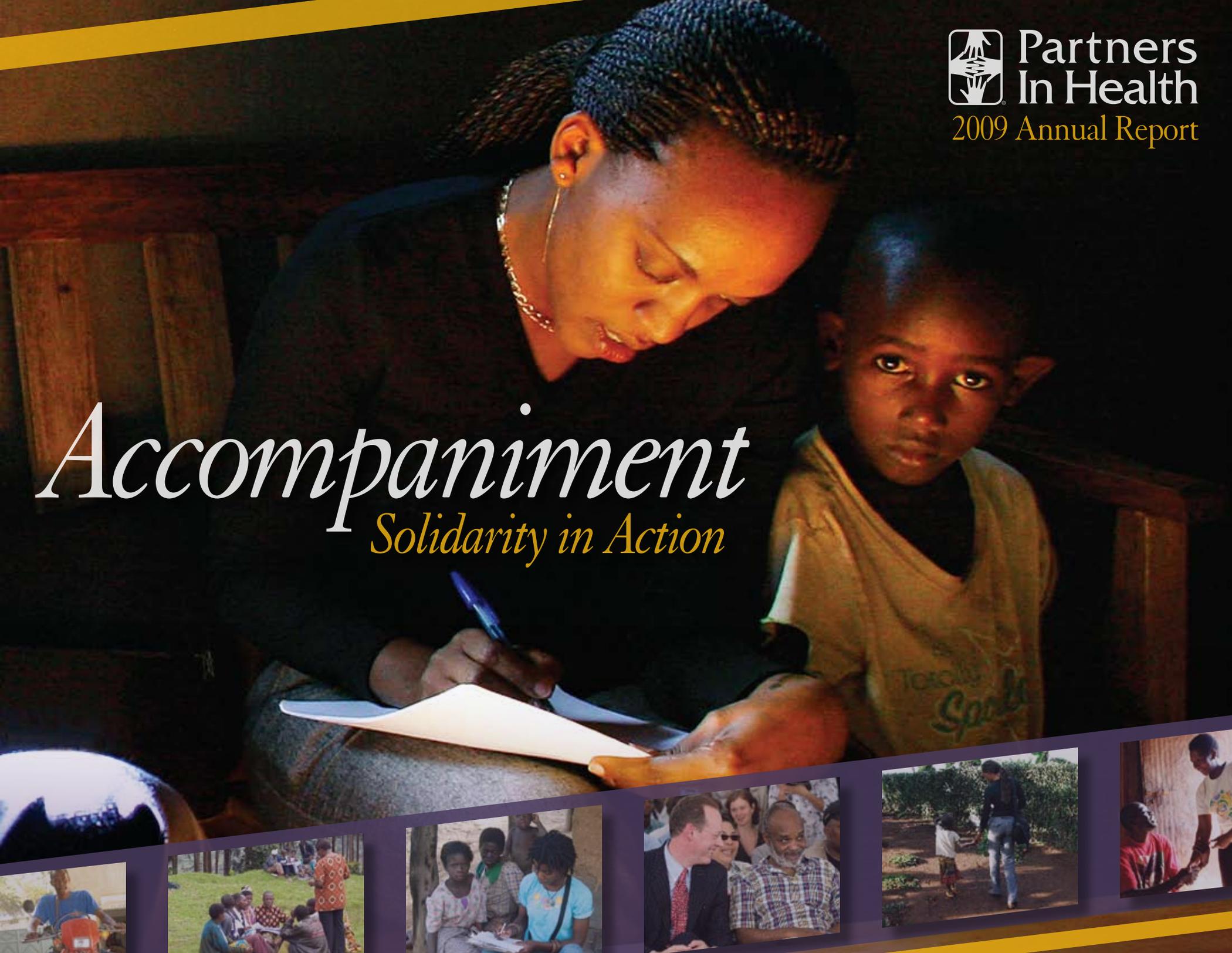


Accompaniment

Solidarity in Action



Director's Message

Dear Friends,

Every year when I sit down to read through this report and write my introductory letter, I am both proud and humbled to reflect on the many accomplishments Partners In Health has recorded over the past 12 months. For me, this is a time to reflect on the many lives that have been changed and the many communities transformed thanks to the steadfast engagement of so many partners—individuals, organizations, and governments—who share our commitment to breaking the vicious cycle of poverty and disease. At the same time, however, it is important to reflect upon and be challenged by reminders that our impressive catalog of accomplishments inevitably falls far short of meeting the needs of the people we serve. That is the case every year. It is especially true in 2009.

On many fronts, the past year was particularly difficult for Partners In Health and for the world. In September, a series of hurricanes and tropical storms ravaged Haiti. Raging floodwaters drowned entire cities and swept away roads and bridges, homes, crops and livelihoods. Less than a month later, the global economy collapsed, bankrupting several of the world's largest banks and manufacturers. The impact on the world's poorest and most vulnerable people was less publicized but even more devastating. In a single year, more than 100 million people were forced into the ranks of the chronically hungry, pushing the total number who go to sleep hungry every night to more than one billion for the first time in history.

The layering of crisis on top of tragedy is not new to Partners In Health. Yet these events challenged us more than ever. As a large organization that must raise most of its annual operating budget during the course of

each year, we had no choice but to spend long hours re-examining our priorities, our strategy for growth, and our contingency plans for a shortfall in our fundraising goals. Even small administrative decisions can have major implications to a program. A change in a budget line can mean the difference between life or death for our patients and their families.

In the midst of crisis, however, we saw more clearly than ever before that we are building, strengthening, and sustaining entire systems of care in places that previously had none. And we were reminded that the fuel for these systems is not merely or mainly the financial and human resources that we are able to muster. Those financial and human resources are essential, but they are the result of something more fundamental—the philosophy and practice of accompaniment that lies at the heart of Partners In Health's approach.

This spirit of accompaniment—the commitment to be there with our patients, come hell and high water, to hear and learn from their voices, to respect their rights and attend to their needs—is embodied in the work of thousands of community health workers, social workers, nurses, doctors, administrators, and drivers who set out each day to serve our patients and their families. This same spirit and commitment also fuels the ever-growing network of supporters and partners who bring resources, expertise, and human capital, who work in solidarity with us and those we serve.

There is a great deal of hope embedded in this notion of accompaniment.



In the past year, we witnessed how such solidarity can transform entire communities, even, or perhaps especially, in the worst of times. In a remote community in Haiti called Boucan Carré, our health center has often been cut off from the community during the rainy season by flash floods in a river aptly known as Folanfe (or “Deep Hell”). The river has lived up to its name, swallowing jeeps and ambulances, sweeping away patients trying desperately to get to the other side, cutting off women dying of obstructed labor from doctors and facilities that could save their lives and deliver their babies.

Since we arrived in the community, we have been advocating for a bridge to be constructed. For six years, we have received little encouragement from institutions and people who insitently cited the obstacles and predicted that we would never get a bridge built. We carried on despite the naysayers and in the face of our own doubts. This past year, as we were mobilizing support to replace other bridges washed away by the hurricanes, we forged the partnerships needed to get the job done, building a consortium of commitment that included the Digicel Foundation; the United Nations; the government of Haiti; and friends at Virginia Tech. By bringing the stories of doctors accompanying patients who died in their arms on the bank of the river to compassionate supporters, to caring engineers, and even to the largest bureaucracies in the world, we can

finally report at the end of this challenging year that a strong and sturdy bridge has been built over Boucan Carré’s waters of hell.

Through all of the trials of the past year, we have felt accompanied by a core network of supporters and friends. That solidarity, in turn, has made us better able to accompany the patients, families, and communities we serve. PIH’s 11,000 employees working in 49 health centers and hospitals across eleven countries have continued to have a vast impact on millions of lives. In the coming year, we will strive to sustain this work and to grow the number of individuals and organizations engaged alongside us so that we can not only keep the promises we’ve made but continue to innovate, deepen our engagement, and further our impact. We ask that you read the stories and information that follow and imagine what is possible if we all redouble our efforts to accompany each other and the communities we serve together.

With sincere thanks,



Ophelia Dahl
Executive Director, Partners In Health





Our Mission

Our mission is to provide a preferential option for the poor in health care. By establishing long-term relationships with sister organizations based in settings of poverty, Partners In Health strives to achieve two overarching goals: to bring the benefits of modern medical science to those most in need of them and to serve as an antidote to despair. We draw on the resources of the world's leading medical and academic institutions and on the lived experience of the world's poorest and sickest communities. At its root, our mission is both medical and moral. It is based on solidarity, rather than charity alone. When our patients are ill and have no access to care, our team of health professionals, scholars, and activists will do whatever it takes to make them well—just as we would do if a member of our own families or we ourselves were ill.

A community health worker checking nutritional status in Rwanda



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*A community health worker
returning home in Lesotho*

*Former MDR-TB patient Louis Marinafasha
greets accompagnateur Lea Kawesa*



Accompanying Patients, Strengthening Communities

Every day thousands of community health workers fan out across the hills of Haiti, the shantytowns of Peru, the mountains of Lesotho, and the streets of Boston. They bring lifesaving medicines and social support to HIV and TB patients and make sure that patient families are getting enough to eat, that their children are going to school, that neighbors who are coughing or running a fever are diagnosed and treated. In the process, they mobilize solidarity as a community-wide immune response to pandemic disease, destitution, and despair. These community health workers embody the meaning of “accompaniment” — the approach to working with poor communities that has been the guiding principle of our work since PIH was founded almost a quarter century ago.

