Introduction

HDI is, and aims to continue being, a small organization where resources are focused on achieving maximal effect from relatively modest funds. As a catalyst uses small resources to achieve significant changes, we provide important beneficial impacts for large populations of those suffering unnecessarily from easily preventable diseases that cause personal denigration and poverty, currently guinea worm disease and lymphatic filariasis (elephantiasis).

During our financial year ended June 30, 2002, HDI’s administrative expenses were less than 0.01% of donated medicines and grant funding, and 2.1% of grant funding for the year.

The book, “Basic Lymphoedema Management” is a highly acclaimed health education and training resource, that HDI was instrumental in getting published during 2002, in support of Lymphatic Filariasis (LF; elephantiasis) Elimination efforts world-wide.

In Africa, HDI-assisted mass drug administration efforts reached 1.8 million Ghanaian and Togolese people during 2002, to help stop lymphatic filariasis transmission. HDI-supported country programs trained 2,423 individuals in various aspects of LF elimination during 2002.

Guinea worm disease (dracunculiasis) now exists only in Africa, and HDI was privileged to be assisting 8 countries that have almost achieved the goal of eradication, as well as war-torn Sudan where more than 80% of the world’s cases remain.

HDI's Executive Director with President Jimmy Carter and our trustee Dr. Donald R. Hopkins (largely covered, behind Mr. Carter), in Oslo the evening before presentation of Nobel’s Peace Prize. (See p. 7. about Nobel Peace Prize Celebrations)
Guinea Worm Eradication, Including Guinea Worm Rewards

Summary
The Conrad N. Hilton Foundation has generously provided HDI with a grant of $300,000 ($100,000 per year) over three years beginning in 2002, for Guinea worm eradication activities in low and middle endemic countries with a particular focus on those with fewer than 100 cases. The grant is also in support of the system of Guinea worm rewards being implemented in all endemic countries except Sudan, Ghana and Togo. The grant was made in response to the proposal put forward by HDI in October of 2001.

The four kinds of activities supported by The Conrad N. Hilton Foundation grant are:

- Technical assistance and program support at critical junctures to countries that have not reduced the number of cases to zero, but have fewer than 100 cases (Benin, Central African Republic, Ethiopia, Mali, Mauritania, Togo, and Uganda)
- Active case searches in selected countries during peak transmission season (such as Ivory Coast and Ethiopia)
- Guinea worm rewards
- Short-term field consultants

In 2002, HDI committed funds to Guinea worm eradication activities in six countries using Conrad N. Hilton funding—Benin, Ethiopia, Mali, Mauritania, Niger, and Uganda—under categories 1, 3, and 4, and in two additional countries using other funds for different administrative reasons. We anticipate that active case searches (category 2) will be of critical importance towards the latter part of the grant period.

Together, from October 2001 to October 2002, the total number of Guinea worm cases in the Hilton-supported countries mentioned above went from 928 to 900. Mauritania, Niger and Uganda all enjoyed a reduction in cases ranging from 46% in Niger to 88% in Uganda, while Benin, Ethiopia and Mali experienced an increase in cases.

It is important to note that increases or decreases in cases reported during 2002 are the result of work done by the national programs during 2001, before this grant became available. Due to the one-year incubation period of Guinea worm, improvements in the number of cases as a result of this grant will only become evident during 2003.

However, feedback from recipient countries indicates that the Hilton Foundation’s funding has played a crucial role, even in this first year. As the number of cases continues to fall, we anticipate that the importance of the grant to recipient countries will increase even further.

Guinea Worm Eradication Activities In Specific Countries

Benin
During the annual Program Review for endemic Francophone countries on October 28th-30 in Nouakchott, Mauritania, it became clear that Benin needs to keep the four locally recruited
technical field assistants currently assigned there, and to have them further intensify containment activities. Through October, the number of cases had increased by 100%, from 49 during the first 10 months of 2001 to 98 cases during that same period this year. Some, but not all of this, is due to the undetected importation of cases in 2001 from a highly endemic area in Togo, just adjacent to the Benin border - an area where the Togo program has until recently been struggling.

