



From
Innovation
To **Transformation**

2011 ANNUAL REPORT

Director's Message

Dear Friends,

As 2011 draws to a close, Partners In Health is approaching several major milestones. On January 12, we will observe the second anniversary of the devastating earthquake that destroyed Haiti's capital and killed over a quarter million people. Six months later, we will celebrate the opening of the 320-bed, national referral and teaching hospital we have been building at breathtaking speed in Mirebalais. Around the same time, we will spend the last of the tens of millions of dollars we received after the earthquake, fulfilling the commitment of our Stand With Haiti plan to invest it all in emergency relief and long-term reconstruction over a 30-month period.

On my first visit to Haiti following the earthquake, I observed, "Haiti's catastrophe will forever divide its history into before earthquake and after." I also realized, although I didn't say so at the time, that the earthquake would demarcate PIH's history as well.

In the two years since the earthquake—with the support of so many of you who have rallied to our side—our Haitian colleagues have truly performed miracles. They have worked tirelessly to provide lifesaving medical care to tens of thousands of people affected first by the earthquake and then, less than a year later, by a deadly outbreak of cholera that has now killed more than 6,500 people and sickened nearly half a million. They have reinforced our own services and supported national initiatives to strengthen rehabilitative medicine, mental health, and other specialties that had always been weak in Haiti and were even more desperately needed by a population scarred physically and emotionally by the back-to-back disasters. And they have managed to push ahead with major initiatives to rebuild Haiti's public systems for health and education of health professionals.

Mirebalais Hospital is not just the biggest reconstruction project undertaken anywhere in Haiti since the earthquake. When it opens it will stand as the finest hospital in the country, as a center of excellence for education of the next generation of Haitian doctors and nurses, and as a beacon of hope for the people of Mirebalais, the Central Plateau, and the entire nation.

Even as we have necessarily focused attention and resources on Haiti, our projects in 11 other countries have not only maintained and strengthened their existing services but have managed to innovate game-changing approaches to maternal mortality, cancer, and other intractable and neglected conditions among the poor.

Complications of pregnancy and childbirth still kill nearly 1,000 poor women a day. Over the past two years, our Lesotho team has pioneered and rapidly scaled up an innovative program that has already recorded significant increases in women receiving pre- and post-natal care and delivering their babies at health centers in some of the world's poorest and most isolated communities.

Director's Message (continued)

Cancer is among the diseases that have been largely neglected in developing countries. Even though developing countries bear 80 percent of the world's burden of cancer, they receive only five percent of the resources devoted to prevention, treatment, and palliative care. Nearly 2.5 million cancer deaths a year in developing countries could be averted using prevention and treatment interventions that are widely available and readily affordable, according to a report published recently by a global task force PIH helped form and lead, along with our partners at Harvard Medical School and Brigham and Women's Hospital. The report highlights PIH projects in Rwanda and Haiti as pioneering initiatives to prevent and treat a variety of cancers, including cervical cancer and Burkitt's lymphoma, a deadly but treatable disease that is the most common malignancy among children in Africa. In 2012, together with the Rwandan Ministry of Health, the Jeff Gordon Children's Foundation, and the Dana-Farber Cancer Institute, we will open the first pediatric cancer center in rural Africa at the new Butaro District Hospital in Rwanda.

These and similar innovations at all of our sites testify to our unyielding commitment to provide the highest quality care to the 2.4 million poor people we now serve directly, even when that means defying conventional wisdom and prevailing policies. They also speak to our dream of transformational change that will make the world a healthier, more equitable place. As we have shown with treatment for multidrug-resistant tuberculosis and HIV, one can lead to the other—well-documented local success to global change of direction, innovation to transformation.

Perhaps our proudest accomplishment over the past year has been our ability to come together, from projects in 12 countries on four continents, to map out a strategy to keep our commitments and further our dreams. At the heart of our strategy is a rededication to the research, education, and training that are essential to our mission—to improving the quality of our work; to creating the evidence base needed to leverage changes in global health policies and priorities; and to building the capacity of individuals and institutions to plan and implement programs that truly benefit the poor.

Our strategic discussions took place in the shadows of the enormous responsibilities we have shouldered since the earthquake and of the daunting fundraising task that looms when our Stand With Haiti Fund is exhausted in mid-2012. I draw profound inspiration from my colleagues who, even as we face the challenge of providing more and better services with fewer resources, have embraced an ambitious strategy: we will continue to meet the needs of the communities we serve, and build on that work with new research and training efforts that will help catalyze policy changes and strengthen the movement for global health equity and social justice.

With that kind of selfless dedication to the greater good, and with your continuing support, I am confident that together we will be able to rise to the challenge, to fulfill our commitments, and to realize our dreams.



Ophelia Dahl
Executive Director, Partners In Health



*The vegetable market
in Neno, Malawi*

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.



*Inauguration celebration for
new hospital in Butaro, Rwanda*



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From Innovation to Transformation

Partners In Health was founded nearly 25 years ago by a handful of people who shared three things: an unflinching, narrowly focused commitment to a single destitute community; grand, wide-angle aspirations to change the world; and the core concepts of what has proved to be a powerful strategy for change.

They were committed to improving the health of some of the world's poorest and most vulnerable people—several hundred displaced peasant families living in a squatter settlement in Central Haiti.

Their aspirations were to help bring about a seismic shift in policies, priorities, and resources that would save and enrich lives not just by the hundreds but for the hundreds of millions of poor people around the world who are denied access to fundamental rights and basic necessities—health care, food, clean water, education, adequate housing, and opportunities to earn a decent living.

And the keys to their emergent strategy for change lay in their commitment to building partnerships, starting with their connections to a major research university (Harvard) and teaching hospital (Brigham and Women's).

It worked. Over the quarter-century since PIH was created, we have managed to fulfill and expand our fundamental commitment. Working in partnership with local communities and governments, we have succeeded in providing universal access to quality care—not just for the squatter community where we began but for a combined population of more than 2.4 million people served by 76 health facilities in 12 countries.