We owe the term and the inspiration to El Salvador’s martyred Archbishop Oscar Romero and other apostles of liberation theology, who defined accompaniment as the concrete expression of their “preferential option for the poor.” In welcoming a group of missionaries to El Salvador, Archbishop Romero explained, “What the people really need is that you simply walk with them in their lives, that you accompany them on their own faith journey, that you are there with them as they struggle to work out their own historical destiny. That’s what the Salvadoran people need.” From Malawi to Boston, our patients remind us every day that that is what they need from us as well—a firm commitment to accompany them on their journey to health and social justice.

“They were like a family to me”

When Partners In Health started working at Rwinkwavu Hospital in Rwanda in 2005, Louis Manirafasha was too sick to take advantage of it. Two years after completing treatment for tuberculosis at another hospital, he was too weak to travel to the hospital on his own. But as PIH built up a network of community health workers in the district, treatment came to him. “The community health workers came with a PIH car and a doctor and took me back to the hospital,” Louis recalls. Tests confirmed that Louis was suffering from multidrug-resistant tuberculosis (MDR-TB), a diagnosis that used to be a death sentence for people living in poor countries.



Louis was so sick that he had to be hospitalized for a full year before he was strong enough to go home and healthy enough not to risk infecting his family. But he still faced another year taking daily doses of potent and debilitating medications. He didn't face it alone. He selected one of the local community health workers, Lea Kawesa, to be his *accompagnateur*.

“Every morning, I would walk a mile to his home,” Lea says. “First I would just talk to him to find out how he was feeling. Then, at 6:30

sharp, I would give him his medicine.” After another year of treatment, Louis is now completely cured of MDR-TB. But Lea still visits regularly. “We just talk about life and about how he and his family are doing,” Lea says. “I also make sure his kids are eating the right food and getting their vaccinations. And I check the health and nutrition of his neighbors.”

Lea isn't the only person from PIH who is accompanying Louis and his family. “When I started getting better, my doctor and *accompagnateur* introduced me to an agricultural expert. They trained us to make a garden so we can grow vegetables and other things.” Louis proudly shows off the garden where he grows eggplant and squash, cassava, and passion fruit. “The garden has helped my family so much,” he said. “We aren't hungry any more. We produce enough to feed ourselves and to earn some money by selling passion fruit.”

“As the name says, PIH really were partners in my health,” Louis concludes. “They were like a family to me.”



Louis Manirafasha
in his garden



“Jean has become like a father to my children”

Rosita Baptiste keeps a broad-brimmed hat with a ribbon planted firmly on her head, indoors and out. It helps her look and feel younger. At age 42, she explains, “I have gray hair because I am always worrying how to take care of my family.” She has a lot to worry about. A single mother of five living in Haiti’s central plateau, she is HIV-positive and destitute.

“When I first found out I was HIV-positive, I was really frightened and upset,” she recalls. And that was before hurricane floodwaters destroyed her home and most of her few belongings. The flood left Rosita homeless, frustrated, and worried. But not for long. The response by Zanmi Lasante (ZL) rekindled her hope and determination.

Before the hurricanes, Rosita had been invited to participate in a psychosocial support group for children affected by HIV and their parents. And as the floodwaters rose around her house, she looked out and saw that help was on the way in the form of Jean Renald Pierre, one of the social workers who runs the support group, and two other ZL staff members. “When I saw Jean and Cate and Rivot coming to help me with water up to their chests, it made me feel like I could live,” Rosita recalls. “Before that, I thought I was going to die.”



Since the hurricane, ZL has rented a house for Rosita and her family, as we have done for all 100 patient families who were flooded out of their homes. Rosita still has worries. “My biggest fear in life is that my children won’t be able to go to school.” ZL helps Rosita with the expenses of sending her children to school. And Jean’s support group has helped her understand and cope with her anxiety.

“Jean is like our teacher,” Rosita says. “He taught me not to be angry all the time, how to talk about myself. He gives us good advice and good ideas about how to live.” So now she has something new to worry about. “I hope Jean and Gary [another ZL social worker] don’t become discouraged. I see how hard they work. Their work is important. It makes a big difference in our lives.”

Jean can reassure her that he’s not about to get discouraged. “I love my work a lot because I see that I am actually helping people,” he says. “With all of the poverty we have in Haiti, finding a way to help our patients—either through a support group or in visiting their homes or providing them with economic support—this makes me feel so gratified.” He reveals his gratification with a wide smile when Rosita remarks that “Jean has become like a father to my children.”

HIV patient and psychosocial support group member Rosita Baptiste

Accompanying Patients, Strengthening Communities



Rosita Baptiste and two of her daughters with social worker Jean Renald Pierre

What community health workers are called upon to do in practical terms varies greatly from country to country based on the needs of our patients. In Haiti or Rwanda, they may distribute malaria medicine and bednets. In Malawi or Lesotho, they may literally carry on their backs patients who are too weak to walk to the health center. In Boston, they may help patients overcome barriers of language and culture during medical appointments or when filling out Medicaid applications.

Everywhere, in the words of Heidi Behforouz, who heads up our PACT project in Boston, they “walk with the patient — not behind or in front of the patient — lending solidarity, a shoulder, a sounding board, a word of counsel or caution. Empowering not enabling.” Everywhere, they serve as an invaluable bridge between the clinic and the community.

That bridge runs in both directions. Accompagnateurs work with us to bring medications, information, and social support to the community. And they bring back to the clinic a profound understanding of the community’s needs that defines our mission and shapes our work. Just as they help us accompany the community, they help the community accompany us on our journey to be of service and truly deserving of the name “Partners In Health.”

Accompanying Partners, Building a Movement



On a broader scale, PIH views accompaniment as a key to meeting two of the biggest challenges we face. In the language of global health and development experts, these challenges are commonly referred to as “sustainability” and “scaleability”—designing and implementing programs that can effect change not just in a single hospital or village but at a national scale and that can eventually be sustained without external assistance.

Our partnerships with Brigham and Women’s Hospital, Harvard Medical School and the Harvard School of Public Health enable us to have an impact far beyond the communities where we work. They accompany us in teaching and mentoring the next generation of global health practitioners, in conducting rigorous research that strengthens our work and provides evidence of its impact, and in leveraging evidence-based lessons from our projects to change policies at a national and global scale.

Building on that foundation of service, training and research, we strive to accompany other individuals, organizations, and governments in their efforts to meet the needs and fulfill the rights of the poor. We provide technical assistance, training, and mentorship; help plan and implement programs; and work side-by-side to build a global movement for health and social justice.

*A Village Health Works staff member
with a child from the community*

“The fight for global health has started”

At PIH’s Fifteenth Annual Thomas J. White Symposium in 2008, a young man from Burundi took the podium. “The fight for global health has started,” he told the rapt audience. “And it won’t be won if only one organization like Partners In Health is in the running, without [other organizations] branching off. It will be won by an army of compassionate people who think globally like PIH people.”

Deo’s reminder that it will take a broad, global movement to break the cycle of poverty and disease was grounded in personal experience—including the experience of having “branched off” to create an organization that shares many of PIH’s core values and principles, starting with recognizing accompaniment as the key to understanding and responding to the needs and aspirations of poor communities. After narrowly escaping genocide in Burundi and Rwanda, after living homeless in Central Park, after completing a degree at Columbia and enrolling at Dartmouth Medical School, and after encountering and working with Partners In Health, Deo created an organization called Village Health Works (VHW, www.villagehealthworks.org) and built a health center in his parents’ home village in Burundi.



VHW’s commitment to accompaniment bore fruit. After initial skepticism, the community pitched in as enthusiastic partners, helping to build the clinic, enlisting as community health workers. When VHW flinched at paying \$50,000 to a construction company to build a road to the clinic, more than 150 villagers turned out with hoes, machetes, and pickaxes and built it by hand.

From the outset, PIH has supported and accompanied VHW in its work. VHW sent nurses and community health workers to observe and train with Inshuti Mu Buzima (IMB), PIH’s project in neighboring Rwanda. PIH co-founder Paul Farmer, Medical Director Joia Mukherjee, and numerous other PIH and IMB staff visited VHW regularly, sharing skills and experience. PIH’s support extended beyond the purely medical to areas like administration and procurement. And as PIH supported VHW, our research and training teams continued documenting lessons from our work and synthesizing them into guides and curricula that are made available for all interested parties through model.pih.org, our online platform for exchanging information and resources. These include a new Program Manager’s Guide and an HIV curriculum for nurses and doctors that will enable us to accompany many more recruits for Deo’s “army of compassionate people.”



Children from the community help build the VHW facilities

“You have to deal with this problem”

The government invited PIH to come to Lesotho in 2006 mainly to bring HIV testing and treatment to remote mountain communities. We soon confirmed our fears that Lesotho was also being ravaged by perhaps the world’s worst epidemic of tuberculosis, with alarming rates of multidrug-resistant tuberculosis (MDR-TB).

On their own, the Ministry of Health had very little expertise and almost no resources for treating and managing MDR-TB. They had no laboratory that could test TB cultures for drug resistance, no hospital equipped and staffed to treat patients who were to be admitted, no community-based system for outpatient care, no supplies of the second-line drugs needed to treat the disease. But they did have a strong commitment to meet the challenge. And in PIH they did have partners who could draw on years of experience with two of the world’s most successful and innovative MDR-TB programs in Peru and Russia, who could help marshal resources from global institutions, and who were committed to accompanying Lesotho’s efforts to build a strong public health system.