While the Benin program is experiencing difficulties, one of the roles of HDI is to be able to address critical situations as they arise. Therefore, HDI provided $53,000 to Benin to enable them to intensify interventions in the form of case containment activities, to improve supervision, and to retain the four needed field assistants.

Because Benin has fewer than 100 cases, The Carter Center is dramatically cutting back on support to Benin for 2003, in accordance with the agreement between WHO, UNICEF, and The Carter Center under terms of their Gates guinea worm eradication grant. It is nevertheless critically important that interventions continue in Benin and are intensified without interruption. Amounts to be provided to Benin during 2003 will therefore have to be decided based on their progress and the situation, as analyzed at the April 1-3, 2003 Program Managers Meeting in Kampala.

**Cameroon**
An allocation of $1,150 was made to Cameroon for rewards in 2002, using non-Hilton funds. For the first time, only one imported case came from Nigeria in 2002, and Cameroon has reported zero indigenous cases since 1997.

**Ethiopia**
In accordance with its request, Ethiopia was allocated $1,905 in 2002 for Guinea worm rewards and cases containment activities.

In 2001, Ethiopia was down to just 10 cases, and we were hopeful that they might have interrupted transmission last year. Because Ethiopia's endemic area is adjacent to war-torn Sudan where more than 80% of the world's cases remain, and because of population movements into accessible areas of Ethiopia from a disputed and inaccessible area along the Sudan border (Akobo), Ethiopia experienced 47 cases this year, of which 40 were reportedly contained. Though the funds provided may seem modest, without the reward system and case containment provisions that this grant makes possible, Ethiopia would surely not have achieved this 84% containment rate in such remote locations, far from the program’s offices in the capital.

Ethiopia has not yet provided detailed plans for 2003 or indicated how its current plans are being modified in view of the unexpected resurgence in case numbers. Still, we anticipate that program support may be necessary for Ethiopia in 2003 at a somewhat higher level than the $824 they received for non-reward activities in 2002.

**Mali**
Mali’s situation is mixed, having experienced problems in part of the country, while they successfully introduced rewards and essentially interrupted transmission in most of the country.
Mali recorded 93% of this year's 552 cases through October in just three districts, although the total itself represents an increase of more than 43%. It became clear at the Francophone Program Review that "...neglect of this area by Mali's program before August 2001 is a major reason why the level of disease is much higher in that part of the tri-border area. " (Burkina Faso and Niger are the two countries that share a border with Mali in this area, where years of insecurity in Mali, as well as the nomadic lifestyle of the inhabitants on all sides of those borders, have posed particular challenges.) The fact that these areas have been accessible during the past year or so, combined with the intense focus on this area as a source of acute embarrassment to the Mali program, have led to greatly intensified attention to this region with Carter Center support. In Mali, HDI is so far only responsible for support of the Reward System, as in all countries implementing that intervention.

In the western part of the country, transmission of Guinea worm disease has essentially been halted. Rewards began being offered at the initiative of President A. T. Toure, who encouraged the program to begin using this intervention, as HDI has also been encouraging Mali to do for several years. With the increased attention to the problem areas during the latter part of 2001 and all of 2002, as well as the introduction of rewards in the least endemic parts of the country, there is hope that Mali will again experience a marked drop in cases during 2003.

The total allocation to Mali during 2002 was $14,886, and we anticipate that their needs will be on the same order for 2003.

**Mauritania**

The Mauritania program is doing reasonably well, having reduced the number of cases to 40 as of November this year, compared with 91 during the same period of 2001. Almost all of Mauritania's cases are now confined to a fairly large, triangular area near the southern border of the country, adjacent to Mali and Senegal. Program activities could be intensified and, in March of 2002, HDI worked with the national program in an effort to encourage it to take a more active stance and modify its approach to case containment. We hope that the program's current plan to decentralize its operations during 2003 will allow more active case containment to occur.

