ANNUAL REPORT

2007

Mission Statement

Health & Development International (HDI) advances world public health, with particular emphasis on underserved populations, which, more than others, are significantly restricted in achieving sound health and economic development.

HDI aims to free populations of degrading, debilitating diseases that can be eliminated as public health problems, but are insufficiently addressed at the time HDI becomes engaged. HDI works in two principle ways: as a catalyst that helps stimulate new actions in responding to important issues, using modest resources, and to put a "finger in the dike," stepping in to solve problems that larger, more cumbersome, organizations are unable to address with the necessary speed and efficiency.

Executive Summary

The most exciting development in all of 2007, is that HDI and Niger launched **the world's first ever program for rapid prevention of obstetric fistula** and of maternal deaths due to obstructed childbirth, a pilot project in Niger's Bankilare Zone.

Bankilare is a multiethnic area that produces large numbers of obstetric fistula cases. HDI's Chair, ambassador Barbro Owens-Kirkpatrick, made great progress during a visit to Niger in April, which was built upon by HDI's Executive Director during a follow-up trip in June, and she officially launched the program on December 1st together with the Governor of Tillaberi Region.

In August, HDI completed a report on clinical and socio-economic outcomes after the first few years of its **West African LF Morbidity Project**. HDI provides post-graduate training to district surgeons, training they otherwise never would have access to. The project teaches an improved, WHO-endorsed surgical procedure for treatment of men who have (sometimes huge) accumulations of fluid in their scrotum due to Lymphatic filariasis. The evaluation was funded by a $50,000 sub-grant from the Bill and Melinda Gates Foundation through the World Bank, which paid for external evaluations in Burkina Faso, Ghana, and Togo. While unacceptably high rates of usually mild but sometimes catastrophic postoperative infections were seen in some settings when the antibiotic cover and/or other specifics prescribed under the procedure were not adhered to, especially during large surgery "campaigns," 92.4% of those found for follow-up in Ghana reported "very high satisfaction with the surgery." And most men not found for follow-up in the large Ghana study were apparently away because they were now employed, often doing agricultural work in other parts of the country, a very good sign.

Six of the eight HDI-assisted countries reported zero cases of Guinea Worm Disease in 2007. Niger, had an 90% reduction from last year - only 11 cases. The eighth HDI-assisted country, Mali, experienced an outbreak this summer that they were unfortunately late in detecting. It is reported to have resulted from a nomadic herder who moved northward from an endemic part of eastern Mali during 2006 and whose case of guinea

worm remained undetected and unreported while he contaminated ponds along his way. Mali reported 313 cases in 2007 compared with 323 in 2006. Apparently, however, Mali too is now ready to begin implementing some of the main strategies that HDI has assisted other countries to implement for several years but which Mali's program has not wished to use.

HDI's support for guinea worm eradication continues to bear fruit. And we're getting close – the world is 99.7% of the way to complete and successful eradication of Guinea Worm Disease. But the job is not yet finished.

Programs

WORLD'S 1ST RAPID FISTULA PREVENTION PROGRAM LAUNCHED

Pilot community-based fistula prevention activities were at the top of HDI's list of priorities in 2007. Having first worked successfully to get policy acceptance for HDI's initiative in the reproductive health community internationally and then nationally in two countries, Niger and Nigeria, HDI has focused this year on getting community-based fistula prevention going in an area that is small enough so we would not have to depend on large external funding of national programs to succeed.

The aim is to reduce deaths to women from obstructed childbirth by at least 75% and reduce new fistula cases by at least 50% by the end of Year 2, with improvements continuing to strengthen from there.

HDI's Chair, ambassador Barbro Owens-Kirkpatrick, visited Niger to stimulate further progress there in April 2007. The Executive Director visited in June and September. The program was launched officially by Tillaberi Region's governor with HDI's Chair, Ambassador Barbro Owens Kirkpatrick on December 1st in the presence of national and local leaders, and supervisors for the program were trained later in the month.