With our support, Lesotho was able to respond quickly and effectively to the crisis. “We went into an emergency mode,” explained Lesotho’s Minister of Health and Social Welfare, Dr. Mphu Ramatlapeng. “In six months, this is what we did: put a new lab in place (actually that took two months); trained staff; refurbished a hospital and turned it into an MDR-TB hospital. You have to deal with this problem in the immediate moment. Our reaction was not typical to the way that most governments or organizations work.”

The Ministry’s partnership with PIH helped make that quick reaction possible. We worked with the Ministry to line up financial support from the Open Society Institute (OSI) for the hospital renovations. We also enlisted the assistance of the Foundation for Innovative New Diagnostics to renovate and equip the national TB laboratory. And with OSI’s backing, we provided training, technical assistance and financial support to build up the clinical staff and a network of community health workers.

Other African countries are now looking to Lesotho and PIH for lessons and technical assistance in building their own programs for community-based treatment of MDR-TB.



Examining a chest x-ray in Lesotho’s national MDR-TB hospital

*An MDR-TB patient with her
mother in Lesotho*



Accompanying Partners, Building a Movement

Our own work and that of other non-governmental organizations play a valuable role in developing new approaches to treating disease and eradicating extreme poverty. But to assure universal and sustained access, successful models must be implemented and expanded through the public sector. Rather than establish parallel systems, PIH works to strengthen and complement existing public health infrastructure in all of the countries where we work.

We build and equip public hospitals and clinics; provide training and supplement salaries for nurses, doctors and other Ministry of Health staff; and assist with planning and implementing comprehensive, community-based health care systems.

With our technical assistance and support, the Peruvian Ministry of Health has built a program for community-based treatment of MDR-TB that now operates on a national scale with the highest cure rate in the world. In Rwanda, a study conducted in partnership with the Clinton HIV/AIDS Initiative costed out comprehensive rural health care, consistent with the government's strategy and PIH principles, at an annual cost of \$28 per person. That's too much for the Rwandan government to cover without assistance today but well within their projected health care budget for the future. We are now working with the Rwandan Ministry of Health to scale up and sustain this model nationwide.



*An expectant mother
in Haiti*

Haiti/Zanmi La

“Building back better” was the theme of the year, as Zanmi Lasante (ZL) worked to help communities recover from the severe flooding inflicted by four hurricanes and tropical storms in August and September 2008. Despite the impact of the hurricanes, ZL also continued to strengthen public health infrastructure and provide services in specialties rarely available in poor communities, including surgery, mental health, and neonatal intensive care.

HIGHLIGHTS OF THE YEAR

- **Provided emergency relief and long-term reconstruction for hurricane victims:** When disaster struck, ZL stepped up immediately to provide shelter, food, clean water, and medical assistance for thousands of people who had been flooded out of their homes. Since the flood waters receded, ZL has helped hundreds of families get back on their feet by building and repairing houses, assisting with school fees, distributing food support, and providing tools, seeds and training for farmers. Construction and renovations were accelerated at the dilapidated hospital in St. Marc, which was overwhelmed with patients from the devastated city of Gonaïves. ZL and the Ministry of Health also accelerated plans to build a new hospital in Mirebalais. In the meantime, ZL improved capacity to treat the people of Mirebalais by training a cadre of community health workers, purchasing an ambulance, and strengthening nearby ZL hospitals.

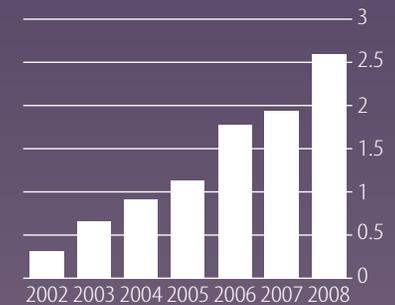
- **Strengthened infrastructure and services in the lower Artibonite:** Having recently expanded from Haiti's Central Plateau across the lower Artibonite to the coast, ZL made it a priority to rebuild the battered public health infrastructure and expand comprehensive health care services in the area. During the year, ZL constructed a new ward for internal medicine, an imaging center, an administration wing and a kitchen at Hôpital San Nicolas in St. Marc. In addition, we began construction on a new pediatric ward and pharmacy depot and renovations on the men's and women's wards. At Petite Rivière, we built a new operating room, a lying-in center, and an x-ray room, and launched a new malnutrition program. Patient encounters in the lower Artibonite region increased to 700,000, driving growth for ZL as a whole to more than 2.5 million.



- **Integrated psychosocial support services as part of comprehensive care:** ZL expanded psychosocial services by training and hiring new staff, including several junior psychologists and social workers, and by conducting specialized trainings on topics such as post-traumatic stress and gender-based violence. Analysis of results from support groups for children affected by HIV and their parents or guardians confirmed statistically significant reductions in levels of depression and anxiety and improvements in overall psychological well-being for both children and adults.
- **Opened the first neonatal intensive care unit in Central Haiti:** In early 2009, ZL opened a neonatal intensive care unit (NICU) in the pediatric ward at Cange, the first of its kind in Central Haiti. NICU staff received specialized training from a pediatric nurse and the head pediatrician at the hospital to care for sick, premature, and low birthweight newborns. The facility is equipped with six incubators—which are almost always full—two radiant warming stations, an oxygen generator, and its own infection control and climate control systems. Babies are referred to the NICU from all ZL facilities in the Central Plateau.



2.6 Million patient visits



4,220 AIDS patients on antiretrovirals

16,547 HIV-positive patients monitored

9,912 children received educational assistance

2,795 adults and adolescents receiving literacy training

9,793 students received free lunches at 27 schools

37.6 tons of ready-to-use therapeutic food for malnourished children produced locally

498 births and **2,146** family planning visits per month at ZL facilities

Staff:

881 medical

1,417 non-medical

2,040 community health workers

Peru/Socios En

In partnership with the Peruvian Ministry of Health, Socios En Salud (SES) continued treatment and social support for MDR-TB and HIV patients. SES also strengthened community outreach, primary health care, mental health, and social support services in the shantytowns around Lima and in other poor communities throughout the country, and campaigned to raise awareness and funds.

HIGHLIGHTS OF THE YEAR

- **Provided treatment and support for MDR-TB and HIV patients:** With technical assistance and training from Socios En Salud, Peru's Ministry of Health now takes primary responsibility for treating MDR-TB nationwide, through a network of 34 regional health districts and 131 hospitals. And Peru boasts the highest cure rate for MDR-TB in the world. SES continues to support nearly 1,500 MDR-TB patients and has extended its reach to other communities, including Pisco, the city devastated by an earthquake in 2007. SES also provides clinical, nutritional and psychosocial support for 1,000 people living with or affected by HIV. In recognition of our work's impact in saving thousands of lives in Peru and around the world, SES was awarded the 2008 Carso Prize for an Exceptional Institution and \$100,000 by the Carso Health Institute, a branch of the Carlos Slim Foundation.
- **Expanded community outreach and services:** SES expanded its programs to reverse the impact of poverty,

A SES health promoter on her rounds

Salud

particularly among women and children, in three shantytown communities outside Lima. Through our *salud infantil* (children's health) program, SES combats malnutrition in children by providing periodic medical exams, supplying nutritious biscuits and meals for underweight children, and giving health and nutrition classes for their mothers. *Salud Infantil* also focuses on education, working with public school teachers to create and use innovative educational materials and games to improve math and language skills among elementary school children. In addition, SES operates 13 health posts in remote, mostly rural communities around Lima. Each of these *botiquines* is overseen by a local woman who has been trained as a health promoter to manage supplies of medicine and coordinate medical and psychological care with SES. In 2008, SES launched an effort to increase green spaces and improve air quality in one of the most polluted districts in Lima. Thirty-seven families participated in a gardening competition.



- **Raised awareness and funds to combat MDR-TB:** SES began its *Danos Una Mano* (Give Us a Hand) campaign as an attempt to build alliances with businesses, the government, and other organizations to raise money for the fight against drug-resistant tuberculosis. Funds raised by the campaign are used to support both clinical services, such as surgery and lab exams, and socioeconomic needs, including food, housing, and jobs. *Danos Una Mano* raised money and awareness through a number of artistic events, including an art exhibit, a contest for short films on the theme of overcoming resistant TB, and a concert. At last count, *Danos Una Mano* had raised more than \$200,000, with a SES match bringing the total to over \$430,000.
- **Provided training in treatment of MDR-TB and HIV:** SES maintained our longstanding commitment to sharing our knowledge and experience, sending a training team to Nicaragua and hosting MDR-TB practitioners from Russia, Pakistan, Azerbaijan, and the United States. SES also hosted representatives from 19 countries on five continents for the World Health Organization's third "TB Consultants Course," marking the first time the course had been conducted in Latin America. SES also organized a conference on the neuropsychiatric and psychosocial aspects of HIV, with an impressive roster of speakers from Peruvian and international universities, including Harvard, the University of Texas, and South Florida University.

SOCIOS EN SALUD BY THE NUMBERS

1,447 MDR-TB and **594** HIV patients supported

4,350 people received nutritional support

55 micro-enterprises launched as income-generating opportunities for patients

1,256 people obtained primary care services at *botiquines*

665 psycho-emotional supports for MDR-TB patients

180 patients received housing support

961 people trained, including 123 doctors, 113 nurses, and 86 health promoters

Staff:

25 medical

102 non-medical

111 community health workers

The Year In Review



*A mother feeds her
malnourished child fruit
from the hospital's garden*

Rwanda/Inshuti

PIH and our Rwandan partner organization, Inshuti Mu Buzima (IMB) continued to improve infrastructure and expand services in the two rural districts in eastern Rwanda where we started working in 2005. And we helped the Rwandan government plan and launch an ambitious program to bring quality health care to every rural district in the country, starting in Burera, one of only two districts without a district hospital.

