingly, and shall not be called in question in any court, except those currently under adjudication.

32. **Dissolution.**—(*1*) At any time that the Board may determine by vote of not less than three-fourths of its sitting members, whether or not present and voting, that the Centre is no longer able to function effectively or is no longer required, the Board may recommend to the Government the dissolution of the Centre.

(*2*) In the event of dissolution, any land or other assets made available to the Centre by the Government, and permanent fixed capital improvements thereon, shall revert to the Government. The other assets of the Centre shall be retained by the Government and by other governments where assets distributed to institutions having purposes similar to Government or other governments where appropriate, and the Board.

ZIAUR RAHMAN, BU,
MAJOR GENERAL,
President.

DACCA;
The 6th December, 1978.

A. K. TALUKDAR
Deputy Secretary.

BGP-78/79-6553G-5,760—14-12-1978

[*Published in the Bangladesh Gazette, Extraordinary, dated the 23rd December 1978*]

GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

MINISTRY OF LAW AND PARLIAMENTARY AFFAIRS

CORRIGENDUM

In the International Centre for Diarrhœal Disease Research, Bangladesh Ordinance, 1978 (Ordinance No. LI of 1978), published in the *Bangladesh Gazette, Extraordinary*, dated the 9th December, 1978, at pages 6285—6295,—

(1) At page 6285, in section 1, in line 1, *for* "international" *read* "International";

(2) At page 6289, in section 7, in clause 2, in sub-clause (*g*), in line 3, *for* "description" *read* "discretion";

(3) At page 6289, in section 8, in clause (*4*), in line 1, *for* "qulified" *read* "qualified";

(4) At page 6290, in section 10, in clause (*2*), in line 1, *for* "mettings" *read* "meetings";

(5) At page 6291, in section 12, in clause (*3*), in the last line, *for* "progrommes" *read* "programmes";

(6) At page 6294, in section 31, in line 1, *for* "Valioation" *read* "Validation";

(7) At page 6295, in section 32, in clause (*2*), in line 3, for the words "The other assets of the Centre shall be retained by the Government and by other governments where assets distributed to institutions having purposes similar to Government or other governments where appropriate, and the Board", *read* "The other assets of the Centre shall be retained by the Government and by other governments where assets are located, and used for similar purposes or distributed to institutions having purposes similar to those of the Centre as may be agreed between the Government or other governments where appropriate, and the Board of Trustees".

A. K. TALUKDAR
Deputy Secretary.

BGP-78/79-6976G-5,765—27-12-78.

Price : 10 paisa.

[*Published in the Bangladesh Gazette, Extraordinary, dated the 24th February 1985.*]

GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

MINISTRY OF LAW AND JUSTICE

NOTIFICATION

Dhaka, the 24th February, 1985

No. 119-Pub.—The following Ordinance made by the President of the People's Republic of Bangladesh, on the 15th February, 1985, is hereby published for general information:—

THE INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH (AMENDMENT) ORDINANCE, 1985

Ordinance No. X of 1985

AN

ORDINANCE

to amend the Ordinance called the International Centre For Diarrhoeal Disease Research, Bangladesh

WHEREAS it is expedient to amend the Ordinance called the International Centre for Diarrhoeal Disease Research, Bangladesh (Ord. LI of 1978), for the purposes hereinafter appearing;

NOW, THEREFORE, in pursuance of the Proclamation of the 24th March, 1982, and in exercise of all powers enabling him in that behalf, the President is pleased to make and promulgate the following Ordinance:—

1. **Short title.**—This Ordinance may be called the International Centre for Diarrhoeal Disease Research, Bangladesh (Amendment) Ordinance, 1985.

Price : 10 Paisa

2. **Amendment of section 1, Ord. LI of 1978.**—In the Ordinance called the International Centre for Diarrhoeal Disease Research, Bangladesh (Ord. LI of 1978), hereinafter referred to as the said Ordinance, in section 1, in sub-section (*1*), *for* the word "Bangladesh" the words, commas and the figure "Bangladesh, Ordinance, 1978" shall be *substituted* and shall be deemed always to have been so substituted.