HDI allocated $12,000 to Mauritania during 2002, and we anticipate that a similar amount will be adequate during 2003.

**Niger**

The Niger program is doing well, thanks to the diligent team leading its Guinea worm eradication efforts. Cases decreased by 62 percent during the first nine months of this year, and the case containment rate increased from 57% to 71% since 2001. Nevertheless, Niger needs to pay special attention to the same tri-border area near Mali. While Niger reported only 107 indigenous cases for the first nine months of 2002, they experienced an outbreak of 74 cases in their Tillaberi Region, adjacent to Mali, where only 14 cases were reported in October of 2001.

Niger is another country which has been rather reticent about introducing Guinea worm rewards, but which began implementing this strategy to improve case detection and containment in a limited area during 2002. Niger intends to expand its reward system, making it available nation-wide during 2003. Therefore, we anticipate needing to allocate more during 2003 than the $9,225 provided to Niger during 2002.
Nigeria
Using non-Hilton funding, HDI also provided support for guinea worm rewards in a part of Nigeria with few if any remaining cases, lying far from remaining endemic areas.

Although Nigeria still has the third highest number of cases, progress in this huge and difficult nation has been extraordinary! Nigeria reported only about 3,000 cases during 2002, compared with 650,000 cases in 1989.

The majority of the remaining cases are confined to a few areas of the country. This means that huge parts of Nigeria are now completely free of guinea worm disease, surrounded by more areas of low endemicity. Nigeria has been very keen to completely free large areas from guinea worm as quickly as possible, so as to be able to concentrate fully on the remaining problem areas. They have therefore introduced rewards in a few, selected formerly endemic areas.

During 2002, HDI therefore provided $8,000 to Nigeria for this purpose, but not from the Conrad N. Hilton Foundation funds, in as much as Nigeria was not originally encompassed by our proposal to that foundation.

Uganda
Uganda achieved an 88% reduction in cases this year, more than any other country, bringing the number down from 50 indigenous cases last year to only 7 indigenous cases this year. They also detected 15 imported cases from Sudan, bringing the total to 22 through December, of which 16 were reportedly contained.

Uganda was allocated $7,400 during 2002, all of it for rewards and case containment centers. While the number of cases should be even lower next year, and hopefully restricted only to imported cases, we anticipate Uganda may need a similar amount in 2003.

Conclusion - Guinea Worm Activities in Low-Endemic Areas
The $100,000 provided by the Conrad N. Hilton Foundation during 2002 has played and continues to play tremendously important roles in the six countries where the funds are currently being used, and HDI used other funds to support rewards in two additional countries.

Thus, HDI helped three countries effectively contain cases in "containment houses" where patients are voluntarily admitted and cared for until their guinea worms have completely emerged. Also, rewards are being offered in eight countries or areas within these countries, where few or no cases remain.

As other partners are finding it difficult to focus on low and middle endemic countries, this grant is also proving tremendously important in Benin, a middle-endemic country, where funding is being provided to improve supervision and case-containment activities with the help of four locally recruited field assistants.
Sudan Guinea Worm Eradication Project

HDI had the stunning good fortune to win an important election early in 2002. Norway’s medical students in all 4 universities voted to dedicate their bi-annual Humanitarian Action Campaign to guinea worm eradication efforts in Sudan, in 2003.

During a week in September 2003, they anticipate raising approximately 2 million Norwegian kroner (roughly $300,000), which will go unshorn to the purchase of medical kits for village volunteers in all of Sudan’s up to 10,000 endemic villages. Remaining funds will be used to purchase an estimated 500,000 pipe filters, to supplement the more than 9 million distributed under the Norsk Hydro pipe filters project in 2001.

As with our previous major initiative in Sudan, this effort is being undertaken in close collaboration with, and support from, Norwegian Church Aid and The Carter Center.