HIGHLIGHTS OF THE YEAR

- **Supported the national community health worker program:** Community health is one of the 10 principles of the Rwandan government's national rural health care framework and a cornerstone of IMB's work. In early 2008, each *umudugudu* (village) in Rwanda, elected two *binomes* or community health workers. The *binomes* visit each household in their village monthly, and serve as the communities' connection to the health system. In Burera, IMB supported rolling out the national community health model across a district with 400,000 people and 13 health centers by providing training and supporting the salaries of community health nurses and supervisors, as well as community health workers.
- **Opened a new district hospital in Kirehe:** In partnership with the Ministry of Health, IMB built a new district hospital in Kirehe in eastern Rwanda to serve a population of more than 260,000. The hospital opened on October 17, 2008. The hospital holds 108 beds in total and includes both women's and men's wards, maternity, surgery, a laboratory, and a

Mu Buzima

pediatric ward complete with a clinic, a play room and counseling space. IMB also opened a temporary Operating Room in which more than 200 Caesarean-sections were performed between February and the end of June.

■ **Improved food security through agricultural assistance and development:** In August 2008, IMB

launched a new program to address hunger and malnutrition by delivering agricultural education and resources both at the hospital and at patients' homes. The agricultural training center at Rwinkwavu Hospital produces food for hospital patients and provides free agricultural education for parents of malnourished children and HIV/AIDS patients. The Center also trains agricultural assistance workers who visit patients' homes weekly to offer technical support and work with the households to develop and achieve weekly agricultural goals.

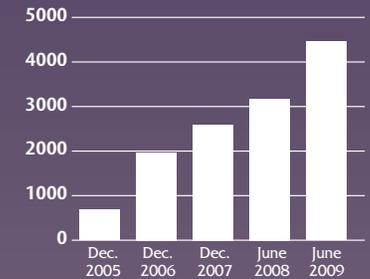


■ **Strengthened women's health services in Burera:** When PIH arrived in Burera, residents recounted stories of women being rowed across Lake Burera for emergency obstetrical care at the nearest district hospital in Ruhengeri. Upon arriving, IMB set to work right away to renovate a temporary hospital facility with a new maternity ward, a temporary operating suite, an ultrasound machine, and a fleet of three ambulances. IMB also supported salaries for two Rwandan nurse-anesthetists and trained community health workers in reproductive health, equipping them with the skills to mobilize women and educate them on the importance of seeking antenatal care and delivering at health facilities.

■ **Expanded psychosocial support for children and adolescents:** Children infected or affected by HIV/AIDS often experience discrimination and rejection in their communities and schools. To give much needed support to these vulnerable children, IMB provides psychosocial support through Saturday Support Groups. Children meet with social workers once a month, both individually and in a group, where they learn about HIV, talk about their fears, experiences, and aspirations, and participate in age-appropriate games and other activities. This year, more than 300 children received counseling each month across seven sites.



4,559 AIDS patients on therapy



53,779 patients tested for HIV

535,618 patient visits
(including 43,999 hospitalizations)

44,153 cases of malaria
diagnosed and treated

19,256 babies delivered

1,100 food packets distributed
each month

687 children received secondary
school fees

Staff:

666 medical

510 non-medical

2,732 community health
workers

Lesotho/Bo-Mpha

PIH Lesotho continued to bring comprehensive primary health care to remote mountain communities, and to provide community-based treatment for HIV and drug-resistant TB. We completed critical infrastructure projects, treated thousands for HIV and TB, initiated activities for orphans and vulnerable children, and piloted women's health programs.

HIGHLIGHTS OF THE YEAR

■ Expanded the comprehensive healthcare program in

rural areas: The Lesotho project expanded our rural initiative to a seventh remote mountain clinic in Manamaneng. With the help of over 1,000 trained village health workers, the clinics provide integrated primary care, HIV/AIDS treatment, and TB treatment, as well as food distribution and supplementation services. Several infrastructure projects were completed, making it possible to transport staff, patients, food, and supplies to the rural clinic sites more safely and rapidly. The projects included a new road at the Lebakeng clinic and a temporary bridge over a river near Nkau.



Children in a mountain community served by PIH Lesotho.

to Litšebeletsong tsa Bophelo

■ **Initiated child-focused activities:** One out of four children in Lesotho has lost one or both parents to HIV, giving Lesotho the highest orphan rate in the world. PIH Lesotho has collaborated with Catholic Relief Services and other partners to scale up services to thousands of orphans in the areas surrounding three of our health centers. Projects include a comprehensive prevention of mother-to-child transmission program, weekly clinic days focused on primary care for young children, and the incorporation of children's health into the village health worker training.

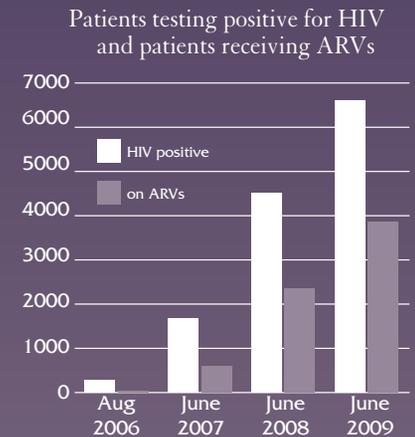


■ **Piloted women's health projects:** The Lesotho team implemented a number of effective, wide-ranging women's health programs, including rehabilitating lying-in houses near each health center to encourage clinic-based deliveries. The team assisted the Ministry of Health in drafting a successful application for Lesotho to receive 120,000 doses of Gardasil © (Human Papilloma Virus vaccine) to protect women against cervical cancer. The team also obtained funding from the Elton John AIDS Foundation to pilot a project that will train traditional birth attendants to encourage women to come to clinic for testing and treatment of HIV and other sexually-transmitted infections, as well as for pre- and post-natal care and assisted deliveries.

■ **Expanded the multi-drug resistant tuberculosis program:** PIH Lesotho has partnered with the Ministry of Health to provide MDR-TB treatment at the community level, training and employing community health workers who visit patients in their homes twice a day. The project trains healthcare staff throughout the country on MDR-TB and MDR-TB/HIV co-infection. All patients with suspected MDR-TB in Lesotho are referred to the project for treatment. The program has become a beacon for other sub-Saharan countries looking to implement MDR-TB treatment; to date, the program has provided training for medical professionals from Ethiopia, South Africa, Swaziland, and Tanzania, and program staff have traveled to Namibia, Swaziland, and Kenya to provide technical assistance.



PIH LESOTHO BY THE NUMBERS



12,168 patients tested for HIV in FY2009, of whom 2,381 tested positive

1,674 HIV patients enrolled on antiretroviral therapy

714 cases of TB diagnosed of whom 49% are co-infected with HIV

320 MDR-TB patients received treatment

3,200 households receiving food supplements

1,000 (approx.) community health workers trained (as of June 30, 2009)

Staff:

55 medical

143 non-medical

1,490 community health workers

The Year In Review

Malawi/Abwen

Little over two years after Abwenzi Pa Za Umoyo (APZU) was launched, PIH's Malawian partner organization has transformed public health infrastructure and services in Neno District. APZU has constructed two new hospitals, refurbished health centers, strengthened staffing throughout the district, and trained nearly a thousand community health workers.

HIGHLIGHTS OF THE YEAR

- **Constructed Lisungwi Community Hospital:** With generous support from the Abbott Fund, construction was completed on a new community hospital designed around a central courtyard to provide improved infection control, patient flow, and an attractive, comfortable atmosphere for both patients and staff. The hospital has 60 beds in pediatric and adult wards, x-ray and ultrasound, and a full laboratory capable of CD4 count testing for HIV patients.
- **Expanded the village health worker model:** APZU adapted a new approach developed in Rwanda that broadens village health workers' responsibilities from focusing primarily on treatment of HIV and TB patients, to covering a fixed number of households for many health-related issues. At APZU, the village health workers are responsible for visiting 30 households once a month. They will continue to care for HIV and TB patients, but will now also care for chronic diseases and basic health needs like antenatal care and childhood vaccinations.



*Food distribution
in Malawi*

zi Pa Za Umoyo

ABWENZI PA ZA UMOYO BY THE NUMBERS

■ **Developed ground-breaking information technology:** The Malawi Ministry of Health (MOH) has piloted an innovative touchscreen system for collecting HIV/AIDS treatment data at the point of care, called the Baobab Antiretroviral Treatment system, or BART. Developed by Baobab Healthcare, BART guides clinical care and improves data accuracy while giving clinicians real-time access to the data. Recognizing the value of BART's point-of-care approach, APZU has been collaborating with Baobab on a new system for primary care that registers patients and records key information such as weight, height, diagnosis and treatment. It has been enthusiastically adopted by APZU's MOH colleagues at Neno District Hospital and is compatible with OpenMRS, an open source electronic medical records system used by APZU, for which PIH is one of the leading architects and developers.