3. **Amendment of section 8, Ord. LI of 1978.**—In the said Ordinance, in section 8,—

(*a*) in sub-section (*1*),—

(*i*) *for* the word "sixteen" the word "seventeen" shall be *substituted;* and

(*ii*) after clause (*b*), the following new clause shall be *inserted*, namely:—

"(*bb*) a member to be nominated by a United Nations agency other than the World Health Organisation to be specified by the Government;"; and

(*b*) in sub-section (*3*), *for* the words "by the World Health Organisation" the words, brackets, letters and figure "under clauses (*b*) and (*bb*) of sub-section (1)" shall be *substituted.*

H M ERSHAD, ndc, psc
LIEUTENANT GENERAL
President.

DHAKA;
The 15th February, 1985.

MD. ABUL BASHAR BHUIYAN
Deputy Secretary (Drafting).

BGP-84/85-5335G-10,940—12-3-85.

রেজিষ্টার্ড নং ডি এ-১

বাংলাদেশ গেজেট

অতিরিক্ত সংখ্যা

কর্তৃপক্ষ কর্তৃক প্রকাশিত

শনিবার, সেপ্টেম্বর ১৬, ১৯৯৫

বাংলাদেশ জাতীয় সংসদ

ঢাকা, ১৬ই সেপ্টেম্বর, ১৯৯৫/১লা আশ্বিন, ১৪০২

সংসদ কর্তৃক গৃহীত নিম্নলিখিত আইনটি ১৬ই সেপ্টেম্বর, ১৯৯৫ (১লা আশ্বিন, ১৪০২) তারিখে রাষ্ট্রপতির সম্মতি লাভ করিয়াছে এবং এতদ্বারা এই আইনটি সর্বসাধারণের অবগতির জন্য প্রকাশ করা যাইতেছে ঃ—

১৯৯৫ সনের ২২ নং আইন

International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978 এর অধিকতর সংশোধনকল্পে প্রণীত আইন

যেহেতু নিম্নবর্ণিত উদ্দেশ্যসমূহ পূরণকল্পে International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978 (LI of 1978) এর অধিকতর সংশোধন সমীচীন ও প্রয়োজনীয়;

সেহেতু এতদ্বারা নিম্নরূপ আইন করা হইল ঃ—

১। **সংক্ষিপ্ত শিরনামা ও প্রবর্তন।**— (১) এই আইন The International Centre for Diarrhoeal Disease Research, Bangladesh (Amendment) Act, 1995 নামে অভিহিত হইবে।

(২) ইহা ১১ই আগষ্ট, ১৯৯৫ ইং মোতাবেক ২৭শে শ্রাবণ, ১৪০২ বাং তারিখে কার্যকর হইয়াছে বলিয়া গণ্য হইবে।

২। **Ord. LI of 1978 এর section 8 এর সংশোধন।**— International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978 (LI of 1978), অতঃপর উক্ত Ordinance বলিয়া উল্লিখিত, এর section 8 এর sub-section (6) এর দ্বিতীয় বাক্যে

মূল্য ঃ টাকা ১.০০

"No Member" শব্দগুলির পরিবর্তে "Subject to provision of sub-section (1) of section 13, "No Member" শব্দগুলি, বন্ধনীগুলি, সংখ্যাগুলি ও কমা প্রতিস্থাপিত হইবে।

৩। **Ord. LI of 1978 এর section 13 এর সংশোধন।**— উক্ত Ordinance এর section 13 এর sub-section (1) এর শেষে ফুল-ষ্টপের পরিবর্তে একটি কোলন প্রতিস্থাপিত হইবে এবং তৎপর নিম্নরূপ শর্তাংশ সংযোজিত হইবে, যথা ঃ—

"Provided that, the Board may in exceptional case, extend the tenure of the Director for a period maximum of which shall not exceed a period equivalent to another term."।