During November of 2002, our Executive Director was privileged to escort a medical student representative from each of Norway’s four universities on a visit to both northern and southern Sudan, together with a representative from Norwegian Church Aid whose services were generously donated by them. Also, HDI funded participation by a professional documentor, who helped the students record their experiences so as to better enthuse their fellow students about the project in the run-up to the September Humanitarian Action Campaign. Remarkably, the students all paid their own airfare when their applications for other funding for this important field visit were turned down!

Two Norwegian medical students also volunteered to help eradicate guinea worm in the field.

Leaders and villagers in and around the government controlled town of Juba in the far south of Sudan, where greatly inspired that not only their national guinea worm eradication program, but also a young lady from a remote country, thousands of kilometers away, cared enough about their well-being to come and work shoulder-to-shoulder with them for weeks on end in their efforts to free themselves of this debilitating, impoverishing, eradicable disease!

At the writing of this report, another young lady is still inside southern Sudan, similarly helping to eradicate guinea worm through a 3-month period in villages accessible from the Nairobi side.
The Nobel Peace Prize Celebrations

Our Norwegian trustees, Dr. Harald Siem and our Executive Director /trustee Dr. Anders R. Seim had the great pleasure of hosting a reception in honor of Mr. Jimmy Carter’s colleagues and senior health advisors, who came with him to Oslo on the occasion of his receiving the Nobel Peace Prize. Among others, these included two of HDI’s own trustees, Drs. Donald R. Hopkins and Peter Bourne. Hospitality for the event was generously provided by the major Norwegian law firm, Advokatfirmaet Grette. Former Foreign Minister, currently Ambassador in Washington, Mr. Knut Vollebæk, and former Minister of Health, Dr. Werner Christie, were among the dignitaries, industry leaders, Norsk Hydro union- and administration representatives, and other invited guests. In recognition of our collaboration on last year’s massive pipe-filters project in Sudan, Norsk Hydro kindly invited our Executive Director to several functions during the Peace Prize celebrations, including a meeting and photo session with President Carter the evening before the Peace Prize ceremony.

Lymphatic Filariasis Elimination (LF)

HDI has managed to help benefit about 1.8 million people in LF areas in 2002, thanks to the Bill and Melinda Gates Foundation, and The Conservation, Food and Health Foundation. We also helped publish a book that should benefit sufferers of LF in all 83 endemic countries around the world.

General Introduction – Filariasis Activities

HDI-assisted distribution of ivermectin and albendazole tablets reached 1,797,678 people in 2002, of which 574,526 are in Togo and 1,223,122 in Ghana. Togo completed its scaling-up process by aiming to distribute drugs to its entire at-risk population, making it the first country in Africa to reach this milestone on the way towards LF Elimination. HDI-supported country programs trained 2,423 individuals in various aspects of LF elimination.

We continue to be an active member of the Gates Grant Review Committee, which manages $20 million in funds provided by the Bill and Melinda Gates Foundation to a wide variety of organizations through the World Bank over 5 years.

HDI directly supports endemic countries, with regard to
- disability prevention and alleviation, concerning both surgery and lymphoedema
- administration of national programs
- training
- supervision
- mass drug administration.

Feed-back from partners in various countries indicates that the Conservation, Food and Health Foundation and the Bill and Melinda Gates Foundation are making important contributions to the elimination of LF, through their support to HDI, for which we are very grateful.
Ghana

As part of its collaboration with HDI, Ghana receives approx. $100,000 in annual support of its LF activities under the Gates Grant. To facilitate the smoothest possible operation and reduce costs, these funds are at our suggestion sent directly to Ghana, not via our accounts. Ghana has expanded its LF Elimination program massively in the past two years. In brief:

- 1.22 million people received drugs (achieving a coverage of 74.1% in a population of 1.65 million (of whom 1,495,600 were eligible for treatment);
- HDI is the donee for Mectizan (ivermectin) being donated by Merck & Co, to use in Ghana for LF elimination, valued at more than $7.9 million;
- HDI supported specialized over-seas training for 2 senior urologist consultant surgeons, in ultrasound diagnostics and LF surgery;
- Ghana held the first hands-on surgical training workshop in Africa, during 2002, taught by the Ghanaian senior urologist consultant surgeons who had received additional over-seas training with the assistance of HDI;
- HDI was able to help the UK government channel funds for LF activities in Ghana;
- Ghana trained 2,049 volunteers and 227 supervisors for drug distribution in the past year;
- HDI provides additional national secretariat support to the Ghana program, not funded by the Gates Foundation;
- HDI has worked with the Ghana team during 2002 to encourage recruitment of additional NGOs, especially national Ghanaian NGOs in support of the program. That process is still under way.

Togo

The Conservation, Food and Health Foundation, generously provided $25,000 in support of specific LF elimination activities in Togo during 2002.

This grant allowed us to support continuation of the start-up phase of the program to Eliminate Lymphatic Filariasis from Togo, at a time when no other funding for this purpose was available. Although Togo’s Ministry of Health had not focused on LF as a health priority until 1997, at HDI’s urging the Ministry then decided to undertake a national elimination program, making Togo the first Francophone country in Africa to do so. Thanks to the HDI and Conservation, Food and Health Foundation support, and additional support subsequently proffered by the UK Government’s development assistance arm (DFID), Togo has been able to expand its activities and is now becoming the first country in Africa to implement LF elimination activities in all its endemic areas.

Specifically, the Conservation Food and Health Foundation grant was to:

1) Train 35 health workers on simple, careful daily hygiene with soap and water for affected limbs, after which they were to serve as trainers for health workers at the regional and village level.

2) Train all of Togo’s 2-3 urologists and at least the one general surgeon in each of the five Regions on the new hydrocele surgery techniques developed by a Brazilian research team.

3) Ensure that alleviation of suffering becomes an integral part of Togo’s elimination program, in addition to the mass distribution of drugs that interrupt transmission.
4) Help create a well-functioning national team for coordinating the program over the long-term.
5) Establish a mutually beneficial, sustainable relationship for collaboration between Togo and Ghana in their respective LF elimination programs.
6) Assist the Togolese government to secure long-term program funding.

Togo reports having reached 574,526 people through its mass drug administration activity during the calendar year of 2002, achieving a 73% coverage in its target population of 784,594 people. All 7 endemic districts (prefectures) are targeted for treatment during the current treatment cycle, but distribution only starts end-January 2003 in the last two districts, bringing the total at-risk population under annual treatment to 1,123,757 and completing the scale-up to all endemic areas of Togo. As in Ghana, HDI is the donee of Mectizan (ivermectin) being donated by Merck & Co to Togo for LF elimination, valued at almost $1.4 million for 2003.

With HDI support (Conservation, Food and Health Foundation funding), Togo now has a secretariat staff member working full-time on LF elimination, compared with the previous situation where all of the team was also involved in other activities. The program now also has its own office within the Ministry of Health compound, furnished and equipped by HDI, whereas it previously operated “out of the briefcase of the program manager”.

HDI encouraged the Liverpool LF Support Center to provide UK government funds. Unfortunately, there was a delay in the transfer mechanism, through no fault of HDI or the Liverpool LF Support Center. The late arrival of funds (insufficient funds during mass drug administration) has been blamed for the relatively low coverage achieved during drug distribution in 2002.

This delay in promised UK government funds caused the program to rely almost completely on the River Blindness Program (which normally distributes ivermectin alone, and only to some of the areas where LF exists), for help during one round of drug distribution. A survey conducted to study the effect this had on drug distribution for LF, seems to give the impression that coverage was maintained at a surprisingly high level but not close enough to the 80% coverage level that is thought to be needed to interrupt transmission.

Although one can hope for UK government funding also for future years, we cannot yet claim to have successfully “helped Togo secure long term funding” for its LF program.