The community-based pilot obstetric fistula prevention program is now operational in Bankilare, Niger, which produces unusually high numbers of fistula cases and other complications of obstructed labor including ruptured uterus and deaths. The project encompasses 90,000 – 100,000 people in different ethnic groups speaking four major langiuages in 293 villages across 4,650 sq. km (3,059 sq. miles) of territory. There is one mid-wife, and one road (unpaved).

Broad-based, inclusive planning process

During two weeks in September, HDI managed, together with a diverse team of ten people that HDI had pulled together for this purpose, to produce the detailed program plans; a detailed budget; data-registration materials for the community, the district, and the national level; and health education materials for village volunteers and their district supervisors. The training materials included a training manual for supervisors, as well as designs for "flip-charts" to be printed on solid cotton cloth and used in the villages.

It was funding from the Conrad N. Hilton Foundation and the Roth Family Foundation that allow HDI to begin implementation before the end of 2007.

Funds are being sought from private individuals, foundations, and NORAD (through HDI-Norway) for continuing implementation through 2008 and beyond. It is expected that the monthly data-collection and analysis will bring sufficient hard data by the end of Year 1 or at latest by the end of Year 2, for us to see the extent to which expansion of the pilot program within Niger and internationally is justified.

CONGRSSIONAL BRIEFING

As part of its effort to mobilize support for rapid prevention of obstetric fistula and maternal deaths, HDI's initiative to organize a Congressional Briefing on obstetric fistula in collaboration with the Global Health Council was successful. On May 3rd, UNFPA, EngenderHealth, The Worldwide Fistula Fund and HDI held the Briefing, hosted by Congresswoman Carolyn Maloney (D-NY) in the Rayburn House Office Building on Capitol Hill. The Briefing was well received, also by Dr. Medhin Zewdu, Special Assistant to Ethiopia's Minister of Health who asked for additional information several weeks afterward.

NO PROGRESS IN NIGERIA

There has not been further progress in getting fistula prevention activities going in Nigeria. That will surely need repeated visits, but it may now be best to focus fully on getting the proof of concept done well and thoroughly in Niger. If successful as we anticipate, that would greatly facilitate efforts in Nigeria and elsewhere.

STRETEGIC PLAN COMPARISON

In relation to HDI's near term (6-12 month) obstetric fistula goals in the Strategic Plan from December 2006, this translates as follows:

⇒ *Mobilize financial and personnel resources needed to fulfill HDI's part*
Partly successful. Ongoing. Received $25,000 grant from Conrad N. Hilton Foundation for fistula work in 2007, which the Foundation in August allowed us to largely re-allocate for the Niger Bankilare initiative. Applying to NORAD (via HDI-Norway) and the Conrad N. Hilton Foundation (via HDI Inc) for additional support. And the Roth Family Foundation provided a grant of $4,500.

⇒ *Continue putting together the partnership of organizations needed to implement the system we have been proposing*
Partly successful. Ongoing. HDI has been successful in putting together a partnership of organizations in Niger; partners include two government ministries, local health officials, a German NGO called HELP, UNFPA, Niger's national guinea worm eradication program, and HDI. Efforts in Nigeria have, however, not continued to bring results in 2007. The effort to build the partnership also continues at the international level where efforts to bring CDC and NIH into this endeavor continue to look promising.

⇒ *Provide in-the-field technical support beginning during the first-quarter of 2007*
Achieved in the 2nd and third quarters, if not during the first quarter.

⇒ *Work intensively with Nigeria and Niger to help organize internal issues*
As elaborated in detail elsewhere in the report, efforts in Niger are continuing apace and coming to fruition, while there has unfortunately been no further response from any level in Nigeria to multiple follow-up attempts from HDI.

⇒ *Take a lead in organizing the annual national and international meetings*
It's reasonable to see the Congressional Briefing as an indication of the success of this effort although it was a one-time event. This work continues.

⇒ *Participate at Congressional briefing February-March 2007 with Global Health Council*
Successfully accomplished.

⇒ *Present at Global Health Council conference in May-June 2007 if the previously submitted abstract is accepted*
HDI's abstract this year was not accepted for presentation, and HDI did not participate at the conference.