আবুল হাশেম
সচিব।

মোঃ মিজানুর রহমান, উপ-নিয়ন্ত্রক, বাংলাদেশ সরকারী মুদ্রণালয়, ঢাকা কর্তৃক মুদ্রিত।
মোঃ আব্দুর রশীদ সরকার, উপ-নিয়ন্ত্রক, বাংলাদেশ ফরমস্ ও প্রকাশনী অফিস, তেজগাঁও, ঢাকা কর্তৃক প্রকাশিত।

রেজিষ্টার্ড নং ডি এ-১

বাংলাদেশ গেজেট

অতিরিক্ত সংখ্যা

কর্তৃপক্ষ কর্তৃক প্রকাশিত

বুধবার, এপ্রিল ২২, ১৯৯৮

বাংলাদেশ জাতীয় সংসদ

ঢাকা, ২২শে এপ্রিল, ১৯৯৮/৯ই বৈশাখ, ১৪০৫

সংসদ কর্তৃক গৃহীত নিম্নলিখিত আইনগুলি ২২শে এপ্রিল, ১৯৯৮ (৯ই বৈশাখ, ১৪০৫) তারিখে রাষ্ট্রপতির সম্মতি লাভ করিয়াছে এবং এতদ্বারা এই আইনগুলি সর্বসাধারণের জ্ঞাতির জন্য প্রকাশ করা যাইতেছে ঃ—

১৯৯৮ সনের ৫ নং আইন

International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978 (LI of 1978) এর অধিকতর সংশোধনকল্পে প্রণীত আইন

যেহেতু নিম্নবর্ণিত উদ্দেশ্য পূরণকল্পে International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978-এর অধিকতর সংশোধন সমীচীন ও প্রয়োজনীয়;

সেহেতু এতদ্বারা নিম্নরূপ আইন করা হইল ঃ—

১। সংক্ষিপ্ত শিরোনামা।—এই আইন International Centre for Diarrhoeal Disease Research, Bangladesh (Amendment) Act, 1998 নামে অভিহিত হইবে।

২। Ordinance LI of 1978-এর section 1-এর সংশোধন।—International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance, 1978 (LI of 1978)-এর section 1-এর sub-section (2)-এর পরিবর্তে নিম্নরূপ sub-section (2) প্রতিস্থাপিত হইবে, যথা ঃ

"(2) It shall continue in force for a period of 30 years with effect from 9th December 1978."

মূল্য ঃ টাকা ১.০০

CENTRE FOR HEALTH AND POPULATION RESEARCH

BYLAWS

As per Resolution 33/BT/June 03, the Board agrees that the following Bylaws shall replace Bylaws adopted by the following Board Resolutions: Resolution 7/June 81; Resolution 16/November 81; Resolution 16/November 81; Resolution 7/June 81 and Resolution 8/June 81.

These Bylaws are the operational rules and policies governing the Board of Trustees of ICDDR,B—Centre for Health and Population Research. They are adopted under the authority of, and are intended to be complementary to, the International Centre for Diarrhoeal Disease Research, Bangladesh Ordinance 1978 (Ordinance No. L1 of 1978), [hereinafter "1978 Ordinance"].

In these Bylaws, words denoting the masculine gender shall also denote the feminine gender and vice-versa.

I. Officers of the Board

I.1. Chairperson

I.1.1. The Chairperson shall serve in accordance with the terms set forth in the 1978 Ordinance, Section 9, (1)-(3).

I.1.2. Should the Chairperson be unable to complete his/her term, the Board shall elect a Trustee to serve as Chairperson during the remainder of the unexpired term.

I.2. Director

I.2.1. The Director shall serve as the Member-Secretary of the Board.

I.2.2. The Director shall serve in accordance with the terms set forth in the 1978 Ordinance, Section 13, (1)-(4) and may establish rules and procedures or issue statements as he or she deems necessary for the smooth operation of the Centre, provided these rules or statements do not contravene these Bylaws, other documents approved by the Board of Trustees, or the Ordinance.

I.2.3 The Director may make public statements concerning the work, objectives and policies of the Centre, as long as these conform to decisions of the Board of Trustees, and the Ordinance.

II. Standing Committees

II.1.1 **Standing Committees**: The Board shall have the following Standing Committees:

Executive Committee
Finance Committee
Fund Development and Oversight Committee
National Liaison Committee
Human Resources Committee
Programme Committee

II.1.2. No Trustee shall serve concurrently as the Chairperson of more than one Standing Committee of the Board.