To date, a total of 2,374 community drug distributors and 147 health care professionals have been trained in the various aspects of the LF elimination program, in Togo’s 7 endemic prefectures. Training in disability alleviation and prevention was given to 857 people in 2002, especially in the 2 districts benefiting from mass drug administration for the first time during the current treatment round.

A training workshop on urogenital surgery in LF was projected for Togo in 2002, with participation from all endemic Francophone countries that have national LF elimination programs. The workshop was to be conducted by urologists from International Volunteers in Urology (IVU), because the group in Brazil was unavailable. Unfortunately, the workshop had to be postponed several times, in spite of concerted efforts by both IVU and HDI, and a planning-visit to the country by IVU’s leader. This workshop is now planned for May 2003.
The NGO-strengthening grant from the Bill and Melinda Gates Foundation allowed HDI to make important contributions to LF elimination at the global level. We managed to stimulate and facilitate completion of training materials of major importance, in the form of the book, “Basic Lymphoedema Management; Treatment and Prevention of Problems Associated with Lymphatic Filariasis”. HDI’s Trustee, Dr. David Addiss is one of the two main authors of this landmark book, about which Prof. Eric Ottesen, (formerly “the world’s dean of LF research” at the National Institutes of Health in Washington, later of WHO, and now of Emory University), wrote, “What a treat it will be for those who face the vexing problem of managing lymphoedema and its complications to find this volume! Sure it will become for them a constant and trusted companion…”

Having designed it for health care workers with only a modest level of education, the authors impressively balance the need for uncomplicated language without the information being simplistic. This health education resource has received strong reviews in the medical press.

So far, HDI has distributed an initial 5 free copies, to each of the world’s national LF elimination programs.

Publication of the Basic Lymphoedema Management book in French is also in progress. Translation and proof-reading are being done in Burkina Faso, as another expression of HDI’s emphasis on south-south support, while publication and printing will be by the same firm that so successfully published the English version, Hollis Publishers in New Hampshire, USA.

**Alleviating Urogenital LF Disability**

As yet a manifestation of HDI’s support for south-south collaboration, we were pleased to sponsor participation at the First International Course on Ultrasonography in Lymphatic Filariasis, in Recife, Brazil, by two internationally respected Ghanaian urologist surgeons, Dr. Sunny Mante and Dr. Ken Aboah. Subsequently, we sponsored Dr. Mante to attend a work-shop on urogenital LF-surgery, taught in Haiti by the same Brazilian team (Drs. Joaquim Noroes and Gerusa Dreyer).

These courses became instrumental in forming Ghana’s policy on how urogenital problems due to LF are to be handled. Through Drs. Aboah’s and Mante’s participation at the
invitation of WHO, they also strongly influenced recommendations by a WHO informal consultation on surgery for LF.

Drs. Aboah and Mante used their previous expertise and new knowledge gained through these two workshops, to hold the first African hands-on surgical training workshop on treatment of LF manifestations in men.

Sierra Leone and LF victims there have even benefited from Dr. Mante’s new knowledge on LF, during his temporary assignment to the UN peacekeeping forces.

**Recruiting and working with other NGOs on LF Elimination**

HDI continued to be active in encouraging other NGOs to support of LF elimination, especially in Africa but also at the 2nd Global Alliance for LF Elimination meeting, in India, May 2002. HDI and Interchurch Medical Assistance (I.M.A.) planned and coordinated the successful NGO Workshop with Gates Grant support. Especially NGOs in India, but also international NGOs got interested in joining the LF elimination effort as a result of that event.

We also participated in the process that led to Gates Grant support being made available in Nigeria, and in Burkina Faso during 2002. As has I.M.A., we have worked with Ghana’s national program to encourage the recruitment of additional NGOs there, and we hope this work may bear fruit during 2003.

Among the NGOs that are already active members of the LF Global Alliance, HDI has been in particularly active collaboration with IVU and I.M.A. in the States and Amaury Coutinho in Brazil, as part of our activity within the Global Alliance for LF Elimination network.

