
# ANNUAL REPORT

# 2006

## Executive Summary

In 2006, progress continued to be made regarding initiatives to eradicate Guinea worm disease and eliminate lymphatic filariasis as a public health issue.

The Conrad N. Hilton Foundation supports the **Guinea Worm Eradication Program** in Mali and Niger. Conditions on the ground in Mali forced HDI to focus more extensively on Niger during 2006. Eradication is moving forward rapidly in several other countries where HDI supports Guinea Worm Programs with the support of the Pro Victimis Foundation.

**The West African LF Morbidity Project** has achieved remarkable success in training surgeons, resulting in more than 1 200 operations on men afflicted with the disease. HDI is working with project coordinator Dr. Sunny Mante to review the planning process and to re-focus where additional training and surgery campaigns might take place, and on expansion to additional countries. A new proposal has been submitted to NORAD for support of the project, which is now administered through HDI-Norway.

As an off-shoot of the West African LF Morbidity Project, a proposal was submitted to the Bates Foundation in San Francisco, to support much-needed surgeries in Togo using project-trained surgeons. And Johnson & Johnson has indicated willingness to consider a proposal in support for the project, although this would go through Interchurch Medical Assistance (IMA) with which J&J has had close ties since IMA's inception.

Work continued to fine-tune plans for **a Program to Prevent Obstetric Fistula**, focusing on Nigeria and Niger as the initial project sites. Following the visit of Ambassador Barbro Owens Kirkpatrick and Executive Director Dr. Anders Seim in January, a plan was finalized with the Ministry of Health in Niger. Niger's plan is ready for presentation to donors, for a program that would prevent obstetric fistula in two districts. Separately, HDI worked with Nigeria's Ministry of Health to develop a plan there too, a plan Nigeria sent to bilateral and multilateral donors near the end of the year for consideration.

At the same time, efforts are continued to identify individual and organizational sources that might support HDI's fistula initiatives.

HDI has also entered into discussions with the Global Health Council and US Congressional staff about ways to better inform US government officials about the problem of obstetric fistula, with the hope of seeing more funding made available for such projects.

The Conrad N. Hilton Foundation's grant honoring HDI Trustee Dyanne Hayes Nash and her many years of service to that foundation, as well as a donation by Dyanne Hayes Nash herself, are what allowed the initial planning process with Niger and Nigeria and the presentation of these concepts at the Global Health Council in Washington to go forward. Staff has continued to develop Obstetric Fistula Program plans while keeping

with the board's directive not to spend money in this area until such funding has been realized.

In **organizational developments**, HDI added two new board members, one from the US and another from the UK, who bring insight, potential development and informational contacts, and additional international perspective to the HDI Board of Directors.

For the first time, HDI published a newsletter, which was sent to colleagues, friends and supporters in North America, Europe, and Africa.

While efforts are ongoing to identify additional sources of income, especially for obstetric fistula and operating expenses, the fundraising needs continue to be of concern for the future of the organization.

Additionally, 2007 will be the final year of Guinea worm support from the Conrad N. Hilton Foundation for Mali and Niger. And 2006 marked the end of HDI's initial grant for Guinea worm projects in other low endemic countries from the Pro Victimis Foundation. New funding sources must be identified soon to continue Guinea worm program activities.

Most significantly, funding for administrative expenses for especially the US office remains a critical issue. As noted in previous reports to the board, the closing of one or both of the HDI offices may cast doubt on the viability of the organization and its ability to impact health concerns in the developing world.

The financial section of this report details a budget forecast for 2007 while audited financials are available separately to all who would like to see them.

## Programs

### GUINEA WORM

Good progress in the **Guinea worm** eradication program continued in all the countries with which HDI is working, with the exception of Mali. In Mali, the situation as concerns previous program management personnel has made progress difficult. The circumstances in Mali (as well as dire need in Niger) necessitated a request to the Conrad N. Hilton Foundation for re-allocation. Hilton Foundation support went primarily to Niger this year, in the hopes that Mali can come around in 2007. In the meantime, HDI worked with The Carter Center as the primary Guinea worm NGO supporting efforts in Mali.

Burkina Faso and Cote d' Ivoire reported not a single indigenous Guinea Worm case for more than seven months of 2006 while Ethiopia reported only one case in 2006. Both of these developments are quite encouraging.

**A brief country-by-country report for HDI-supported countries is as follows:**

**Benin** has not reported any new endemic case in over two years, further solidifying the feeling that transmission has been broken. Case detection activities continue to ensure that the disease is not re-established through importation.

**Burkina Faso** reported three indigenous cases of Guinea worm this year compared with 24 cases in 2005. Two additional cases were imported from Ghana. While the low percentage of cases contained in 2005 was a concern, the report that all endemic cases were contained in 2006 is absolutely encouraging.

**Cote d'Ivoire** reduced the number of indigenous cases from nine in 2005 to five in 2006, all of which were reportedly contained. These gains have been achieved despite the ongoing civil strife within Cote d'Ivoire.