II.2. Appointment of the Director to Standing Committees of the Board

II.2.1. The Director shall serve as a member of the Executive Committee, the Fund Development and Oversight Committee and the National Liaison Committee.

II.2.2. The Director of the Centre shall not serve as a member of any other Standing Committees of the Board.

II.3. Executive Committee

II.3.1 *Composition*: The Executive Committee is composed of the Chairperson of the Board, Chairpersons of the Finance Committee, Human Resources Committee, the National Liaison Committee, the Programme Committee and the Centre Director. At least one of the Bangladeshi Trustees must serve on the Executive Committee.

II.3.2 *Term of Service*: The Board shall appoint the Executive Committee annually. The term of service is one year beginning on December 1st of each year.

II.3.3. The functions of the Executive Committee are as follows:

II.3.3.1. To act for the Board in the interim between Board meetings on all matters, which the Board delegates to it. Such matters shall be delegated by resolution of the Board at the Full Board meeting immediately preceding the meeting of the Executive Committee.

II.3.3.2. To act for the Board in the interim between Board meetings on matters requiring immediate Board action. Such matters shall be delegated by resolution of the Board prior to the meeting of the Executive Committee. The vote to delegate a decision to the Executive Committee may be conducted by electronic means and shall be submitted to the Board Chairperson.

II.3.3.3. To approve any withdrawal of funds from the endowment accounts as recommended by the Director and endorsed by the Centre's Head of Finance in periods between meetings of the Full Board.

II.3.3.4 To determine urgent (but not routine) personnel actions involving IPOs (International Professional Officers) such as establishment of new positions, selection of new staff holding rank of P5 and above.

II.3.4 *Quorum:* Four members of the Executive Committee constitute a quorum for the purpose of conducting Executive Committee business. The Executive Committee shall not ordinarily proceed unless a quorum is present to deliberate on such matters before it.

II.3.5. The Executive Committee may conduct its meeting by conference call, teleconference or in person.

II.3.6. All decisions of the Executive Committee require the affirmative vote of the majority of members of the Committee.

II.3.7 Should a tie vote occur, the Director will not vote.

II.3.8. All decisions of the Executive Committee shall be reported to the Board at its next meeting in accordance with Section 12(2) of the Ordinance.

II.4 Finance Committee:

II.4.1 *Composition*: The Finance Committee is a Committee of the Whole composed of the Full Board. One member of the Board of Trustees shall serve as Chairperson and one member shall serve as Deputy Chairperson.

II.4.2 *Chairperson and Term of Service*: The Finance Committee Chairperson shall be appointed for at least two consecutive years, the term of service beginning on December 1st of each year. The Finance Committee Chairperson may be re-appointed for the duration of their proscribed term of service.

II.4.3 The functions of the Finance Committee are as follows:

II.4.3.1 To ensure the viability of the Centre over time by:

i. determining that adequate funding resources are available in order to sustain the organization and its programmes,

ii. exercising a fiduciary role with regard to resources entrusted to the organization, and

iii. overseeing financial operations through budgetary review, ensuring the implementation of sound investment policies, and authorization and enforcement of accepted accounting procedures.

II.4.3.2 To consult with the Head of Finance and his or her team on the Centre's key financial activities for the period of October through

March at the June Board meeting and the period of April through September at the November Board meeting.

II.4.3.3 To assess the Centre's financial performance, based on the Centre's income, expenditures and investments.

II.4.3.4 To review financial indicators including: an examination of how donor contributions have increased or declined; the source of donor contributions; the balance between restricted (direct project funding) and unrestricted funds awarded to the Centre; annual, cumulative and projected deficits.

II.4.3.5 To recommend to the Board to approve the Audited Financial statements presented at the June Board meeting along with the Auditor's Report for the previous fiscal year.

II.4.3.6 To recommend to the Board the approval of the appointment of Auditors' for the Centre and the payment of fees.