■ **Increased ART clinics:** In 2009, APZU doubled the number of clinics providing antiretroviral treatment (ART) for HIV patients from two to four. Doubling the number of ART clinic sites will allow more patients to enroll in ARV treatment regimens. This should also improve patients' ability to seek care and adhere to their treatments by making it easier for many patients to travel to and from clinics. With more ART sites, APZU has increased staff capacity to provide care and treatment for HIV in Neno District. Each of these sites has a village health worker program based at its clinic. APZU plans to double the number of clinics again by June 2010.

■ **Provided homes, schools, and jobs:** APZU's Program on Social and Economic Rights (POSER) built 20 patient houses, supported 378 children's schooling expenses, and supported vocational programs through community-based organizations and women's groups. POSER also provides clothing, food and agriculture support to families in need. The vocational and income generating programs at community-based organizations include carpentry, tailoring, fish farming, goat husbandry, and permaculture sustainable agriculture programs. Seven community-based organizations are currently being supported. Three income-generating activities are supporting vulnerable women. These include a knitting program, a bakery, and a restaurant. Local women's groups run the programs and receive all the proceeds.



17,294 patients tested for HIV

2,400 HIV patients receiving antiretroviral therapy

232,966 outpatient visits at 10 facilities

660 women enrolled in Prevention of Mother to Child Transmission program

34,000 bednets distributed

20 houses built for families of patients

378 children receiving tuition support

556 community health workers trained

Staff:

103 medical

276 non-medical

543 community health workers

The Year In Review

Russia/ Партнеры во имя Здоровья

PIH Russia expanded and extended its services to improve treatment and outcomes for TB patients in Tomsk Oblast and provided intensive assistance to new MDR-TB programs in two neighboring territories in Siberia.

HIGHLIGHTS OF THE YEAR

- **Expanded and extended MDR-TB and TB work in Tomsk:** PIH continued to enroll new MDR-TB patients from both the prisons and the civilian population into our program in Tomsk Oblast in Siberia. Another 177 patients were started on treatment during the year. PIH also worked with our partners in Tomsk to secure a six-year, \$13.1 million continuation grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The grant will enable us to continue and expand our work after the current five-year grant runs out on December 1, 2009. Under the new grant, PIH and our partners will be able to extend coverage to all TB patients in Tomsk, including those with drug-susceptible, poly-resistant, and MDR-TB.
- **Provided TB testing and prevention services for HIV patients:** While the population of HIV-infected individuals is small in Tomsk Oblast, the rate of new infections is high, particularly among population groups who are also at high risk of infection by TB. In order to reduce the risk of HIV/TB coinfection, PIH provided tuberculosis skin tests to 500 HIV-positive patients in both the civilian and prison sectors. Of that population, 131 patients were prescribed medication along with additional food support to prevent latent infections from developing into active cases of TB.
- **Provided intensive assistance to MDR-TB programs in two new territories:** With help from the Eli Lilly and Company Foundation and the Russian Health Care Foundation, PIH helped launch MDR-TB programs in Novosibirsk and Altay Kray, two territories bordering Tomsk Oblast. PIH provided intensive technical assistance to strengthen the capacity of TB providers to manage MDR-TB, establish regular clinical consultations, and improve collaboration between the prison and civilian sectors. In their first 18 months, the programs enrolled 1,400 patients on treatment.

BY THE NUMBERS

897 new TB patients
and 177 new MDR-TB
patients enrolled

Default rates reduced to
1.9% for TB and
10.7% for MDR-TB

840 new TB and
MDR-TB patients
received nutritional
support

115 doctors from 10
countries in the former
Soviet Union trained in
MDR-TB management

Staff
6 medical
11 non-medical

*A laboratory technician
with samples*

USA/PACT

The Prevention and Access to Care and Treatment (PACT) Project broadened its Directly Observed Therapy (DOT) program to assist more patients suffering from HIV/AIDS. PACT also continued development of a new program to provide community-based care for patients with diabetes and began adapting its model to serve patients at high risk for complications from multiple chronic diseases.

HIGHLIGHTS OF THE YEAR

- **Improved Directly Observed Therapy (DOT) services to reach more patients:** PACT continued to serve HIV/AIDS patients throughout Boston and branched out from the Roxbury/ Dorchester neighborhoods to include Milton, Everett, Cambridge, Somerville and East Boston.
- **Prepared to launch diabetes project:** PACT's diabetes team worked closely with the Codman Square Health Center in Dorchester to finalize plans for implementing and evaluating a program that will employ community health workers (CHWs) to support patients with diabetes. Enrollment of 150 patients into the program was scheduled to begin in October 2009. The team will be collecting data on the feasibility and acceptability of integrating the CHW model into community health centers.
- **Developed a model for community-based treatment of chronic disease:** Over the past year, PACT has developed a "generalist" CHW model that allows for a holistic and coordinated approach to treating patients who suffer simultaneously from two or more chronic conditions, such as HIV, diabetes, asthma, chronic obstructive pulmonary disease, cardiovascular disease, and mental illness.

BY THE NUMBERS

137 patients received community-based care

22 new patients enrolled on treatment

39 patients served with Directly Observed Therapy (DOT)

5,538 DOT visits and **4,592** health promoter visits made

321 total patients served since the program was started

Staff
16 non-medical
12 community health workers



A member of PACT's harm reduction team doing street outreach

Mexico/EAPSEC

Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC) continues to train and support Community Health Promoters throughout the state of Chiapas. The organization makes long-term commitments to communities, leading a transformative process of education, organization and action.

HIGHLIGHTS OF THE YEAR

- **Helped build a state-wide health promoter network:** EAPSEC held two coordination and education conferences with health promoters from throughout the state of Chiapas. Topics included a discussion of Mayan history and an exchange of information about medicinal plants, including when their use is appropriate. Overall EAPSEC seeks to give participants new tools to analyze the world around them as well as ways to confront challenges.
- **Organized certificate programs for health promoters:** EAPSEC acted as a key organizer for certificate programs in collective health for advanced health promoters. The average participant had over five years of experience and left the course equipped with new information on the social determinants of health, ecology and health, and management and health policy. The program also served as a valuable cultural exchange, bringing together mestizos (people with mixed European and Amerindian heritage) and members of several indigenous groups—Zoques, Tzeltals, Tzotziles and Mams—to share experiences.
- **Advocated for TB treatment and the right to health:** Chiapas continues to suffer some of the highest tuberculosis incidence and mortality in Mexico. Mexico's national congress issued a directive requiring each state to undergo an audit of its tuberculosis-control program by the state Health Institute. As a member of the Committee, EAPSEC is using this development as leverage to demand the creation of an ongoing accountability mechanism: the Citizens Advocacy Center for the Right to Health.
- **Developed software to support health promoters:** EAPSEC collaborated with D-Tree International and Dimagi, Inc., to develop decision-support programs on mobile devices. The goal of the software is to help Health Promoters diagnose and manage common diseases, using a programmed decision tree based on medical evidence. Health promoters and physicians recently performed a first qualitative pilot. The software has the potential to support health workers' ability to deliver a high standard of care in remote areas.



A boy wearing a cast to treat a club foot

Electronic Medical Records

The PIH informatics team continued to expand the use of OpenMRS at our sites. OpenMRS is an open-source medical record system that has been developed since 2004 by PIH and several partner organizations, including the Regenstreif Institute at the University of Indiana and the South African Medical Research Council. It is now being implemented around the world in over 20 countries and has become the foundation of a large international collaboration.

HIGHLIGHTS OF THE YEAR

- **Developed tools to improve reporting and case management:** The informatics team made significant progress in developing new form-entry tools in an open-source environment, as well as easy-to-use reporting tools to allow non-programmers to report outcomes and other important data for HIV/AIDS, TB and other diseases. In Rwanda and Malawi, we also developed tools for primary care and chronic disease management, such as heart failure.
- **Expanded the capabilities and use of OpenMRS for MDR-TB management and research:** The MDR-TB module to track the treatment of patients with multi-drug resistant tuberculosis is now running in Haiti and Pakistan and is being implemented in Rwanda in partnership with the government. In Lima, Peru, new research data management tools were used for a large NIH-funded study of MDR-TB transmission.
- **Helped build local programming capacity:** With support from the Canadian government's International Development Research Centre (IDRC), we launched a mentor-driven training course in Kigali, Rwanda for ten Rwandan computer programming graduates, focusing on Java programming and practical skills in healthcare informatics. Skilled Rwandan programmers are especially critical in the Government of Rwanda's plan to implement OpenMRS on a national level and also contribute to the government's larger strategy to create a strong information technology sector.
- **Fostered OpenMRS collaboration:** In May 2009, PIH hosted an OpenMRS conference in Boston. The meeting was attended by over 50 people representing our partners and interested organizations and was webcast to colleagues and collaborators in Rwanda, Peru, Nicaragua, and the United States.



Working on the antenna for a hospital network in Malawi

Training

PIH's training department continued to develop curricula and guides and to build training teams at each of our project sites. The training program aims not only to synthesize experiences and standardize training at our sites but to make training materials available for adaptation and use by other organizations working to reduce poverty and health disparities around the world.