As anticipated, renewed efforts in **Ethiopia**, including training local villagers in affected areas and access to endemic regions following relatively peaceful times in neighboring Sudan, have resulted in tremendous progress. In 2006 there was a 97% reduction in cases, from 29 in 2005 to just one single reported case this year. It was contained.

Due to administrative problems in **Mali**'s Guinea Worm Eradication Program as alluded to in the introductory summary, HDI felt it was better for that program to have one major donor coordinating efforts within and outside the country. As a result (and because of pressing needs in Niger), HDI secured the Conrad N. Hilton Foundation's permission to re-allocate financial support that was initially budgeted for Mali in 2006. Normally, the Conrad N. Hilton Foundation's grant to HDI for Guinea Worm Eradication is for activities in both Mali and Niger. As anticipated and hoped, management changes in the Mali program during 2005 have begun to show results. There has been a 51% reduction in reported cases (from 656 to 323) between 2005 and 2006. And 82% of those cases were reportedly contained.

At the same time, efforts in **Niger** have been intensified. Niger's program "took off" in connection with two visits from HDI's executive director, in January and March this year. Involving staff from all levels - from the districts to the national leadership - Niger further intensified its plan for detecting and containing every case of Guinea worm. While there was a decrease from 175 cases in 2005 to 108 in 2006, it represented a slower rate of decline than is required. In other words, intensification of effort in the Niger program was needed. In what one hopes is an early sign of results from the intensification, Niger's 82% case containment rate this year is very encouraging.

**Uganda** again reported no new endemic cases in 2006 but importations continue from Sudan. They were reportedly all contained this past year.

## LYMPHATIC FILARIASIS

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. The project is now supported by the Government of Norway, 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). 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 and encouraging surgery projects to treat afflicted men throughout the region's most affected areas.

Since the project began two years ago, workshops have been conducted in Burkina Faso, Ghana, Mali, Niger and Togo. As a result, over 1,200 surgeries have been performed by surgeons trained through the West African LF Morbidity Project.

HDI has submitted a funding proposal to the Government of Norway (NORAD) for renewed support of the West African LF Morbidity Project and to the Bates Foundation in San Francisco to support additional surgeries in Togo.

The LF Surgery Handbook, completed in English in 2005, was translated into French during 2006 by Professor Michel Kaboré in Burkina Faso and proofread by Mrs. Danis Siem (wife of former HDI trustee Dr. Harald Siem who is now on the board of HDI-Norway). Costs for the translation will be reimbursed by I.M.A. (Interchurch Medical Assistance) under a grant from Johnson & Johnson in support of the West African LF Morbidity Project under which J&J has also provided surgical materials via I.M.A.

**OBSTETRIC FISTULA**

Throughout 2006, HDI focused on the development of program models and fundraising proposals to energize its obstetric fistula initiative. In January, HDI's trustee Ambassador Barbro Owens Kirkpatrick and the executive director visited Niger to begin working with authorities and develop a plan for the rapid prevention of obstetric fistula. As the year progressed, the proposed 2-district program for Niger was completed, the budget was translated into French, and the plan made ready for presentation to Niger's bilateral and multilateral partners. However, by the end of the year Niger had yet to appoint a "sparkplug" person to lead the work there.

Meanwhile, officials in Nigeria who attended the HDI, UNFPA, CDC-sponsored conference on obstetric fistula at Emory University in October 2005, continued to express interest in using HDI's experience in disease eradication to prevent fistula and to eliminate this condition as a public health concern in their country. HDI worked with ministry and other officials in Nigeria at the end of October, and Nigeria's Ministry sent the resulting plan to its major bilateral and multilateral donors for consideration.

HDI is proposing to help establish a data collection, analysis, reporting, and prevention system beginning at the village level. Trained village volunteers would collect data on pregnancies, obstructed labor, and the incidence of fistula; educate women who are at risk; introduce early individual evacuation planning for obstetric emergencies; and initiate monthly collection and analysis of information between villages and program managers at the national and international level. Information collected monthly by the village workers would also be used at the national level to improve obstetric outcomes and put together accurate data on the problem of obstructed labor and resulting fistula, assist in the allocation of health care resources to where they are needed most, and help plan for facility upgrades and additional training.

The proposed HDI program would provide support for sub-national coordination meetings in Nigeria and Niger and for annual international program review meetings that may also include Ethiopia (where effective obstetric fistula treatment activities are underway, e.g., the Addis Ababa Fistula Hospital, but good data collection and prevention is not).

In short, the plan includes implementation of all 11 elements of successful disease eradication efforts in accordance with recommendations from the Atlanta Meeting in October 2005.

In short, the essentials are in place to begin rapidly preventing obstetric fistula if political will and financial resources can be mobilized. By utilizing village volunteers (primarily women) to provide health education and to collect and report data, and make emergency evacuation plans with individual women and those who make decisions about them, resources can be better targeted where needed and policy changes leading to substantial success in preventing and treating obstetric fistula can be initiated.

## Finances

HDI's financial year ends June 30th. Audited financials and IRS tax returns are available separately from this report for anyone who would like them.

## Fund Development

While progress continues to be made in HDI's program areas and in the development of its new initiatives in obstetric fistula, fund development remains a critical issue. The identification of new funding sources and the presentation of HDI's case has been a major activity in 2006. However, funding for administrative costs and for a comprehensive in-country fistula program has not yet been significantly successful.