II.4.3.7 To recommend to the Board the approval of the annual budget as proposed by the Centre's management.

II.4.3.8 To make recommendations to the Board on how to better allocate Centre resources to assure its continued financial viability, based on financial information and advice provided by the Centre's accountants and financial advisors.

II.4.3.9 To prepare Draft Resolutions and proposals regarding financial matters, which require the Board's approval. Such financial matters include but are not limited to: the approval the Centre's overdraft facility; the withdrawal of funds from the Centre's investment accounts such as the Endowment funds and reserve fund; the appointment or change of banking institutions, financial managers and investment firms; and, the change of banking signatories or individuals authorized to sign financial documents on behalf of the Centre.

II.4.3.10 To review financial information including a forecast and financial assessment of the impact of any recommendations of changes in the salary structure as recommended by the Director, the Centre's management, employees of the Centre, the Human Resources Committee of the Board or other Committees of the Board.

II.5. Fund Development and Oversight Committee

II.5.1. *Composition*: The Fund Development and Oversight Committee is composed of four members of the Board of Trustees from the following regions: 1 Trustee from a developed country, 1 Trustee from Bangladesh, 1 Trustee from another developing country and the Director.

II.5.2. *Term of Service on the Committee*: The members of the Fund Development and Oversight Committee will serve one-year terms beginning December 1st of each year, except for the Director, who shall serve for at least the first two years of his tenure as Centre Director. Appointments to this Committee can be renewed for two consecutive terms. No Trustee shall serve more than

three consecutive years, unless such Trustee has professional expertise and experience in fund development and was selected as a Board member primarily due to his fund development expertise.

II.5.3. *Functions* of the Fund Development and Oversight Committee are as follows:

II.5.3.1 To support the fundraising function of the Office of External Relations and Institutional Development (ER&ID) in the following manner:

i. To approve fundraising strategies prepared by ER&ID and endorsed by the Director of the Centre.

ii. To appoint one Trustee to represent the Board for the annual Hospital Endowment fundraising event or any other key fundraising events world wide.

iii. To identify individual trustees who can assist the Centre in introducing the Director and the ER&ID officers to potential donors or those who will be approached for specific donations.

iv. To appoint, where appropriate, Trustees, former Trustees or other key individuals to accompany the Director of the Centre, the Head of ER&ID, officers of ER&ID and members of the senior management team on visits to donors and potential donors to the Centre.

v. To recommend approval of the members of the Fund Management Committee.

vi. To encourage Trustees to participate in the Centre's fundraising initiatives through direct financial support and expanding the network of contributors to the Centre.

II.5.3.2. To oversee the activities of the Centre's Endowment funds through the following means:

i. Review and approve any change in the Bylaws of the Board of Trustees or of the U.S.-based Fund Management Committee, where such changes affect the management of or distribution of funds from any of the Centre's Endowment accounts.

ii. Review the financial statements of the Centre's portfolio of investments prior to the Committee meetings and provide any comments on the portfolio of fund assets at the Committee meetings.

iii. Review reports to the Board of Trustees prepared by the Fund Management Committee of the Centre's endowment portfolio and provide comments to the Board when deemed necessary.

II.5.4 *Creation of an Advisory Board*: The Fund Management Committee may make recommendations to the Board of Trustees of individuals to serve on an Advisory Board to assist the Board of Trustees with fundraising. The Fund

Management Committee may recommend individuals in the following categories to serve as members of the Centre's Advisory Board:

i. former Trustees who have demonstrated continued interests in expanding the Centre's donor base;
ii. individuals with expertise and a track record in fundraising; or
iii. individuals who have contributed substantial resources in the global health community.

II. 6 National Liaison Committee

II.6.1. *Composition*: The National Liaison Committee shall be composed of four Trustees, including the Director and one Trustee that is a representative of the Government of the People's Republic of Bangladesh. The Chairperson of the Committee shall be a national of Bangladesh.

II.6.2. *Term of Service*: Members of the National Liaison Committee shall serve at least one term of two consecutive years.