GUINEA WORM

As was reported in 2006, "Good progress in the Guinea worm eradication program continues throughout the countries with which HDI is working, with the exception of Mali," although Mali, which suffered an outbreak, did see an 81% reduction in cases in the rest of the country through August.

12 – 18 consecutive months with zero indigenous cases in HDI-assisted countries through December 2007

Ethiopia has reported no cases for 18 months, Cote d'Ivoire 15, Burkina Faso 13, and Togo 12 months, in addition to Benin and Uganda which have not had indigenous cases since 2004 but continue to be at risk due to importation from neighboring countries that remain endemic.

HDI's efforts to help **Niger** intensify its guinea worm eradication program have clearly paid off. Assertions to that effect from all levels of the program seem to reflect reality much more than politeness. After rather lack-luster performance for several years, the Niger program took off and implemented several intensifying modifications following a visit from HDI's Executive Director in January 2006, while other interventions have certainly also been important. The number of guinea worm cases in Niger was down to 11 in 2007, a 90% reduction from 108 cases in 2006. Also, interventions HDI suggested in January 2006 completely dried up the reports of sporadic "cases" which the program experienced in 2005 in localities that had not previously been endemic. The ex-patriot Carter Center consultants that have now been sent to help Niger stop transmission are clearly making very important contributions. But it's also clear that the adjustments which Niger's program made in collaboration with HDI, in both 2006 and in June 2007, are bringing significant benefits.

Past problems with the Guinea Worm Eradication program's administration in **Mali** have come home to roost yet again. There was an outbreak near the border with Algeria that the Mali team detected only in August, although cases had apparently been occurring for one or two moths before that. The outbreak occurred in an area that is reported to not to have experienced guinea worm for years and years, into which the disease was reportedly introduced last year by a nomadic herder who went undetected and contaminated ponds as he went northward though a sizable piece of territory. And an area with about 30 cases was uncovered only when a case imported into Niger was detected there and traced back to a particular location in Mali. That said, Mali made better progress this year, which can be ascribed to the new leadership's focused efforts and the assistance provided by Mali's partners. Outside of the outbreak, Mali registered an 81% reduction in cases though August of 2007 compared with the first eight months of 2006.

FUNDING FOR HDI'S GUINEA WORM ERADICATION EFFORTS

Fondation Pro Victimis, supporter of HDI's work in the most low-endemic countries, has announced a new grant from the 2nd-half of 2007 though 2009, allowing us to support those countries right through to the end.

The second consecutive 3-year **Conrad N. Hilton Foundation** grant to HDI for guinea worm eradication ended in 2007. The Hilton Foundation indicated at the start of this second grant, that this was the last guinea worm eradication funding they would be providing. The initial Hilton Foundation grant was for several middle- to low-endemic countries. The second grant was for Mali and Niger only, and intended to reinforce the foundation's considerable support for safe water supply in those two countries under its WAWI program, the West African Water Initiative.

It is clear that both foundations have made very significant contributions to guinea worm eradication through their support of HDI's work in these countries.

Tefala passes her high school exam, postponed by Guinea Worm

As an aside, it's a pleasure to inform the Board that Tefala, a young lady in Togo, has successfully passed her high school exam!

This rural Togolese girl saw her education in the capital interrupted when she got sick with guinea worm a few years ago, just two weeks before her final exam. Not knowing about guinea worm or how to prevent it, she had contracted the disease during a visit to her parents, back home, the preceding year. Prevented from studying and taking her exam because she was sick – and the final exam is all that counts in their system - she nevertheless helped the program tremendously on a volunteer basis in her village and the surrounding area as soon as she recovered. That was in a population where the program was really struggling. With her own meager funds, not knowing she would be reimbursed, she among other things secured the mother's permission and brought a very small child to the hospital's case-containment center by motorbike-taxi for bandaging and care. HDI is thrilled to congratulate Ms Tefala on completing her high school education against all odds and in spite of having been interrupted by guinea worm!

STRETEGIC PLAN COMPARISON

In relation to HDI's near term (6-12 month) guinea worm eradication goals in the Strategic Plan from December 2006, this translates as follows:

⇒ *Implement the Hilton Foundation grant in its final year (2007) in Mali and Niger*
Completed.