HDI´s US office will close in early 2007 if no new funds for operating expenses come in. Fortunately, the HDI-Norway office has received a bit of a reprieve as a result of a donation by Høegh Stiftelsen, one of HDI's two initial donors in 1990.

It should also be noted that 2007 is the final year of the Conrad N. Hilton Foundation grant for Guinea worm eradication in Mali and Niger. The foundation said from the outset of the current, second three-year grant, that after 2007 they will no longer support HDI's Guinea worm activities.

While 2006 was supposed to be the end of Guinea worm support in other low endemic countries from the Pro Victimis Foundation Switzerland, a request was made to them for a no-cost extension into 2007, using funds not expended in 2005. While the current grant from Pro Victimis (even with the no-cost extension) was to mark the end of their support, they have indicated that HDI may be able to come back for additional funding once current grant activities have been completed.

Finally, staff will continue working with the board to identify individuals and organizations that might help fulfill HDI's needs for administrative (operating) support and to begin in-country fistula initiatives, and to garner Guinea worm program support beyond 2007.

## Board development

The board set a goal of adding 2-3 new members in 2006, and HDI is honored that two impressive individulas have joined the Board of Trustees. Logan Nakyanzi is executive producer for Air America in New York while Roger Tutt lives in the UK and is retired after an illustrious career in that country's Foreign and Commonwealth Office (Ministry of Foreign Affairs).

Mr. George van Ausdall decided to step down upon turning 75, after generously serving HDI as a trustee and its treasurer since the organization's inception in 1990. HDI is enormously grateful to Mr. van Ausdall for the tremendous contributions he made to the organization's work during all of those 17 years!

## Other Activities

Dr. Seim presented a paper on "***The Community-Based Catalyst Approach to Public Health***" at the Global Health Council's Annual Conference in June. The presentation was successful and follow-up contacts were made, including with staff of Senator Edward Kennedy and the Global Health Council's congressional liaison. Discussions with the Global Health Council continue. Points being discussed include the possibility of HDI and other NGOs presenting a briefing on obstetric fistula to members of the US Congress in early 2007.

In August, over 200 copies of the first HDI newsletter were mailed to supporters, colleagues, and friends. About 60% were mailed in the US, with the remaining 40% sent to Europe and Africa. In 2007 and thereafter, HDI plans to publish two issues of the newsletter each year, for distribution in the spring and fall.

**HDI Inc.**
**2007 Budget Forecast**

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|---|---|---|
| **Guinea worm** | | |
| Mali & Niger | $100,000 | |
| Support low endemic countries | 20,287 | |
| Total Guinea worm programs | | $120,287 |
| **Lymphatic Filariasis** | | |
| Togo field activities | 15,000 | |
| Togo secretariat | 3,000 | |
| Staff travel | 3,000 | |
| Total LF | | 21,000 |
| **Obstetric Fistula Staff** | | |
| Salary | 50,000 | |
| Health insurance/benefits | 10,800 | |
| Travel | 18,000 | |
| Telephone, fax, postage, etc. | 2,000 | |
| Total for obstetric fistula staff | | 80,800 |
| **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** | | |
| Salary | 61,000 | |
| HDI-paid FICA | 4,350 | |
| Travel | 3,000 | |
| Telephone, fax, postage, etc. | 2,300 | |
| Accounting fees | 4,500 | |
| Fundraising fees | 5,000 | |
| Total US Office | | 80,150 |
| **Board Meeting** | | 2,500 |
| **Total 2007 Budget Forecast:** | | **$396,937** |

## 2007 Budget Forecast Assumptions

- Implementation of complete program and administrative activities in the 2007 budget forecast is dependent upon fundraising revenue.

- Mali and Niger Guinea worm program as funded by third (and final) year grant from the Conrad N. Hilton Foundation.

- A no-cost extension from the Pro Victimis Foundation has been promised, using the $20,287 that had been kept in reserve for any emergency in 2005 and ended up not being disbursed then. There may be a possibility of additional funding beyond the no-cost extension, even though Pro Victimis Foundation does not normally provide more than about two years of funding for any event or project.

- LF activities in Togo assume funding from the Bates Foundation. If such funding is not forthcoming, LF activities in Togo will be curtailed.

- US office budget reflects a slight salary increase ($4,300) and a significant decrease in health insurance benefits (about $18,800), as the deputy executive director was able to obtain health insurance at a substantially reduced cost. As a result, the US office will save about $1,200 each month.

- 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.

- Hiring a full-time person to coordinate obstetric fistula activities (likely located in a home office) is dependent upon obtaining full funding for this position. Support envisioned as HDI's contribution to the two initial pilot countries (for essential activities not expected to be supported by country-specific bilateral donors to those countries) is similarly dependent upon securing funds for obstetric fistula prevention.

Total 2007 budget without fistula position and paid executive director salary: **$241,137**

## HDI's 2006 Financials

HDI's financial year ends June 30th. Audited financials and IRS returns are available separately, for all who would like to see them.