II.6.3. The National Liaison Committee advises the Director on the progress made in expanding health research, services and training activities between the Centre and national institutions. In doing so, the Committee will provide oversight on the activities of the Centre's Programme Committee. In consultation with the Programme Committee, it will ensure that the Centre is supportive of and avoids actions prejudicial to the interest of research in similar fields carried out by local NGOs, national research institutes and other national organisations in Bangladesh.

II.7. Human Resources Committee

II.7.1. *Composition*: The Human Resources Committee is a Committee of the Whole composed of the Full Board. One member of the Board of Trustees shall serve as Chairperson and one Board member shall serve as an alternate or Deputy Chairperson.

II.7.2. *Chairperson and Term of Service*: The Human Resources Committee Chairperson shall be appointed for at least two consecutive years, the term of service beginning on December 1st of each year. The Human Resources Committee Chairperson may be re-appointed for the duration of their proscribed term of service.

II.7.3. The functions of Human Resources Committee are as follows:

II.7.3.1. To recommend to the Full Board the creation of new positions at the international professional level as recommended by the Head, Human Resources.

II.7.3.2. To provide oversight of the strategic manpower plan to ensure that key posts within the Centre are filled timely.

II.7.3.3. To evaluate and approve the selection process to fill vacant international professional posts.

II.7.3.4. To examine the credentials and qualifications of individual candidates selected by the Centre's management team to fill vacant international professional posts at the P-5 level and above. To make final recommendations to the Full Board in the selection of such internationally recruited staff.

II.7.3.5 To ensure that the Centre's compensation and appraisal structures for both international professionals and national officer categories provide a fair and equitable method for rewarding employees to encourage their maximum contribution in achieving the Centre's goals.

II.7.3.6 To monitor the Centre's policies and procedures to ensure gender equality.

II.7.3.7 To review the qualifications of the candidates nominated in accordance with the ordinance to serve as Trustees and make recommendations to the Full Board using the following criteria for selection:

(i) Requirement under Sec. 8(3) of the Ordinance regarding membership, from developed and developing countries;
(ii) Equitable geographical distribution;
(iii) Balance of different disciplines represented in the Board; and
(iv) Gender Balance.

II.7.4. The Human Resources Committee shall make recommendations to the Board to approve Centre-wide policies that create or change systematic approaches to compensation, promotions and changes in the pay scale.

II.8 Programme Committee

II.8.1. *Composition*: The Programme Committee is a Committee of the Whole composed of the Full Board. One member of the Board of Trustees shall serve as Chairperson and one Board member shall serve as an alternate or Deputy Chairperson.

II.8.2. *Term of Service*: *Chairperson and Term of Service*: The Programme Committee Chairperson shall be appointed for at least two consecutive years, the term of service beginning on December 1st of each year. The Programme Committee Chairperson may be re-appointed for the duration of their proscribed term of service.

II.8.3. The Programme Committee advises the Director on the organisation of the Scientific Programme, which includes:

II.8.3.1. Reviewing any plans for scientific outputs of the Centre and making recommendations to the Full Board for endorsement or changes of any proposed plans, including the Centre's Strategic Plan.

II.8.3.2. Approving review procedures for Scientific Reviews of the Centre's Programmes and Divisions, including the specific activities to be reviewed.

II.8.3.3 Providing to the Director and senior management team the Board's final evaluation and assessment of the Centre's Programme or Division reviews.

II.8.3.4 Monitoring and reviewing the procedures of the external Scientific Review Committee that carries out a technical review of the Centre's scientific programmes as prescribed in Section 12(3) of the Ordinance.

II.8.3.5 Reviewing the Centre's coordination of its research activities with other institutions in Bangladesh.

III. Call of Meeting of the Board

III.1. General Meeting of the Board

III.1.1. The procedures and protocol governing General Meetings is set forth in Section 10 (1)-(3) of the 1978 Ordinance. A majority of the sitting membership shall constitute a quorum.

III.1.2 A General Meeting of the Board shall take place in the fourth quarter of the calendar year but no later that 15th November on an annual basis. Additional general meetings of the Board may be agreed to by the Full Board in accordance with Section 10 (1)-(3) of the 1978 Ordinance.