Our pioneering efforts have helped overturn global policies that had deliberately denied treatment to the poor for drug-resistant tuberculosis and HIV. The partnerships with Harvard and Brigham and Women's have steadily evolved and strengthened, enabling us to constantly improve our work and expand our influence through monitoring and evaluation, rigorous research, informed and inspired teaching, and advocacy that is both impassioned and evidence-based.

The combination of service, training, research, and advocacy has become a powerful engine for change—for strengthening entire health systems as we treat the individual patients within them; for revitalizing one destitute community, and using what we learned there to help shift national and global priorities; for moving from innovation to transformation.



*Community health worker makes home visit in Rwanda
Credit: Matthieu Zellweger*

From Innovation to Transformation

(continued)

Through our example, backed by solid evidence of its impact, we have also helped change policies and mobilize resources for the innovation that has been central to our success—building a platform for high-quality, comprehensive care on the foundation of networks of trained, supported, and paid community health workers.

The use of community health workers (CHWs) is widespread. Systems for training, supporting and supervising, and paying them, however, are not. In many places, the poor are expected to serve as health volunteers in their own impoverished communities, often working without either support or compensation. We insist that poor people must be paid for their labor, and employ community health workers—or *accompagnateurs*—as the foundation of an integrated health system, with training and support from local health centers and connections to a nearby referral hospital. This health system is an unparalleled platform for delivering comprehensive, high-quality health care to the poor. Together with our partners, we have conducted the research to prove it.

With patients suffering from drug-resistant tuberculosis and HIV, research at multiple PIH sites has documented the impact of daily visits from community health workers who deliver medicines and provide emotional and social support. We have been able to demonstrate that more patients adhere to their treatment regimens and fewer are lost to follow-up than in many programs here in the United States.



In Rwanda, with support from the Doris Duke Charitable Foundation, we are documenting the impact of accompaniment from community health workers on delivery of primary health care in an impoverished rural setting. And in Boston, we have shown that CHWs can both improve health outcomes for the most vulnerable HIV patients and dramatically reduce the costs to the health system for emergency room visits and hospitalizations.

Over the past several years, our example and the research demonstrating its impact have helped move paid CHWs to the forefront of global strategies for improving health care and addressing a desperate shortage of health workers in poor countries. The World Health Organization issued guidelines endorsing the vital role of CHWs in HIV programs and explicitly calling for them to receive “adequate wages and/or other appropriate and commensurate incentives.” Earlier this year, a coalition of organizations including the Earth Institute, UNAIDS, and the UN Secretary General’s Office launched a campaign to train and recruit one million additional CHWs in Africa as a key to achieving the Millennium Development Goals.

Surveying socioeconomic needs of HIV patients in Malawi



From Innovation to Transformation

(continued)

PIH co-founder Paul Farmer refers to the essential role of research and training in strengthening our delivery of care as a “feedback loop,” borrowing a term from microbiology and systems science. Others have called it an “amplification loop” or an “engine of change.” Whatever term we use, the integration of research, training, and advocacy with our healthcare delivery has been essential both to maintaining the quality and success of our programs and to extending their impact far beyond the communities we serve.

Over the past two years, we have backed up our relentless commitment to providing the highest standard of care for our patients by making strategic investments to reinforce our capacity and partnerships for research and training. Some of our key accomplishments and plans include:

- **Strengthening our monitoring and evaluation capacity**, both at our headquarters in Boston and at our project sites. The increased focus on monitoring and evaluation included development of a standard set of cross-site indicators to facilitate more consistent reporting and analysis and to foster quality improvement by highlighting strengths and weaknesses in our programs.
- **Implementing research projects**, documenting, among other things: the impact of accompaniment on the delivery of primary health care in an impoverished rural setting in Rwanda; the impact of shifting tasks among doctors, nurses, and community health workers in Haiti; the dynamic feedback between poor health and poverty; and whether and how constructing a new hospital and strengthening the health system stimulated economic development in a poor and isolated rural district in Malawi.
- **Addressing the need for more advanced post-graduate medical training** in Haiti by collaborating with the state university to create the country’s first residency program in family medicine. The program will train six residents a year at the public hospital Zanmi Lasante operates in St. Marc.
- **Building and strengthening cross-site quality improvement teams** drawing on the clinical, research, and mentorship skills of our partners at Harvard Medical School and Brigham and Women’s Hospital to improve our services, build local capacity and document our work in specific program areas.
- **Constructing major teaching hospitals** in both Rwanda and Haiti. Butaro Hospital in Rwanda opened

*Newborn baby rests in
Butaro hospital in Rwanda*

From Innovation to Transformation

(continued)



in January 2011. More than half of the construction of Mirebalais National Teaching Hospital in Haiti has been completed since ground was broken in June 2010. When the hospital opens in 2012, it will create a standard of excellence for the education of nurses, medical students, residents and other health professionals in Haiti.

- **Expanding the scope of our training curriculum** for community health workers. Available in five languages (English, Haitian Creole, Kinyarwanda, Sesotho, and Chichewa), the curriculum originally focused primarily on training CHWs to accompany HIV and TB patients. Twelve new primary health care modules are now being developed, covering topics such as family planning, reproductive health, malnutrition, and vaccinations.
- **Launching the Programs in Global Health and Social Change** at Harvard Medical School with a mission to advance the evidence base for effective health care delivery for the poor and to link this research to medical education and practice. The programs include six that focus on clinical specialties—*infectious disease, mental health, newborn health, primary care, noncommunicable disease, and surgery*—and three devoted to medical education, public policy, and health system strengthening.
- **Publishing the Program Management Guide**, a compendium of lessons and strategies drawn from over 20 years of experience that have helped PIH implement and improve our programs—from planning the layout of a health facility, to working with the public sector, to procuring medicines and supplies, to hiring local residents.

Pediatric TB patient in Lesotho



From Innovation to Transformation

(continued)

Strengthening the feedback loop of research and training is absolutely essential both to fulfilling our commitments to the communities we serve and to leveraging their example to help advance our mission of health and social justice for the poor on a world scale. Over the past two years, staff and partners from all of our projects have engaged in an intensive effort to focus our strategic vision and programmatic priorities.