⇒ *Implement the Pro Victimis grant using the no-cost extension*
Successfully completed. Technical and financial reports were accepted and approved by that foundation, and HDI received a new follow-on grant.

⇒ *Make a renewed proposal to Pro Victimis in accordance with their invitation*
A new grant for 2nd-half 2007 though 2009 was approved for the amount that HDI applied for, $78,930 over the 2.5-year period. The grant does not cover Mali or Niger.

LYMPHATIC FILARIASIS

As reported in 2006, the major thrust of HDI's work to prevent and treat lymphatic filariasis remains largely within the context of the **West African LF Morbidity Project**, which was initially supported with funding from the Bill and Melinda Gates Foundation through the World Bank and is now supported by the Government of Norway through NORAD and administered through HDI-Norway.

The aim of the project is to rapidly benefit the large number of men in West Africa who suffer from LF-hydrocele (now often called filaricele), and thus to benefit their families too. Due to LF, these men have fluid in the scrotum, which can be the size of a basketball and can weigh 15 kilograms. The pain and social degradation are almost unimaginable and the economic disabilities to themselves and their families are apparent.

The project is reaching its objectives by teaching West African surgeons the latest techniques throughout the region's most affected areas.

As of 2007, the project has reached six countries. A second excellent African surgeon, Prof. Serigne M. Gueye, urologist and highly regarded professor of surgery in Dakar, Senegal who is also fluent in English, joined HDI's effort in 2007. He too is now carrying out the trainings, and HDI therefore expects then 12-country target to be reached much more quickly than would otherwise be possible. HDI-Norway applied to NORAD for 2008-funding but has no assurance that it will be extended beyond the normal, now completed, three years to which NORAD generally limits its support.

The Bates Foundation support for additional surgeries in Togo and International Foundation support of $17,000 for additional surgeries in Burkina Faso (announced in February 2007) have been kept in abeyance while awaiting the external evaluation concerning those countries that arrived this summer. The funds will now be used in ways

that take the lessons learned through the HDI-initiated evaluation into account, to assure as best we can that appropriate quality of care is given in all work that HDI supports.

The English version of the LF Surgical Handbook has been updated in light of lessons learned through the evaluation, and it has been sent for translation into French.

Assistance to Togo's LF Elimination Program continues. HDI is donnee for the over 900,000 doses of Mectizan donated by Merck & Co. Inc. for annual Mass Drug Administration to stop LF transmission in Togo.

Also, HDI successfully got through the Expression of Interest phase and was invited to submit a proposal for USAID funding for Control of Neglected Tropical Diseases in Togo. This is a follow-up of the successful AREF (Atlanta Research and Education Foundation) grant. The AREF grant, for which work in Togo was completed early this year, explored possibilities for integrating activities of various disease-control programs. It was carried out in close collaboration with CDC. The AREF grant was made before the term "Control of Neglected Tropical Diseases" even really existed. Of the many who expressed interest, apparently about ten organizations were invited to compete for the 2-3 grants of $1.5 million that were announced for 2007.

Unfortunately, Togo was not selected for a Control of Neglected Tropical Diseases grant.

STRETEGIC PLAN COMPARISON

In relation to HDI's near term (6-12 month) LF Elimination goals in the Strategic Plan from December 2006, this translates as follows:

⇒ *Implement the Bates Foundation grant for LF-surgery in Togo*
Been on hold waiting for the external evaluation. Will now be done in ways that take the lessons learned from the evaluation into account.

⇒ *Wrap up reporting to World Bank and others on results of Gates funding for the external evaluation of the West African LF Morbidity Project*
Successfully completed. A copy of the report's overview section has previously been distributed to the Board, and copies of the full report are available to those who would like it.

⇒ *Finish implementing the CDC-collaboration grant for integration of programs in Togo*
Successfully completed.

As reported to the Board in May, HDI was invited to submit a proposal to Research Triangle Institute for USAID funding for continued support of Togo's LF program as part of an Integrated Control of Neglected Tropical Diseases grant. In the end, Togo was not selected.