HIGHLIGHTS OF THE YEAR

- **Trained community health workers to improve patient care:** PIH trained more than 2,200 community health workers in 2008 and plans to train close to 4,000 more by the end of June 2010. The trainings are based on the PIH *accompagnateur* curriculum, which has now been translated into Haitian Creole and the local languages of Rwanda, Lesotho and Malawi. While initially envisaged to focus on training in the management of HIV, the curriculum has been expanded to include units on a wide range of primary health care topics, including malaria, reproductive health, nutrition, and childhood illnesses.
- **Prepared new materials for program managers and for nurses and physicians:** The training department achieved significant progress in developing two new PIH publications: a Program Management Guide and an HIV curriculum for nurses and physicians. With input from PIH project managers, clinicians, and administrators in Boston and at all of our sister organizations, the Program Management Guide provides recommendations for program planning and implementation, including how to support clinical services, build site infrastructure, and establish a stable human resources system. The HIV curriculum uses a case-based approach to train clinicians in PIH's community-based model of care. Both documents will be completed and made available for free download in 2010.
- **Supported training initiatives by partner organizations and governments:** The value and growing impact of PIH's training program could be seen in projects around the globe. In Liberia and Burundi for example, projects are drawing on our training materials to replicate key elements of PIH's rural health care model. The *accompagnateur* curriculum is also being used to train CHWs in South Sudan, Zambia, Pakistan, and the Dominican Republic. The Government of Rwanda has made a commitment to adapt and use PIH's *accompagnateur* training curriculum nationwide as part of its plan to scale up a national rural health care framework based on community health workers elected in every village.

Advocacy

Backed by generous funding support from the Skoll Foundation and the John M. Lloyd Foundation, PIH achieved significant success in advocating for a model of comprehensive community-based health care that supports the public sector and focuses on those who are most vulnerable.

HIGHLIGHTS OF THE YEAR

- **Advocated for changes in global health policy:** PIH collaborated with several partner organizations to publish a report with global health recommendations for the new Administration and Congress. Consistent with PIH's principles, the recommendations covered all facets of global health from fully funding PEPFAR II and supporting the public sector to rescinding the Global Gag Rule and paying community health workers.
- **Helped build a unified movement for the right to health:** In May 2009, PIH hosted a two-day meeting attended by representatives from many different global health constituencies to develop a unified movement around the right to health for all. By bringing together leading advocates for HIV/AIDS, tuberculosis, primary health care, sexual and reproductive rights, women's health, and child health, the conference was able to build upon both the founding principles adopted at the Alma Ata Conference on Primary Health Care in 1978 and the success of the HIV/AIDS movement in mobilizing resources and commitment to address the global epidemic. Conference participants drafted a declaration calling for solidarity in the global health community to achieve the right to health for all persons.
- **Advanced socioeconomic development in Haiti:** PIH raised awareness and support for equitable socioeconomic development in Haiti within Congress and the Administration by organizing several meetings with members and staff, by hosting multiple Congressional delegation visits to Haiti, and by Paul Farmer speaking to Senate Chiefs of Staff and Committee Chiefs about Haiti. PIH representatives attended and spoke at the Donor's Conference for Haiti in April 2009 and with our partners, the RFK Center for Justice and Human Rights and the NYU School of Law's Center for Human Rights and Social Justice, organized a briefing in Congress following the Conference.
- **Combated pervasive hunger and malnutrition:** PIH drew attention to the intersection between the right to food and a rights-based approach to health by meeting with congressional staff about integrating components of this model into new food security bills and speaking on a panel at a conference on "The Human Right to Food and the Global Food Crisis: Root Causes and Responses", hosted by the United Nations. To spread the word on a wider scale, PIH also drafted an emergency resolution on food security that was adopted by the American Public Health Association in 2008.



SES health promoters in Peru

Research

Research conducted with our partners at Brigham and Women's Hospital, Harvard Medical School, and the Harvard School of Public Health is an essential part of our work. Our programs and our advocacy work are shaped and strengthened by studies that examine the challenges we face and measure the impact of our efforts.

HIGHLIGHTS OF THE YEAR

- **Assessed the impact of global health initiatives on health systems:** As part of a research program initiated by the World Health Organization, PIH and Brigham and Women's Hospital studied the impact on health systems in Haiti and Rwanda of large-scale funding earmarked for specific diseases provided by global health initiatives (GHIs) like the President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Data collected from eight facilities in the two countries were used to assess changes in infrastructure, human resources, clinical outcomes (for both the diseases targeted by the GHIs and other conditions) and access to services. The study found that GHI funding was associated with improvements at all of the sites in physical and laboratory infrastructure, in referral networks, in human resources, in access to services and in clinical care of both targeted (mainly HIV) and non-targeted diseases. No evidence was found to support charges that GHI funding detracts from comprehensive primary healthcare services.
- **Measured the benefits of laboratory information systems:** The Electronic Medical Records (EMR) team at PIH and Brigham and Women's Hospital completed two studies on laboratory information systems in Lima, Peru. In the first study, a system based on personal digital assistants was shown to reduce the rate of errors in TB laboratory data by 57.1 percent and to reduce the time taken for results to be entered into the EMR by 65 percent, compared to the control group. In a second, larger study of over 1,800 patients, the eChasqui system was shown to reduce reporting errors in TB drug-sensitivity test results by 82 percent. The system also shortened the time for physicians to access data and through an internal survey system showed that 60 percent of duplicate tests were unnecessary.
- **Earned a major grant to evaluate the impact of comprehensive, community-based care:** PIH partnered with the Rwandan government, Brigham and Women's Hospital, and Harvard Medical School and School of Public Health to obtain an \$8 million grant from the Doris Duke Charitable Foundation to conduct a rigorous evaluation of the effectiveness, cost, and overall impact of a comprehensive approach to delivering public health services in rural Rwanda. The grant will support implementation of integrated primary care services at 10 health centers, including the establishment of a network of trained, supervised and fairly compensated community health workers. The research agenda over five years is directed towards a rigorous economic and program evaluation of the cost and efficacy of the intervention in improving health access and outcomes.

A laboratory worker in Lesotho

Selected Publications

Betancourt TS, Speelman L, Onyango G, Bolton P. A qualitative study of mental health problems among children displaced by war in northern Uganda. *Transcultural Psychiatry*. 2009 Jun;46(2):238-56.

Blaya JA, Cohen T, Rodriguez P, Kim J, Fraser HS. Personal digital assistants to collect tuberculosis bacteriology data in Peru reduce delays, errors, and workload, and are acceptable to users: cluster randomized controlled trial. *International Journal of Infectious Diseases*. 2009 May;13(3):410-8.

Cohen T, Colijn C, Murray M. Modeling the effects of strain diversity and mechanisms of strain competition on the potential performance of new tuberculosis vaccines. *Proceeding of the National Academy of Sciences U S A*. 2008 Oct 21;105(42):16302-7.

Furin JJ, Behforouz HL, Shin SS, Mukherjee JS, Bayona J, Farmer PE, Kim JY, Keshavjee S. Expanding global HIV treatment: case studies from the field. *Annals of the New York Academy of Sciences*. 2008;1136:12-20.

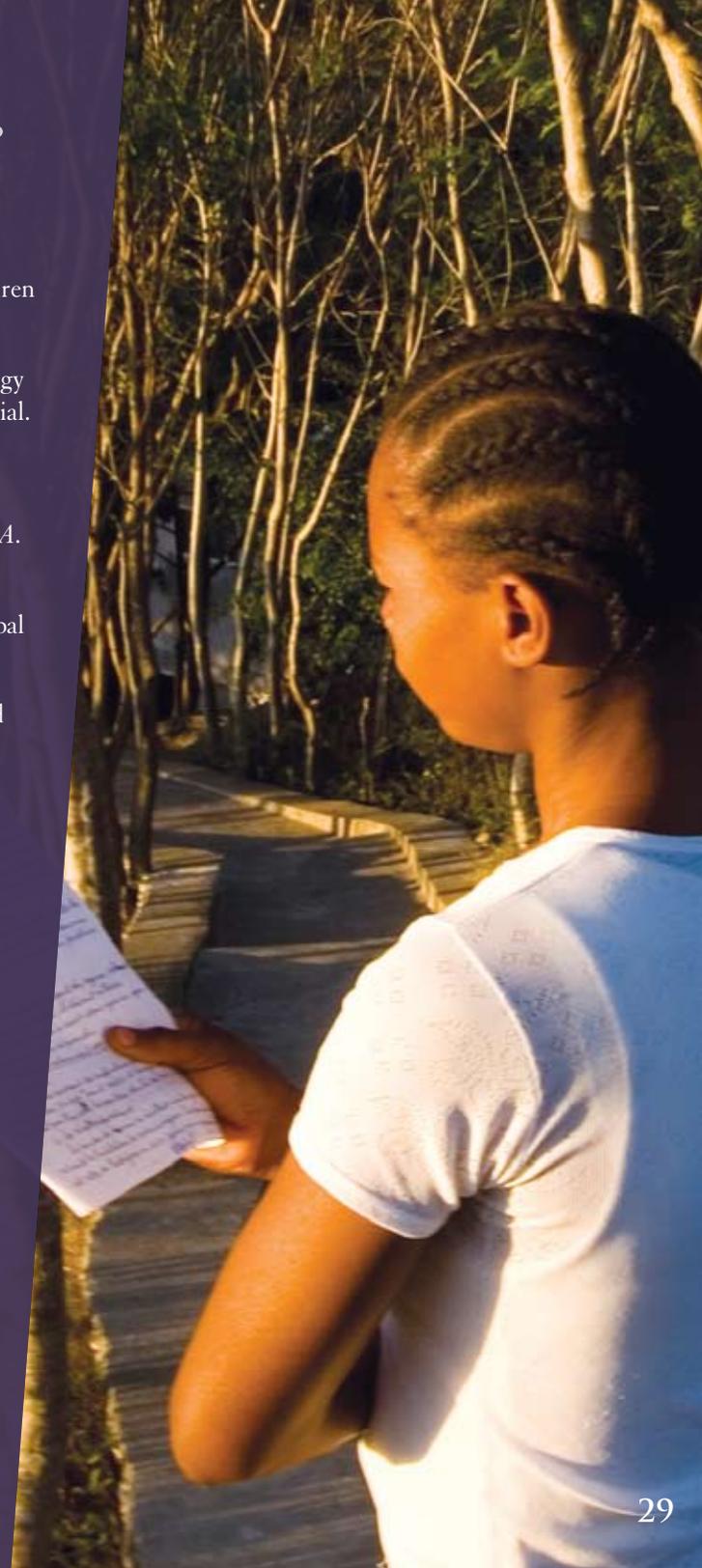
Keshavjee S, Gelmanova IY, Farmer PE, Mishustin SP, Strelis AK, Andreev YG, Pasechnikov AD, Atwood S, Mukherjee JS, Rich ML, Furin JJ, Nardell EA, Kim JY, Shin SS. Treatment of extensively drug-resistant tuberculosis in Tomsk, Russia: a retrospective cohort study. *Lancet*. 2008 Oct 18;372(9647):1403-9.