This initiative has mapped out a strategic framework to inspire and guide our work—four overarching transformative goals; seven strategic objectives that will help us advance those goals over the next two to three years; and to reach each of those objectives, one or more transformative projects.


Our transformational goals are broad and ambitious:

1. *comprehensively lessen the burden of disease among the poor;*
2. *build the capacity of individuals and institutions to deliver the highest standard of health care to the poor;*
3. *break the cycle of poverty and disease; and*
4. *build a movement for social justice that universalizes the notion that the poor deserve quality health care.*

For each of these goals we have identified ways of measuring progress and have specified objectives and transformative projects with clearly defined targets for the next several years.

Take goal number one. Lessening the burden of disease among the poor means nothing less than reducing, and ultimately eliminating, the deadly disparities in health between and within countries. A child born in one of the world's poorest countries today can only expect to live around 50 years. In developed countries, average life expectancy is closer to 80. The gap in life expectancy between rich and poor within countries is also wide. In most African countries, the wealthiest fifth of the population lives 20 to 50 percent longer than the poorest. Achieving our goal requires first eliminating these disparities within the countries where we work, and then, building on our example and partnerships, substantially reducing disparities between rich and poor countries worldwide.

To get there, we have committed ourselves to several medium-term objectives: to strengthen and document our integrated healthcare model; to demonstrate the value of community health workers to solve a variety of health problems, both in poor countries and with vulnerable populations in the United States; to pursue innovations in health for the poor focused on specific clinical services, such as treatment for MDR-TB, maternal and neonatal health, cholera, mental health, and cancer and other non-communicable diseases; and to build capacity of local health-related practitioners through high-quality, service-based education and training.



*Hiking to the health center
in rural Lesotho*

From Innovation to Transformation

(continued)

From innovation to transformation, via projects, objectives, and goals—an example illustrates PIH's theory of change in action. The project is the Maternal Mortality Reduction Program in Lesotho. The objective is to tenaciously pursue and prove innovations in health for the poor, led by a focus on specific clinical services integrated into a strengthened health system. The overarching goal is to lessen the burden of disease among the poor.

In Lesotho, one out of every 62 women can expect to die from hemorrhage, obstructed labor, or other complications of pregnancy and childbirth. In the rich, industrialized countries, the risk of pregnancy-related death is vanishingly small: one in 4,300. Overall, more than 99 percent of the nearly 1,000 maternal deaths that take place every day worldwide occur in developing countries. And virtually all of these fatalities are what PIH co-founder Paul Farmer has called “stupid deaths”—deaths that could easily be prevented with proven interventions that are routinely available in rich countries.

This grotesque injustice—death by lottery, by the accident of being born poor in a poor country—is what we are determined to change, in Lesotho and around the world.

Since it was launched in 2010, PIH-Lesotho's Maternal Mortality Reduction Program (MMRP) has trained and employed more than 600 women—many of them traditional birth attendants who had formerly helped women deliver their babies at home—to locate all expectant mothers in their villages, accompany them to regular pre- and post-natal visits, and bring them to the clinic to deliver their babies with the help of a doctor or nurse-midwife.



The target of the MMRP is clear and simple—zero preventable maternal deaths in Lesotho. Progress toward that goal is being monitored meticulously. The program is overseen by the nurse who heads PIH-Lesotho's Monitoring and Evaluation team. And we are using our Electronic Medical Records system and Geographical Information System technology so that we can map the locations of all pregnant women and maternal health workers and overlay information about visits to the health center, complications, deliveries, and health outcomes.

Lessons extracted from this information through analysis and research will be used to strengthen the project and to advance our strategic objective of proving the impact of innovations in specific clinical services built on our integrated platform of care. And that, in turn, will help us mobilize support for changes in policies and priorities that could reduce maternal mortality, lessen the burden of disease, and increase life expectancy for the poor worldwide.

Maternal health workers in Lesotho

Haiti/Zanmi La sante

Continuing to rebuild from the unimaginable disaster of the January 12, 2010 earthquake, Zanmi Lasante (ZL) provided urgent care and ongoing community outreach in response to widespread cholera outbreaks, continued constructing a state-of-the-art hospital in the Central Plateau, and strengthened specialized services.

Highlights of the Year

Responded to the cholera epidemic: Since the first cases of cholera were confirmed by the Haitian Ministry of Health in October 2010, ZL worked tirelessly to treat over 75,000 cases, conduct community education and outreach, and strengthen the infrastructure necessary to provide clean water and basic sanitation for Haitians most vulnerable to the outbreaks. On the international stage, PIH/ZL advocated for a comprehensive, community-based strategy for prevention and treatment—including oral vaccination campaigns and attention to the structural causes of cholera, such as improved water and sanitation infrastructure. Thanks to funding from the US government and the World Bank, ZL was able to build and operate cholera treatment facilities and oral rehydration posts, train additional community health workers, and provide mental health and psychosocial support to cholera survivors.



Completed over 50 percent of construction on Mirebalais Hospital:

By May 2011, construction teams had already completed more than 50 percent of construction of a flagship national referral hospital and teaching center in Mirebalais. The 180,000-square-foot, 320-bed facility will change the face of public health care in Haiti by providing

Cholera patient receives intravenous rehydration

Haiti/Zanmi La sante

(continued)

comprehensive clinical services, many of which—such as neonatal intensive care and thoracic surgery—are not currently available at any public facility. When the hospital becomes fully operational, it will be the largest functioning hospital in the country, with the capacity to treat upwards of 500 patients per day and provide high-quality education for nurses, medical students, and resident physicians.



Provided mental health, psychosocial support, and rehabilitative services: Since the earthquake in January 2010, ZL's Mental Health and Psychosocial Support team has more than doubled the number of psychologists, social workers, and community health workers trained to identify, refer, and support people suffering from myriad mental health problems. The services provided, such as the treatment of depression, anxiety, post-traumatic stress, and psychosis, have been integrated into the comprehensive system of care at all ZL sites to better support the mental health needs of all our patients.