III.1.3 The Executive Assistant, a person designated by the Director, who is not a member of the Board, shall prepare summary records of meetings of the Board. The Executive Assistant shall distribute these to Trustees as soon as possible after the close of the meeting to which they relate. Trustees shall inform the Executive Assistant in writing of any corrections they wish to have made, within such period of time as the Executive Assistant may specify, taking the circumstances into account.

III. 2. Special Meetings of the Board

III.2.1. The Chairperson shall convene such special meetings of the Board as are regarded as necessary to conduct business of the Centre. He will provide notice by electronic means of such meetings to the other Trustees not less than 30 days in advance and shall indicate at that time the reason for the meeting.

III.2.2. The Chairperson shall convene special meetings upon a request subscribed by five or more Trustees, provided the Trustees state fully in writing and disseminate to other Trustees by electronic mail or other telecommunications the reason for the meeting. The agenda of such meeting shall be limited to the questions having necessitated the meeting.

III.2.3. Should the Chairperson be unavailable by reason of incapacity to convene a special meeting, the call for such a meeting may be issued and convened by the Director.

IV. Agenda of the Meeting

IV. 1. A provisional agenda of each meeting will be drawn up by the Director in consultation with the Chairperson and circulated at least three weeks prior to the meeting with the relevant documents.

IV.2. The agenda of each regular meeting will include:

IV.2.1 Items which the Board has carried over from a previous meeting;

IV.2.2 Any item proposed by a Trustee, including the Director.

IV.3. Any proposals, except carry-over items for the agenda at a regular meeting, must reach the Director not less than four weeks before the commencement of the meeting.

IV.4. In addition, the agenda of at least one meeting of the full Board a year will include the approval of:

IV.4.1 A proposed annual budget of receipts and expenditures; and

IV.4.2 A report of activities and finance (as prescribed in Section 18 of the Ordinance) for the previous year

IV.5. The Board shall not ordinarily proceed unless it determines otherwise, to the discussion of any item on the agenda until at least 48 hours after the relevant documents have been made available to the Trustees.

V. Voting Rights

V.1. Voting at General Meetings of the Board

V.1.1. No Trustee may vote at any Board meeting by proxy or by any other methods than in person.

V.1.2. Except as otherwise specifically provided in the Ordinance and in the Bylaws, all decisions of the Trustees shall be made by a majority of the votes cast.

V.1.3. The Board shall normally vote by show of hands, unless a Trustee should request a secret ballot.

V.2. Voting Without Meeting of the Board

V.2.1. Whenever any actions must be taken by the Board which, in the judgment of the Chairperson, should not be postponed until the next General meeting of the Board and does not warrant the calling of a special meeting, the Chairperson shall present to each member by electronic mail or other

telecommunications a motion embodying the proposed action with a request for a vote by electronic mail with signature within a given time.

V.2.2. If any Trustee objects, the matter will be deferred to a General Meeting or a special meeting called by the Chairperson to consider the matter.

V.2.3. At the end of the period prescribed for voting, in the absence of objection, the Executive Assistant shall record the results and notify all the Trustees. If the replies received do not include a majority of the number of Trustees, which would be required for a quorum at a meeting, the matter shall be deferred to the next meeting.

VI. Elections of the Chairperson of the Board

VI.1. *Venue and Requirements*: The Board Chairperson shall be elected at the November meeting of the Full Board, where a quorum of the Board is present. The election for the Chairperson cannot be conducted through electronic mail or other telecommunications.

VI.2 *Balloting*

VI.2.1. Vote shall be conducted by secret ballot.

VI.2.2. Each member of the Board proposes one name only by ballot. The name obtaining a simple majority of votes will be elected Chairperson.

VI.2.3. If the candidate elected is unable or unwilling to serve, the procedure shall be repeated in full.

VI.2.4. If there is no majority, the two names with the highest number of votes will be regarded as candidates.

VI.2.5. A ballot with two names is regarded as void.

VI.2.6 Should a tie vote occur, the incumbent Chairperson will not vote.