Mathew TA, Yanov SA, Mazitov R, Mishustin SP, Strelis AK, Yanova GV, Golubchikova VT, Taran DV, Golubkov A, Shields AL, Greenfield SF, Shin SS; Tomsk Tuberculosis Alcohol Working Group. Integration of alcohol use disorders identification and management in the tuberculosis programme in Tomsk Oblast, Russia. *European Journal of Public Health*. 2009 Jan;19(1):16-8.

Mitnick CD, Shin SS, Seung KJ, Rich ML, Atwood SS, Furin JJ, Fitzmaurice GM, Alcantara Viru FA, Appleton SC, Bayona JN, Bonilla CA, Chalco K, Choi S, Franke MF, Fraser HS, Guerra D, Hurtado RM, Jazayeri D, Joseph K, Llaro K, Mestanza L, Mukherjee JS, Muñoz M, Palacios E, Sanchez E, Sloutsky A, Becerra MC. Comprehensive treatment of extensively drug-resistant tuberculosis. *New England Journal of Medicine*. 2008 Aug 7;359(6):563-74.

NYU School of Law Center for Human Rights and Social Justice (CHRSJ), Partners In Health (PIH), RFK Memorial Center for Human Rights, and Zanmi Lasante (ZL). *Woch nan Soley: The Denial of the Right to Water in Haiti*. New York, NY: NYU CHRSJ, PIH, RFK, and ZL, 2008.

World Health Organization Maximizing Positive Synergies Collaborative Group, Samb B, Evans T, Dybul M, Atun R, Moatti JP, Nishtar S, Wright A, Celletti F, Hsu J, Kim JY, Brugha R, Russell A, Etienne C. An assessment of interactions between global health initiatives and country health systems. *Lancet*. 2009 Jun 20;373(9681):2137-69.





*Students in a classroom
in Rwanda*

Finance & Governance

Financial Review

Partners In Health has faced many financial challenges in its twenty plus years, and fiscal year 2009 was certainly no exception. As we watched the financial markets tumble, our immediate concern was over the impact this would have on our patients, among the most vulnerable to any economic decline. As we reevaluated our spending plans in early January, there was much pressure to cut back due to financial concerns. We delayed and postponed all that we could, made a few difficult cuts, but mostly resolved that we just had to raise the funding needed – somehow. Given that we had budgeted for an increase in expenditures from \$51 million to \$64 million, raising revenues to this level in the distressed economy, the worst any of us have ever seen, was a considerable challenge. Thanks to the incredible generosity of our donors, however, by the end of June, we had largely closed the gap, realizing a 20 percent increase in revenues compared to last year.

Our longer term investments declined by \$3.3 million, reducing our reserves in the Thomas J. White Fund (the “Fund”) from \$16.2 million to \$13.6 million, after factoring in new gifts to the Fund. This level of reserves is uncomfortably low given that we now support 49 sites worldwide and over 11,000 employees – a substantial majority of them living in settings of extreme poverty – and expend over \$5 million per month.

Cash constraints are particularly acute in November and December, in advance of the holiday giving period during which fully a third of the annual dollar value of our individual gifts is received. So we have embarked on a strategy to rebuild the reserves over time, primarily through new gifts to the Fund. As we move ahead on these plans, we find ourselves reflecting on how very lucky we are to have this Fund, set up by some visionary donors who knew that times like this were possible. It is solely due to this Fund that we have not needed to make draconian and painful cuts for our fiscal year 2010 as we will draw down the Fund through December to provide for the level annual expenses while we await the yearend giving season.

As we look ahead, we are planning to hold spending relatively steady with this past fiscal year and hope to raise revenues at the same level, as well. In an organization that has experienced such significant recent growth – and faces such enormous need – achieving a steady state year is in itself quite a challenge. So we are looking to expand our sources of revenue, building especially our individual giving program and also our public sector revenue stream, in order to allow for future growth.

We are so very grateful for your continued interest and support of Partners In Health.

Donella M. Rapier

Chief Financial Officer



Children in a psychosocial support group in Rwanda

Financial Review

STATEMENT OF ACTIVITIES

(dollars in thousands)

For the year ended

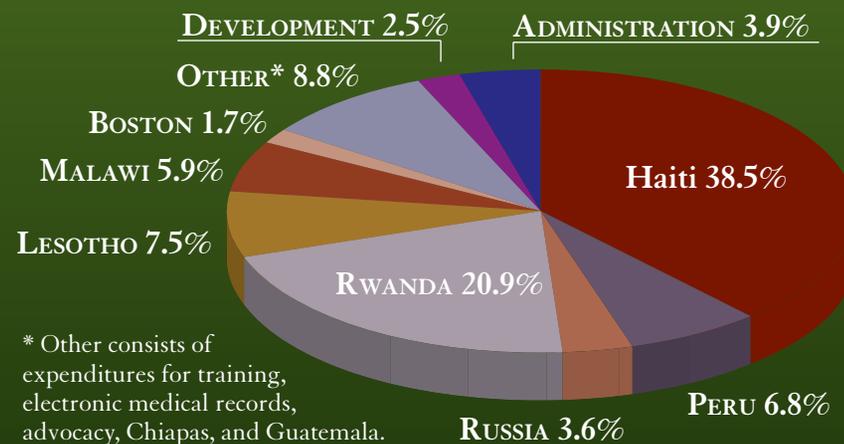
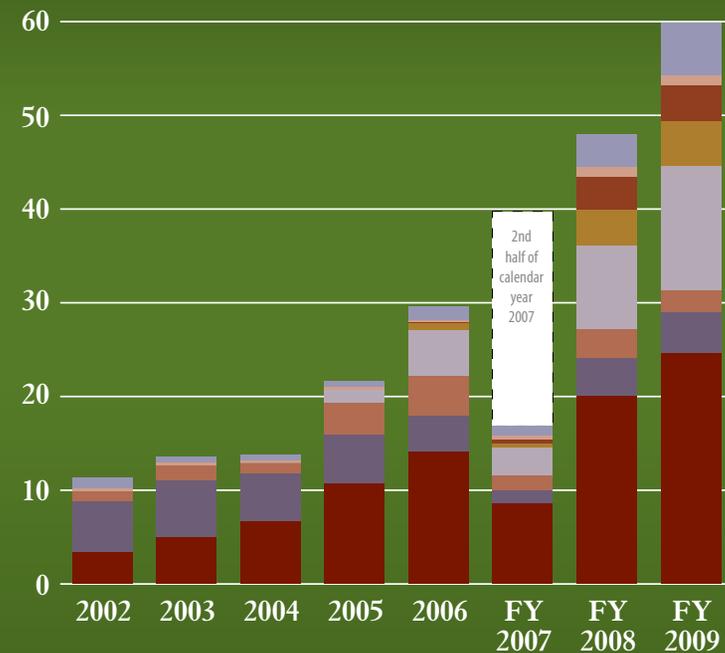
June 30, 2009 June 30, 2008

REVENUE		
Contributions, grants and gifts in kind		
Individuals and family foundations	\$30,131	\$26,786
Foundations and corporations	14,915	13,130
Governments, multilateral & research institutions	14,468	11,278
Special events	2,180	498
Gifts in kind and contributed services	1,523	1,196
Other income	152	51
Total revenue	63,369	52,939
EXPENSES		
Program services	59,855	47,976
Development	1,590	1,189
Administration	2,490	1,734
Total expenses	63,935	50,899
Excess/(shortfall) of revenue over expense	(566)	2,040
Investment income/(loss)	(3,324)	(249)
Change in net assets	(3,890)	1,791
Currency translation adjustments	(59)	133
Net assets at beginning of year	32,676	30,752
Net assets at end of year	28,727	32,676

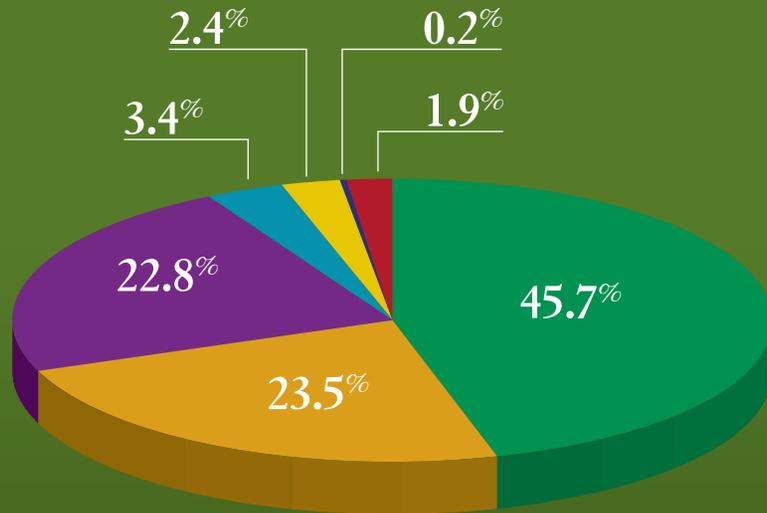
Note: Just 6.4% of total expenditures in FY09 went toward administration and development, with the vast majority of funding going directly to program activities.