ZL also trained seven rehabilitation educators to provide specialized rehabilitative accompaniment to an estimated 225 patients, many of whom were injured in the earthquake. In addition, plans were completed for Haiti's first wheelchair-accessible public sector rehabilitation center at the hospital ZL runs in partnership with the

Ministry of Health in Saint-Marc. This facility will provide rehabilitation services and be the site for a nine-month Rehabilitation Technician Training program.

Cared for children with physical and developmental disabilities: Zanmi Beni, Creole for “Blessed Friends,” is home to 50 unaccompanied minors and vulnerable children with physical or developmental disabilities, abandoned in the crumbled pediatric ward of Port-au-Prince's General Hospital in the days following the earthquake. In April 2010, ZL purchased land in a quiet neighborhood of Port-au-Prince to build what is now a safe haven and caring home providing the children an educational and loving environment in which to thrive. Zanmi Beni strives to reduce the stigma and discrimination faced by children with special needs, and has already become a model center for addressing special needs in resource-poor settings.



BY THE NUMBERS

2.8 million total patient encounters (all services included)

13,784 children received educational assistance

53 houses constructed or repaired

6,268 HIV-positive patients on treatment

482 TB patients treated

Approximately **75,000** cholera patients treated

9,780 children treated for moderate or severe malnutrition

25,269 active users of modern contraception methods

98,735 pregnant women seen in antenatal clinic

Staff:

1,192 medical

1,841 non-medical

2,378 community health workers

Peru/Socios En Salud

On July 9, 2011, Socios En Salud (SES) celebrated 15 years of providing high-quality treatment and support for tuberculosis and HIV patients in some of the poorest areas of Peru. This year, SES continued to grow, increasing social and economic support for patients, conducting advocacy initiatives to increase public awareness of TB and HIV, and engaging in research and trainings to inform the clinical management of both illnesses.

Highlights of the Year



Provided socioeconomic support to patients with MDR-TB and HIV: Patients receiving treatment for TB and HIV need to have sufficient food and housing to ensure a sound recovery. This year, in partnership with the Peruvian Ministry of Health, SES continued to provide multi-drug

resistant tuberculosis (MDR-TB) and HIV patients with the nutritional support, transportation, and pre-constructed, well-ventilated houses that allow patients to recover at home with their families while reducing the risk of transmission.

Scaled up outreach and training for TB control and prevention: As part of national efforts to scale up TB prevention and early diagnosis efforts among general and high-

Peru/Socios En Salud

(continued)



risk populations, SES trained university educators and administrators in TB prevention, and began studies in indigenous communities in Peru related to risk factors and vulnerability for TB. In addition, SES collaborated with the Ministry of Health to provide training on MDR-TB treatment and prevention to doctors, nurses, and community health workers in Lima and the southern Pisco region. At the national level, SES reached more than 7,000 university students with TB health campaigns on campuses across the country, and ran mass media campaigns estimated to have reached 1.5 million people.

Contributed to research on MDR-TB and HIV: SES provided oversight and research capacity for the EPI project: a study of the transmission dynamics of MDR-TB, enrolling 4,000 patients and 20,000 of their household contacts. SES and the Ministry of Health will use the results of this research to reinforce early detection efforts and improve coverage by the national TB strategy. And in a study that seeks to show the impact and cost-effectiveness of community-based intervention in HIV treatment, SES worked in 92 health posts to enroll patients living in extreme poverty who had recently begun treatment but were at risk of non-adherence.



Provided patients with options for sustainable income generation: SES's income generation project offers interest-free loans to TB and HIV patients and their families to start small businesses, helping them gain economic independence, improve self-esteem, and reignite their will to recover from their disease. This year SES provided in-house training, small loans and staff accompaniment to 97 current and former patients to start or expand small businesses including a taxi service, a juice stand, and a curtain-making enterprise. Within a year the average per capita household monthly income of those patients more than doubled—from \$48 to \$114.

BY THE NUMBERS

Treated more than **10,500** MDR-TB patients to date with a **75%** cure rate—the highest in the world

150 university staff trained in TB prevention

Approximately **800** MDR-TB and HIV patients received socioeconomic support

2,063 MDR-TB patients and **6,413** contacts enrolled in TB transmission research study

More than **1,800** food baskets distributed

Staff:

111 medical

195 non-medical

174 community health workers

Rwanda/Inshuti Mu Buzima

By collaborating with the Rwandan Government on a variety of projects—building a hospital in a previously underserved rural region, creating a district model that can be scaled up nationwide, and constructing new homes for a historically marginalized community—Inshuti Mu Buzima (IMB) helped to transform the health system in three districts of rural Rwanda.

Highlights of the Year



Opened state-of-the-art hospital in rural Burera district: Inaugurated in January 2011, Butaro Hospital now brings high quality medical care and serves as a flagship center for medical education and innovation for the entire east Africa region. In addition to the four basic services—maternity, internal medicine, surgery, and pediatrics—

the new hospital includes an emergency department, full surgery ward with two operating rooms, intensive care unit, neonatal intensive care unit, outpatient ophthalmology and gynecology services, and significantly expanded laboratory capabilities.

Constructed in partnership with the Rwandan Government, which is supporting more than 40 percent of the operating costs, the facility features modern measures for infection control, including natural cross-ventilation reinforced by large ceiling fans and ultraviolet lights, secluded patient wards around courtyards, and an effective spatial triage system allowing for separation of patients based on their condition.



*Newborn twins in Butaro Hospital
Credit: Matthieu Zellweger*

Rwanda/Inshuti Mu Buzima (continued)

Expanded services from seven to 22 health centers in the Eastern Province:

With support from the Doris Duke Charitable Foundation, IMB expanded to 15 new health centers in Southern Kayonza and Kirehe Districts. With the addition of these facilities, IMB now covers all health centers in the districts. The major components of this project include social support programs, increased human resources and service delivery support, constructive nursing supervision, and an enhanced network of community health workers. IMB's research and monitoring and evaluation programs will document this strengthened healthcare system, allowing other districts to scale up and replicate the model.