⇒ *Continue as donee for the Mectizan donation from Merck & Co to Togo through H&D ("old HDI", the 501 c 3 private operating foundation)*
This successful partnership between HDI, Merck & Co, and the LF Elimination Program in Togo continues.

⇒ *Continue to support the Togo LF secretariat*
This too continues. Half of the cost of Togo's LF secretariat has now been taken on by a large USAID-supported LF-morbidity project that supports especially India and Nigeria, and where HDI and CDC successfully got Togo included. In other words, HDI has succeeded in lessening the burden on its own resources by recruiting others to assume a significant part of the cost.

FINANCES AND ADMINISTRATIVE ARRANGEMENTS

HDI's financial year ends June 30th.

While HDI's bookkeeping arrangements have improved considerably in recent years compared to just a few years ago when bookkeeping entries were done just once a year, there is room for further improvement. HDI-Norway is changing its bookkeeping computer program to one that has several advantages. Among others, the auditor and bookkeeper can have access to the books directly via the internet, and headings are available in English, all at lower cost. After board consideration, HDI Inc. adopted the same bookkeeping system, in this case of course with US-dollars as the base-currency. That will allow an even more complete, up-to-date, and more easily available overview of the organization's financial situation at any given time. Information about any given posting will be available by clicking on the entry, which will bring up the scanned invoice that lies behind that entry. The executive director, the Board, and Mr. Johansen, economist, MBA and former chief financial officer of the SAS Radisson Hotels chain who regularly helps HDI on a pro bono basis, all believe the envisioned change-over will provide further, needed improvement in the ability to easily see the organization's financial situation at any time.

Together with electronic banking access which was also arranged late in 2007, these modifications should prove a quantum leap towards truly up-to-date financial oversight of HDI's situation for all involved parties, including staff, the Treasurer, any external accountant or economic advisor, and the auditor.

As reported previously, HDI closed its Chicago office when Michael Pajonk resigned as of May 17th to work in a more financially secure organization. The Chair is kindly hosting HDI's US-based operations in California until a more permanent solution can be found.

Fund Development

While progress continues to be made in HDI's program areas including development of its new initiative in obstetric fistula, fund development remains a critical issue. The identification of new funding sources and the presentation of HDI's case has been an important activity in 2007 too.

However, funding for administrative costs and for a comprehensive in-country fistula program have not yet been significantly successful beyond the wonderful support from the Seth Sprague Educational and Charitable Foundation for US-based costs, and a $25,000 1-year grant for obstetric fistula prevention through the Conrad N. Hilton Foundation and the generous $4,500 donation from the Roth Family Foundation. The 2007 Hilton Foundation grant follows the $10,000 grant last year in honor of Dyanne Hayes Nash, now HDI's treasurer. As reported above in the section on obstetric fistula, the Hilton Foundation grant and the Roth Family Foundation grant allowed HDI to begin implementing village-based prevention activities in Niger near the end of 2007.

HDI's administrative expenses in Norway for bookkeeping (also for the US-organization) and for other office expenses in Norway that support the US-based organization, have now largely been taken over by HDI-Norway.

Meanwhile, staff continues to seek new sources of funding for operational expenses.

Finally, staff hopes to continue working with the board to identify individuals and organizations that can assist in fulfilling HDI's needs for administrative (operating) support, and to continue in-country fistula initiatives beyond 2007, as well as Guinea Worm Program support for Mali and Niger.

Board development

Staff has sought to continue its success from 2006, when Logan Nakyanzi, an executive producer for Air America in New York, and Roger Tutt, a distinguished and retired British Foreign Service professional joined HDI's Board of Trustees. The aim has been to find an additional 1-2 board members, especially people whose commitment to women's issues and strong business and/or philanthropic experience can help guide HDI.

Other Activities

HDI sent a second newsletter in February and a third in December 2007.

The plan is to send two newsletters per year, one of them with a letter appealing directly for support, even though the reduction in staffing makes that a much bigger challenge. With the community-based pilot project just launched in Niger, and specific costing for that project in hand, HDI has news to distribute and something very attractive and specific that we need funding for.

HDI Inc. FINANCIAL OVERVIEW

The financial report for the year ended June 2007 will be available as soon as it has been audited. The audit is ongoing, and proceeding smoothly.