PROGRAM COSTS 2002-FY2009

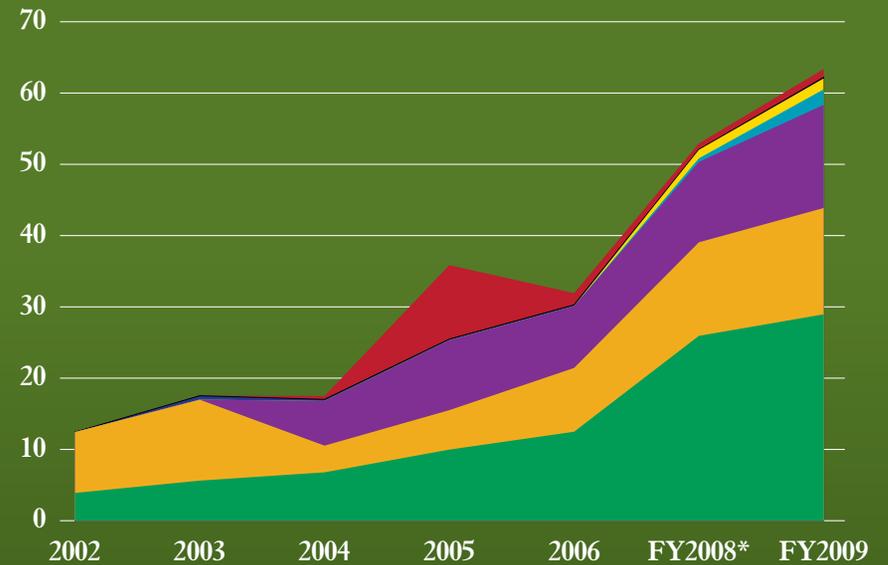
(DOLLARS IN MILLIONS)



REVENUE BY SOURCE 2009



REVENUE BY SOURCE 2002-2009



* In 2007, PIH changed from a calendar year end to a fiscal year ending June 30. As a result, 2007 has been excluded due to only 6 months of operating results in that fiscal year.

INDIVIDUALS AND FAMILY FOUNDATIONS
 FOUNDATIONS AND CORPORATIONS
 GOVERNMENTS, MULTILATERAL AND RESEARCH INSTITUTIONS

SPECIAL EVENTS
 GIFTS IN KIND AND CONTRIBUTED SERVICES

OTHER INCOME
 GIFTS TO THE THOMAS J. WHITE FUND

Financial Review

STATEMENT OF CASH FLOWS

For the year ended June 30,

(dollars in thousands)	2009	2008
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	(\$3,890)	\$1,791
<i>Adjustments to reconcile change in net assets to net cash used in operating activities</i>		
Depreciation and amortization	460	274
Net realized and unrealized losses on investments	3,634	1,084
Currency translation adjustments	(60)	133
<i>Changes in</i>		
Accounts receivable	(311)	(131)
Contributions receivable	(2,127)	(234)
Grants receivable	(182)	(3,410)
Prepaid expenses and other assets	(30)	99
Accounts payable and accrued expenses	591	(494)
Net cash used in operating activities	(1,915)	(888)
CASH FLOWS FROM INVESTING ACTIVITIES		
Additions of property and equipment	(569)	(2,074)
Sales of investment securities	11,329	9,942
Purchases of investment securities	(7,550)	(10,623)
Net cash provided by/(used in) investing activities	3,210	(2,755)
CASH FLOWS FROM FINANCING ACTIVITIES		
Borrowings on line of credit	3,500	–
Repayments on line of credit	(3,500)	–
Net cash provided by financing activities	–	–
Net change in cash and cash equivalents	1,295	(3,643)
Cash and cash equivalents at beginning of year	3,923	7,566
Cash and cash equivalents at end of year	5,218	3,923

BALANCE SHEET

as of June 30,

(dollars in thousands)	2009	2008
ASSETS		
Cash and cash equivalents	\$5,218	\$3,923
Accounts receivable	1,077	766
Contributions receivable	2,362	235
Grants receivable	4,122	3,940
Prepaid expenses and other assets	142	112
Investments	15,649	23,063
Property and equipment, net	2,725	2,615
Total assets	31,295	34,654
LIABILITIES AND NET ASSETS		
<i>Liabilities</i>		
Accounts payable and accrued expenses	2,322	1,978
Amounts owed – fiscal agencies	246	–
Total liabilities	2,568	1,978
<i>Net assets</i>		
Unrestricted		
Currency translation adjustments	242	301
Undesignated	7,093	10,021
Thomas J. White Fund	13,641	16,241
Total unrestricted net assets	20,976	26,563
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Total net assets	28,727	32,676
Total liabilities and net assets	31,295	34,654

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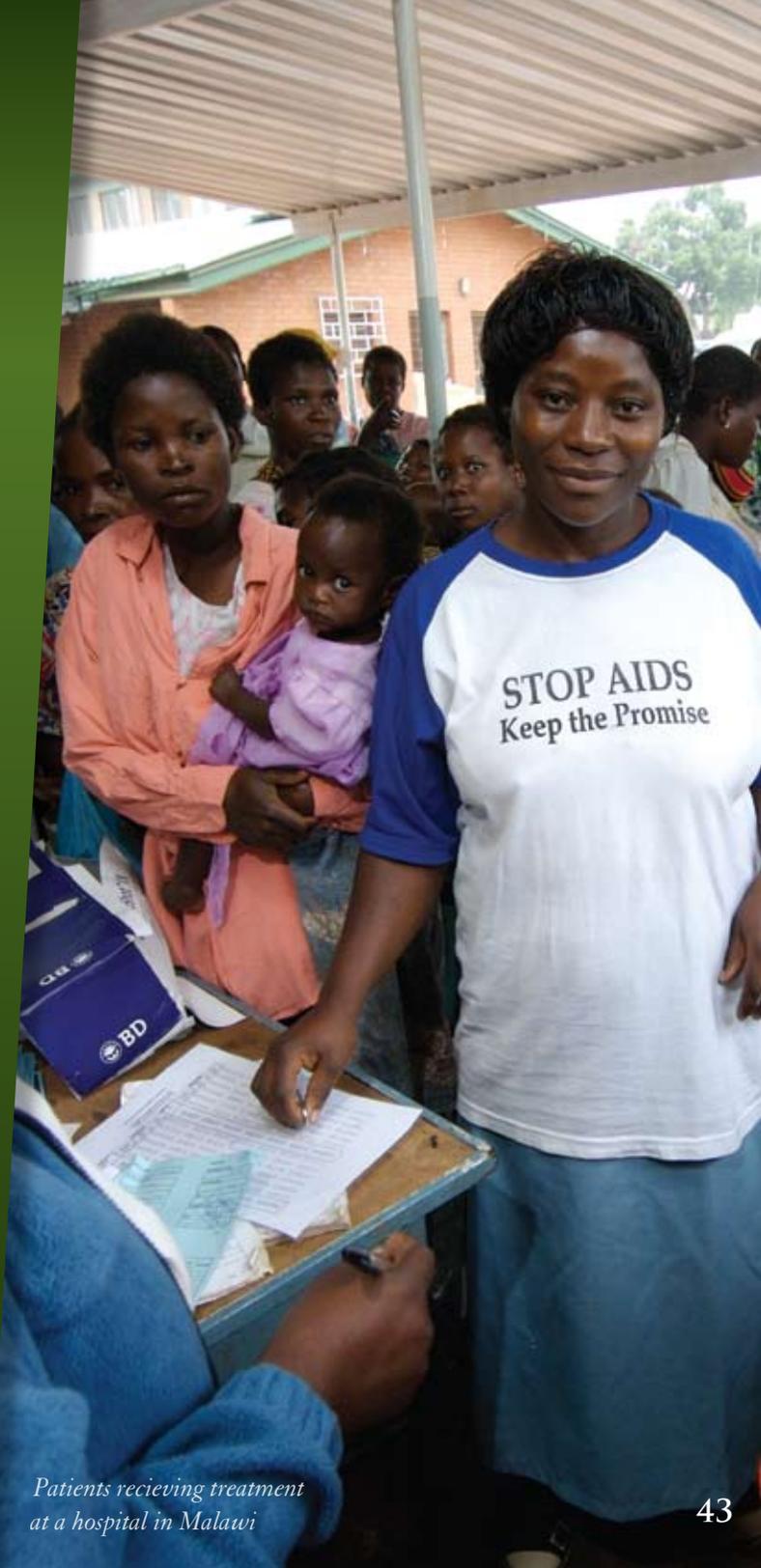
Guitèle Nicoleau

Haun Saussy

Amartya K. Sen

Loune Viaud

Thomas J. White









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