Supported Rwandan Government in cervical cancer screening, treatment, and training:

Beginning in August 2010, PIH worked to enable Butaro, Rwinkwavu, and Ruhengeri Hospitals to offer cervical cancer screening. Combined, the hospitals provided screenings to more than 1,200 women, and treated 56 with cryotherapy. In June 2011, IMB organized a three-week training on quick and low-cost approaches to screening for cervical cancer. This training is part of PIH's collaboration with the non-profit PATH and the Ministry of Health to support Rwanda's National Cervical Cancer Plan. The plan includes HPV vaccination for adolescents, screening for HPV and cervical cancer using Visual Inspection with Acetic Acid, and treating precancerous lesions with cryotherapy.



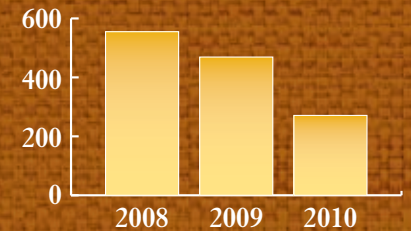
Provided social and economic support for a marginalized community:

In partnership with the local community, and as part of the Rwandan Government's initiative to eliminate grass-roofed houses, IMB constructed 39 houses for families from the marginalized pygmy community in the remote hills of northern Rwanda. Replacing leaky, grass-thatched huts, the new houses were built with sturdy walls and metal roofs, ensuring equity while complying with district housing standards. In addition to housing, IMB and Burera district officials provided a full package of support to the pygmy community, including *mutuelle* health insurance subscriptions for every family, agricultural and food support, and school support for every child, including the costs of uniforms, shoes, notebooks, and other fees.

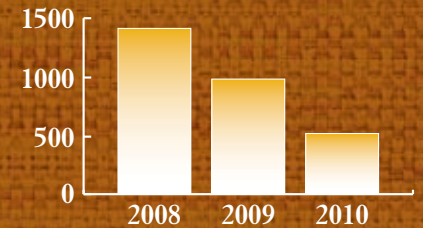


BY THE NUMBERS

Under-5 Deaths in Burera District



Malnutrition Cases in Burera District



660,137 total patient visits

5,910 HIV patients on treatment

19,759 babies delivered in health facilities

107,980 patients tested for HIV

37 health centers supported

554 secondary school students received tuition coverage

37,200 people received *mutuelle* health insurance coverage

Staff:

865 medical

1,146 non-medical

3,313 community health workers

Lesotho/ Bo-Mphato Litšebeletsong tsa Bophelo

In the five years that PIH has been working in Lesotho, we have expanded comprehensive health care services to seven health centers and one hospital in the mountainous, rural areas. This year PIH-L continued to provide comprehensive services at the community level—sending community health workers to the homes of pregnant women and patients with tuberculosis and HIV—and in clinics, focusing on providing safe deliveries and high-quality pre- and post-natal care.

Highlights of the Year

Expanded rural healthcare support: In March 2011, PIH-L expanded its network of supported health facilities in the rural mountain districts to include Mamohau Hospital. When PIH-L removed user fees at the hospital in April, the number of patient visits more than tripled. Working with the Ministry of Health and Social Welfare and



the Christian Health Association of Lesotho, PIH-L is providing training for staff and community health workers, medical supplies and equipment, and improved infrastructure. In addition to increasing the number of people in the mountains who are receiving high-quality

health care, Mamohau will serve as an emergency referral facility for all PIH-L clinics, providing emergency obstetric services and serving as a base for training and research activities. With the addition of Mamohau, PIH-L now serves an estimated 235,000 people in rural Lesotho.



*An HIV patient with her children
Credit: Ilvy Njokikjien*

Lesotho/Bo-Mphato Litšebeletsong tsa Bophelo (continued)

Scaled up Maternal Mortality Reduction Program:



PIH-L scaled up a successful pilot program to improve access for women in the mountains of Lesotho to comprehensive pre- and post-natal care, and to delivery at health facilities with a skilled nurse-midwife. This year PIH-L added 450 community health workers trained to educate women about the importance of facility-based care during pregnancy, and accompany them to health clinics. PIH-L also built maternal waiting houses at six clinics, where pregnant women who live far from the health facility can stay to ensure they are close by for delivery. By connecting women and children to the health system at a critical time, this program is also increasing the number of HIV-positive women who receive services to prevent transmission of HIV to their children, the number of children who receive vaccinations and are screened for malnutrition, the number of HIV-positive women screened for cervical cancer, and the number of women who receive family planning.

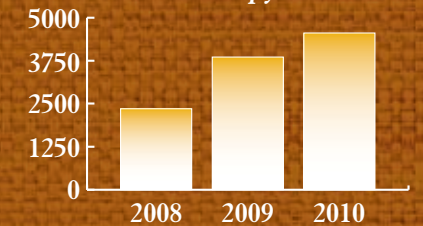
Spearheaded MDR-TB treatment and training: PIH-L began treating drug-resistant tuberculosis in 2007. Since then, PIH-L has led the national program for multidrug-resistant tuberculosis (MDR-TB), with over 200 trained community health workers helping patients take medications and cope with side effects and socioeconomic challenges. The Lesotho MDR-TB program has treated more than 600 patients to date and has gained international recognition as a model for community-based care. This year, the program hosted 50 visiting health professionals from countries including Zambia, Ethiopia, Zimbabwe, and Swaziland, and ran a training program for doctors on treating MDR-TB in areas of high HIV co-infection.



Provided social support to vulnerable patients: In addition to improving access to medical care, PIH-L continued to support the social and economic needs of our patients. The program to support orphans and vulnerable children now provides more than 75 children with services that include food packages, school fees and psychosocial support. Partnering with the World Food Program, PIH-L also provided food packages to pregnant women and children at several clinics, with the goal of improving nutrition and health outcomes for this vulnerable group. Additionally, PIH-L began supporting a community-run pre-school in Nkau, where children too young for primary school can play and learn. The school has been so successful that the community is building a larger space to accommodate more children.