VI.3. *Procedure for Counting the Ballots in the Election of the Board Chairperson:* The Director and the Executive Assistant to the Board shall count the ballots. The Executive Assistant shall report the result to the Full Board and record it in the minutes of the Board meeting.

VII. Trustees

VII.1. *Terms of Service:* The terms of Trustees (except the Director) shall begin upon appointment and shall extend for three years

VII.2. *Attendance:* A Trustee shall attend at least two General meetings of the Full Board during his or her Term of Service. The Full Board may select a replacement of any Board member who fails to attend two consecutive General meetings of the Board.

VII.3. *Honorarium:* Each Trustee shall receive an honorarium (the Director shall not receive the honorarium) for each day spent on the business of the Centre,

and shall be reimbursed for the actual costs of travel on the business of the Centre, and shall receive a per diem as specified by the regulations of the Centre while travelling on the business of the Centre.

VII.4. *Personal Expenses* The Board of Trustees shall set the levels of honorarium and reimbursement for the purpose mentioned in Sec. VII.3, bearing in mind the financial resources to the Centre and the practice of other comparable organizations.

VII.5. Selection of Trustees

VII.5.1. **Nomination Process**

VII.5.1.1 The following rules shall apply to nominating candidates to fill a vacancy on the Board of Trustees with the exception of the position of Director of the Centre.

VII.5.1.2. *Notice*: For the purpose of holding elections to fill vacancies in seats of members at large as specified in Sec. 8(1)(d), of the 1978 Ordinance, the Director of the Centre by notification shall invite nominations from the following:

(i) Members of the Board of Trustees
(ii) The six regional offices of the World Health Organization
(iii) Countries that have demonstrated their interest in the functioning of the Centre
(iv) Relevant research institutions

VII.5.1.3. All nominations must be received by a closing date as specified in the notice.

VII.5. 2. Qualifications of Board candidates

The nominated individuals shall be persons qualified to serve by reason of scientific, research and administrative or other appropriate experience in accordance with Sec. 8(4) of the 1978 Ordinance, and the nomination should be accompanied by a statement of facts to that effect.

VII.5.3. Selection Process

VII.5.3.1. *Vote Conducted by the Full Board:* The Board of Trustees will select new Board members in accordance with the voting procedures set forth in Section V.1.3. of the Bylaws.

VII.5.3.2. The Board will select one of the Trustees, who is not a candidate for election, to preside over the meeting, in case the Chairperson is a candidate for re-election as a Trustee.

VIII. Fiscal year

The fiscal year of the Centre shall be from 1 January through the following 31 December.

IX. Retirement Fund

As provided by Resolutions 9/Dec. 83 and 5/June 84, the Retirement Fund for the Centre's staff was established. This fund does not constitute an asset of the Centre and as such is not governed by Article 32(2) of the Centre's Ordinance.

X. Amendments

These Bylaws may be amended only by a majority vote of the Board of Trustees at a meeting of the Trustees where a quorum is present. The Board may amend the Bylaws only if a majority of the Trustees present at the prior meeting of the Board approved those proposed changes in the Bylaws at that meeting.

XI. Indemnification

Every member of the Board of Trustees shall be indemnified by the Centre against all expenses and liabilities, including counsel fees, reasonably incurred or imposed upon such member in connection with any threatened, pending or completed action, suit or proceeding to which he/she may become involved by reason of his/her being or having been a Trustee, or any settlement thereof, unless adjudged therein to be liable for negligence or misconduct in the performance of his/her duties. The Trustee will provide the Centre with prompt written notice of any claim, suit, action, demand, or judgment for which indemnification is sought.

If the Centre agrees to provide attorneys reasonably acceptable to the Trustee to defend against any such claim, the Trustee shall cooperate fully with the Centre in such defense and will permit the Centre to conduct such defense and the disposition of such claim, suit, or action (including all decisions relative to litigation, appeal, and settlement). In such cases where the Centre agrees to defend against such claims, the Centre shall keep the Trustee informed of the progress in the defense and disposition of such claim and to consult with the Trustee with regard to any proposed settlement.

The foregoing right of indemnification shall be in addition to and not exclusive of the right set forth in Section 15 of the 1978 Ordinance.