**Strengthening HDI’s Situation as an NGO**

HDI did not hire an administrative assistant this year, after all. There were a number of reasons for that decision. We did, however, renew HDI’s outmoded computer equipment, procuring hardware and software that allows our executive director to do dictation straight into the computer, where it is converted into text. The new, more powerful equipment has considerably rationalized and strengthened HDI’s operation in this and other ways.

Based on discussions among trustees in early 2002, we began looking to identify a person as an assistant executive director. The aim is to have this person be located in the States, with special responsibilities in relation to Board development, reporting, and resource mobilization in close collaboration with the Norway-based Executive Director. This position requires a special combination of qualities, also in terms of ability for close team-work at a distance, combined with a high degree of independence. The position has not yet been filled.

Also, during the last months of the year we began using the Gates Grant to support the cost of office rent. Space had previously been provided pro-bono by the local medical group, since HDI was founded in 1990. This partnership of primary care physicians had now expanded and moved to another location with no space for HDI. We therefore began renting modest but well suited office space in a different building beginning in late 2002, and are very appreciative of the support the Gates Grant provides for that purpose.
The Josephine Bay Paul & C. Michael Paul Foundation in New York City again kindly provided an unrestricted donation to HDI’s work, at the suggestion of its trustee, Mr. Hans Ege, the retired Morgan Stanley banker. As part of his fundraising support, Mr. Ege also invited our Executive Director to a meeting of Norwegian-American New York businessmen.

Ms. Pam Wuichet of Project Resource Group and Mr. Phil Mazzara, both in Atlanta, Georgia, have continued to provide generously of their time and concern for HDI, as we strive to strengthen our Board and the breadth of our support.

Mr. Tom Johansen of Sollihøgda, Norway continues to volunteer generously, in helping us with financial planning and oversight.

Support through these specific actions and partners, as well as for the other activities outlined above, has been of very significant importance to HDI in 2002.

Plans and Commitments

In the year to come, we will do our best to help reduce guinea worm in the least-endemic countries, and hopefully begin to see the impact of support provided in 2002 by the Conrad N. Hilton Foundation. Also, we hope to see several additional countries reduce their guinea worm level to fewer than 100 cases.

A major part of HDI’s focus this year will be on the Humanitarian Action Campaign by all of Norway’s 3,000 medical students in the country’s 4 universities. During one week in September, they hope to raise about 2 million kroner (approx. $300,000), in order to supply a medical kit to the village volunteer in every endemic village on both sides of the front lines in Sudan. As described above, preparations are already well under way, and the intensity of our engagement will of course increase as the September 8-13th dates for the Campaign approach.

In support of lymphatic filariasis (LF) elimination, one of our main objectives is to see the French version of “Basic Lymphoedema Management” successfully to completion.

Because our funding of activities in Ghana exceeds what is received from the Gates Foundation and as we have no targeted funding in support of LF elimination in Togo during 2003, we must strive particularly hard to mobilize funds for these two areas of our work this year.

And we hope to see the fruits of Board development activities begun during 2002.

Not withstanding the tremendously generous funding for specific activities from the Conrad N. Hilton Foundation, the Bill and Melinda Gates Foundation, and support from our other donors, as well as the small percentage HDI uses in overhead compared with the value of funds and drug donations that we handle, our support for essential core costs and some key program activities remain precarious. HDI will for this and other reasons continue to focus its efforts to strengthen its Board of Trustees, its ability to support Board engagement, and its resource mobilization ability in the coming year, while maintaining HDI’s special characteristics.
HDI is, and aims to continue being, a small organization where resources are focused on achieving maximal effect from relatively modest funds (currently less than 0.01% of the value of donated drugs and grants). This will remain true, even as we strive to strengthen our organizational ability to carry out our objectives.

**Budget and Audited Accounts**

HDI’s budget for the year 2003, and our audited accounts, are available separately.

Photo credits:
David Burke, Norsk Hydro: Dr. Seim with President Carter
Øystein Rakkenes: Both photos of the medical students in Sudan