BY THE NUMBERS

Patients Receiving Antiretroviral Therapy



14,771 patients tested for HIV, of whom 1,269 (8.6%) tested positive

777 patients newly enrolled on ART

437 new TB patients, of which **148** had drug resistance and **256** had HIV co-infection

76,954 outpatient visits

14,933 total food packages distributed to patients

1,922 prenatal care visits

456 deliveries at clinics

12,631 total immunizations

10,474 total family planning visits

Staff:

79 medical

133 non-medical

1,745 community health workers

Malawi/Abwenzi Pa Za Umoyo

By providing equipment previously unavailable in Malawi, promoting women's health and disease prevention, and supporting community programs, Abwenzi Pa Za Umoyo (APZU) continued to make strides to improve public health infrastructure and services in rural Neno District.

Highlights of the Year

Opened Malawi's first rural microbiology laboratory: In September 2010, APZU inaugurated a new microbiology lab at Neno District Hospital, making it the first district hospital in Malawi able to perform routine blood cultures, a vital diagnostic tool for detecting



life-threatening infections ranging from typhoid to sepsis. The lab was opened through a partnership between APZU, the Malawian Ministry of Health and the Centers for Disease Control and Prevention. Before the lab opened, doctors had to send samples to a lab in the capital city of Lilongwe and wait weeks for results. Now, clinicians can have answers and prescribe treatments for their patients within just 48 hours.

Prevented malaria through distribution of bed nets: Each year, Malawi's people endure millions of cases of malaria and mourn the death of thousands—most of whom are women and young children. To help fight malaria in Neno District, APZU partnered with Together

Malawi/Abwenzi Pa Za Umoyo (continued)

Against Malaria to provide long-lasting insecticide-treated bed nets to pregnant women, new mothers, and their newborn children. These nets offer important advantages over nets traditionally available in Malawi, as they last up to five years and do not require recipients to treat them again with insecticides. Provided at the district's prenatal clinics, ART centers and maternity wards, the nets encourage women to seek primary healthcare services and complement APZU's existing work with the Ministry of Health to distribute nets at the community level. To date, over 400 women and newborns have benefited from the program.



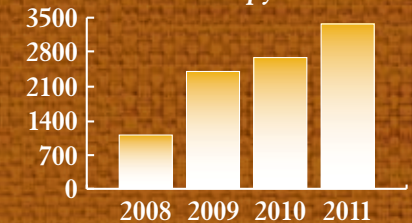
Promoted women's health through screening and treatment for cervical cancer: Rarely encountered in rich countries and entirely preventable with vaccinations, proper screening, and removal of precancerous lesions, cervical cancer kills over 1,500 women in Malawi each year. In partnership with the Malawian Ministry of Health, APZU scaled up a successful cervical cancer-screening program across 10 health facilities in Neno District. The program uses Visual Inspection with Acetic Acid to identify precancerous lesions and a liquid-cooled probe to freeze and remove them (cryotherapy). Over the last year, more than 400 women were screened for cervical cancer and dozens were treated effectively with cryotherapy.

Fought malnutrition in a new nutritional rehabilitation unit: On May 26, 2011, Neno District Hospital admitted its first patients into a new Nutritional Rehabilitation Unit (NRU)—the first of its kind in the district. In Malawi, 20 percent of children under the age of five are moderately or severely underweight, and over half suffer from moderate or severe stunting due to chronic malnutrition. Supported by a partnership between APZU, the Malawian Ministry of Health, and the Clinton Health Access Initiative, the NRU provides specialized care to dangerously malnourished children. The NRU is part of APZU's comprehensive community-based nutrition program, which identifies and treats malnourished children under the age of 12 in the district, as well as pregnant women and new mothers.



BY THE NUMBERS

Patients Receiving Antiretroviral Therapy



379,171 outpatient visits across **12** APZU facilities

1,419 children received nutritional and educational support

740 patients received socioeconomic support in kind, cash, and housing

14,505 community members enrolled in the Neno Community Support Initiative

2,856 food packages distributed to HIV and TB patients

61 hospitalized patients provided with financial and material support

Staff:

175 medical

490 non-medical

691 community health workers

Russia/ Партнеры во имя Здоровья

PIH-Russia celebrated its tenth year treating patients with multidrug-resistant tuberculosis in Tomsk Oblast in Siberia. The program has expanded out of Tomsk to five additional regions, and continues to improve care for tuberculosis patients through research and comprehensive, patient-centered treatment.

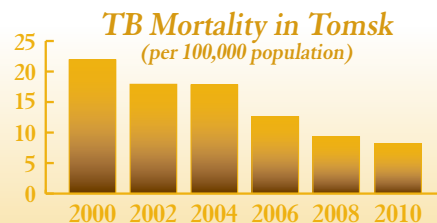
Highlights of the Year

Celebrated 10 years of treating multidrug-resistant tuberculosis (MDR-TB): When the treatment of multidrug-resistant tuberculosis with second-line drugs was adopted by the World Health Organization, it was called DOTS Plus—projects implemented in addition to standard Directly Observed Therapy (DOTS) aimed at treating drug-resistant TB patients. In 2000, PIH brought DOTS Plus to Russia, choosing Tomsk as the first Russian site to implement the international standards. Now, 10 years later, Tomsk's MDR-TB project has treated more than 2,100 drug-resistant TB patients, and cut the TB mortality rate by more than 60 percent.

Expanded community-based care to additional regions: In October 2010, PIH-Russia received a \$1.5 million grant from USAID to create Patient Centered Accompaniment (PCA) projects—expansions of the existing Sputnik project in Tomsk—in five new regions in Russia. The PCA projects provide care at home or in the community for patients who have difficulty making daily visits to a health facility for the intensive treatment regimen needed to cure MDR-TB, especially patients affected by homelessness, poverty, alcohol and substance abuse, HIV, and previous incarceration. The PCA projects enrolled approximately 700 high-risk patients and will screen up to 10,500 of their contacts (people who may have been exposed to TB or MDR-TB) over the next five years.



Continued MDR-TB training and research projects: In collaboration with Harvard Medical School and Brigham and Women's Hospital, PIH-Russia conducted three workshops on MDR-TB, providing specialized training to doctors and program managers from 25 territories to improve the quality of services they provide. In June 2011, PIH-R concluded a six-year clinical trial that incorporated treatment for alcoholism—a condition present in more than half of all TB patients in Tomsk district—into standard TB care. Preliminary results show that this intervention is highly feasible as an integrated component of TB care, and has been widely endorsed by providers and patients.