2008 Budget Forecast

Guinea worm		
Mali & Niger	20 000	
Support low endemic countries	37 673	
Total Guinea worm programs		57 673
Lymphatic Filariasis		
Togo field activities	15 000	
Togo secretariat	3 000	
Staff travel	3 000	
Total LF		21 000
Obstetric Fistula (Please see note below)		
Salary in Niger + office costs	41 500	
Bankilare Program Costs ´08	102 964	
Total non-investment fistula costs ‘08		144 464
Norway office		
Salary (Please see note below)	75 000	
Rent	4,200	
Accounting fees	5,000	
Utilities	4,000	
Bank fees	500	
Misc.	500	
Staff travel (admin.)	3,000	
Total Norway office		92,200
US Office (Please see note below)		
Salary	25 000	
Health insurance/benefits/ payroll tax etc	5 000	
Rent		
Travel	3 000	
Telephone, fax, postage, etc.	2 300	
Accounting fees	4 500	
Fundraising fees	5 000	
Total US Office		44 800
Board Meeting		2 500
Total 2008 Budget Forecast		**$362 637**

2008 Budget Forecast Assumptions

- Implementation of complete program and administrative activities in the 2008 budget forecast is dependent upon fundraising revenue.

- Mali and Niger Guinea worm assistance depends on finding new funding, in light of the Conrad N. Hilton Funding coming to an end in 2007.

- As budgeted under a new grant from the Pro Victimis Foundation.

- LF activities in Togo are based on funding from the Bates Foundation of $15,000 for LF-surgeries. Implementation will start late in 2007, now that the report of the LF-surgeries evaluation is in hand.

- US office budget reflects estimates of what it may cost to hire staff for a US office, depending on the person's qualifications etc, when that is re-established.

- While the Norway budget includes a $75,000 salary for the executive director (as previously requested by the board), this item will not be supported without additional income. The executive director has served without compensation for most years since HDI was founded.

- Budgeted amounts are for a well qualified physician who has been identified to work in a 75% position. A proposal for $115,692 (90% of the cost) has been sent to NORAD. Proposals are also being sent to major foundations that have shown interest in HDI's fistula activities. The budget for Bankilare's fistula prevention program (last Quarter 2007 plus 2008) follows this page.

Total 2008 budget without the paid executive director salary: **$ 287 637**

HDI
4th Quarter 2007 and 2008 Budget Forecast
Obstetric Fistula Prevention Pilot Project in Bankilare, Niger

OPERATING COSTS		
Start-Up Costs – 4th Q. 2007		
Mobilizing meetings, leaders, pop, etc	6 166	
Training supervisors	3 084	
Village Volunteer training materials	28 667	
HDI 3-week trip to Niger, Nov-Dec	5 000	
Data registration forms, printing	2 917	
Total Start-Up 4th Q. 2007		45 834
Start-Up Costs - 1 st Q. 2008		
Training village volunteers	14 838	
Follow-Up round after 1st training	692	
Total Start-Up 1st Q. 2008		15 530
Total Start-Up Operating Cost		**61 364**
Running Costs		
Local Rep. Salary (total comp.), Niger + office costs	41 500	
Book-keeping/admin. assist (when need)	5 000	
Monthly supervision & village data collection	19 531	
May '08 Evaluation meeting, Niamey	1 367	
Annual Nat'l Program Review, Dec.	1 952	
Annual Re-training of Supervisors '08	3 084	
HDI – 3 additional trips 1st pilot year	15 000	
Total Running Costs '08		**87 434**
Total non-investment costs '07-'08		**148 798**
INVESTMENT COSTS		
Toyota Hilux DoubleCab bil/pickup - 1	30 000	
Laptop computers - 3	5 000	
Fax, printer, scanner, copier - 1	850	
Powerpoint Projector - 1	2 300	
Codon Radios - 2 , 1 for ea. of 2 existing 4WD ambulances serving Bankilare; Are already in all health centers and the local hosp.	7 064	
Total Initial Investments		**45 214**
Total '07 – '08 Fistula Budget		**$194 012**