800 TB and MDR-TB patients received daily food packages in order to stimulate adherence to the treatment provided.

629 HIV-positive patients screened for TB

119 HIV patients at risk of co-infection enrolled on preventive TB treatment, of whom 90% completed the full course of treatment.

Staff:

7 medical
15 non-medical

TB patient receiving medicine and a food package

Kazakhstan

Due to the success of the PIH-Russia program in treating multidrug-resistant tuberculosis (MDR-TB) for the past 10 years, the government of neighboring Kazakhstan invited Partners In Health to provide technical assistance in Karaganda and Pavlodar Oblasts, two regions bordering Siberia where these drug-resistant strains of tuberculosis are quite prevalent.

Highlights of the Year

Expanded services, opened new office in Kazakhstan: In April 2010, PIH opened a new country office in Almaty, Kazakhstan. The PIH program in Kazakhstan (PIH-KZ) scaled up TB coverage by adding three patient-centered accompaniment teams in Karaganda and Pavlodar Oblasts, treating TB and MDR-TB patients in the civilian and prison sectors. Since opening, PIH-KZ has provided several monitoring visits and organized trainings for more than 250 participants to learn about tuberculosis detection, treatment, and follow-up.



Introduced a new training initiative for TB treatment: Setting out to improve patients' adherence to treatment, PIH-KZ collaborated with teams from PIH-Russia to develop and introduce a new training initiative for TB treatment. It focuses on TB nurses, enabling them to act as TB counselors or supporters to patients during the entire course of their treatment. The training contains 10 modules on various aspects of TB treatment, including information on patients' rights, social support, and adherence. To date, PIH-KZ has delivered the training to 107 TB nurses from the public and prison sectors of Karaganda and Pavlodar.



Influenced national TB policies: PIH-KZ plays a leading role in improving the management of drug-resistant tuberculosis at the national level. In the last year, PIH-KZ contributed to the development of the National Decree on MDR-TB and the National Guidelines on Medical Management of MDR-TB, both of which were approved by the Kazakh Ministry of Health for further implementation. These policies will increase access to adequate treatment for patients across the country who are suffering from drug-resistant TB.

511 drug-resistant TB patients enrolled in DOTS-Plus treatment, with 217 patients in Karaganda and Pavlodar prisons.

255 TB doctors received intensive training on Medical and Program Management of MDR-TB.

54 TB patients received patient-centered accompaniment at home.

Staff:

7 medical
2 non-medical



A nurse visiting a patient at home

USA/PACT

This year, the Boston-based Prevention and Access to Care and Treatment (PACT) project became further integrated into the Boston healthcare system, refreshed its strategic planning efforts, and made new connections with US healthcare policymakers. PACT also invested in refining its HIV program to better serve Boston's at-risk HIV/AIDS patients.

Highlights of the Year

Received federal funding to improve HIV care for Boston's at-risk HIV population:

This year, PACT received a five-year federal grant through the Ryan White HIV/AIDS Program, the largest funder of HIV/AIDS care in the US. This marks the first time the organization has awarded a grant to a community health worker (CHW) program in Massachusetts. Working in partnership with the Massachusetts Department of Public Health, PACT will use this funding to continue providing care to Boston's most vulnerable HIV-positive patients.



Completed strategic planning to impact US health care: PACT received strategic planning support from the Harvard Business School Community Action Partners (CAP) to improve PACT's focus and develop a plan to achieve the greatest possible impact on the domestic healthcare system. As a result, PACT integrated its clinical and training leadership staff into the primary care transformation efforts of the state's largest hospital network—Partners Healthcare. PACT provided training and technical assistance for their two most innovative care delivery models: Brigham and Women's Hospital's medical home project and Massachusetts General Hospital's care management program for high-risk Medicare patients.

Developed relationships with federal and state healthcare policymakers: The PACT team developed many new relationships in the Boston statehouse and on Capitol Hill, meeting frequently with policymakers to enhance their knowledge of the PACT community health worker model and its potential for systemic change. Supported by these new connections, PACT has submitted proposals to the Center for Medicare and Medicaid Services (CMS) Innovation Office and identified opportunities to participate in Massachusetts' patient-centered medical home (PCMH) transformation efforts.

85 patients served in HIV project.

Approximately **5,160** health promotion and DOT home visits.

More than **300** healthcare providers trained on PACT model.

Staff:

1 medical
12 non-medical
9 community health workers

PACT patient taking medicine for HIV

Mexico/EAPSEC

In addition to their continued support and training of community health workers (*promotores*), Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC) worked to improve TB care and provide social support for women in the state of Chiapas.

Highlights of the Year

Hosted a forum on the right to health and tuberculosis in Chiapas: EAPSEC, together with other members of the Citizens' Observatory for the Exercise of the Right to Health (OBCIUDES), convened and organized the "Forum on the Right to Health and Tuberculosis in Chiapas." Epidemiologists and researchers discussed the state of the TB epidemic, including evidence suggesting that many children with TB go undiagnosed. The forum also served to review the state TB program from the perspective of civil society, highlighting the challenges community members face when trying to get TB care. To help address these challenges, the forum featured a nurse from PIH's partner organization Socios En Salud who shared successful TB management strategies employed in Peru.

Focused on supporting and empowering women: EAPSEC facilitated a process of reflection for women's groups in the town of Siltepec in southern Chiapas, identifying ways for them to better exercise their rights. Groups addressed topics such as identity and self-esteem, how to make nutritious meals using local foods, the production of edible mushrooms, bread-making, and utilizing nutritious edible plants often mistaken for weeds. It is difficult for women to participate in such programs, due both to a heavy workload at home and to attitudes that discourage women from being active outside the home. Despite these difficulties, the program has achieved a high participation rate and has served 154 women to date.



Provided community validation of forthcoming edition of "Where There Is No Doctor": As a result of EAPSEC's strong community relationships and decades of experience, the Hesperian Foundation asked EAPSEC to coordinate a process of community validation of several chapters of the new version of the book *Where There Is No Doctor*. EAPSEC facilitated the participation of 12 *promotores*, all with several years of experience as local trainers, to review the chapters related to parasitic diseases and disease prevention. *Where There Is No Doctor* serves as a reference tool for *promotores* in Chiapas and for other community health worker programs across the globe.

Staff:

1 medical
4 non-medical

A community health worker on a home visit

Guatemala/ETESC

With initiatives in environmental health, improved capacity for cancer screenings, and outreach projects advocating for the rights of indigenous communities, Equipo Técnico de Educación en Salud Comunitaria (ETESC) continued to work toward better health and human rights in the rural communities of Huehuetenango, Guatemala.

Highlights of the Year

Launched Environmental Health Program in indigenous communities: ETESC helped 175 vulnerable families address the root causes of harm to both health and the environment in their communities. The families received training on environmental health issues, then selected an activity to address their top concern. They unanimously chose to install improved wood-burning stoves manufactured by HELPS International. By cutting indoor smoke from open cooking fires by up to 90 percent, these new stoves will decrease the serious risk of respiratory diseases such as pneumonia, asthma, and emphysema. They will also decrease the amount of wood fuel used by as much as 50 percent, helping preserve local forests and avoid erosion and landslides.

Collaborated with clinics to stop cervical cancer deaths: Despite being one of the most preventable cancers, cervical cancer is the leading cause of cancer death among women in Guatemala and many other poor countries. This year, ETESC collaborated with a local government health post and a private women's clinic to improve access to screening and treatment for cervical cancer. Traditional prevention requires multiple patient visits—a chain of care that is easily broken when time and transport costs present barriers to women. ETESC's new program introduced the screen-and-treat method, which allows women to receive results—and when necessary, treatment—in just one visit. Four clinicians received instruction in this method from master trainers, as well as crucial equipment and supplies. In the first three months of the program, more than 300 women were screened.

Advocated for an indigenous voice in development: Due to insufficient land rights and worker and environmental protections, large-scale projects such as mines and highways often harm local communities. Guatemalan law holds that indigenous communities must be consulted before such projects are undertaken—a process often glossed over or ignored altogether. ETESC has been a leading voice in a coalition of civil society groups that proactively advocates for and implements such consultations. This year, intending to give this mechanism more weight, ETESC conducted advocacy campaigns to give official legal status to these consultations.

Staff:

10 non-medical

Women with improved wood-burning stoves

Medical Informatics

The Medical Informatics team facilitated the routine collection and use of data as a core part of PIH activities, used to improve quality and access to care, program and supply-chain management, and research. The team continued to contribute as one of the leading developers of OpenMRS, an open-source Electronic Medical Record (EMR) system pioneered at PIH sites and now used in 49 countries.

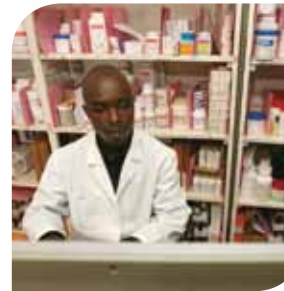
Highlights of the Year

Expanded the scope of data captured in OpenMRS: In Malawi, PIH expanded HIV EMR coverage from six health centers to 13. In Rwanda, new modules for chronic diseases such as hypertension and diabetes were added, and infrastructure was deployed to allow remote data entry in all supported districts. PIH also streamlined the MDR-TB records system in Haiti for entry of essential reporting and patient monitoring data.

Built capacity for OpenMRS in Rwanda: PIH supported the Government of Rwanda's national rollout of OpenMRS through training, mentoring and capacity building. PIH developers worked closely with our Rwandan counterparts, trained in a PIH eHealth course, to develop the required software. A major milestone was the deployment of OpenMRS at Musha Health center, the first of four Phase I sites chosen for the national rollout.

Piloted new software for inventory and supply-chain management: The Medical Informatics team continued work on new, open-source software for inventory and supply chain management, aiming to prevent stockouts of essential drugs and medical supplies by providing PIH with real-time inventory levels and streamlining the process of requesting and shipping new stock. PIH built and tested new features for inventory management and shipping at warehouse sites in Miami and Boston.

Deployed innovative point-of-care EMR systems: A point-of-care system for collecting and accessing primary care data was piloted at Rwinkwavu Health Center in Rwanda. The system uses touchscreen computers to capture patient demographics and essential visit information in real time, eliminating time-consuming data entry and providing immediate access to patient information. PIH registered 7,365 patients at Rwinkwavu Health Center with this new system. In Malawi, PIH continued to collaborate with Baobab Healthcare on a point-of-care system for HIV data, expanding the software to capture new data required as part of Malawi's revised HIV program guidelines.



Collecting GPS data in Rwanda

The Year In Review

Training

PIH's training department works to strengthen training programs and systems in our project sites through standardized, culturally sensitive curricula and dedicated training teams focused on local capacity building. This year we developed new curricula, supported clinical and community health worker training programs, and provided materials and technical support across PIH sites. The training department also serves as a resource for organizations around the world to build capacity and maximize the impact of services.

Highlights of the Year

Enhanced training, mentoring, and supervision of clinicians: The training department supported the launch of Mentoring and Enhanced Supervision at Health centers (MESH), a new initiative implemented in two districts in Rwanda focused on clinical training of health center nurses, their ongoing mentoring and support, and program monitoring for quality improvement. MESH targeted four key aspects of clinical care: women's health, pediatric care, acute adult care, and infectious disease. Across these topics, 142 nurses, 27 social workers, and 12 health center directors received training. Additionally, 563 doctors, nurses, and social workers in Rwanda received training on a range of topics, from malnutrition and neonatal care to pharmaceutical management and family planning.

Trained community health workers in active case finding and primary health care: With the support and collaboration of the World Bank and the Haitian Ministry of Public Health and Population, the PIH training department contributed to efforts to control the cholera epidemic in Haiti. The training department developed and produced a training unit on cholera, coordinated the training of 90 trainers and 350 community health workers (CHWs), and will provide a second round of training for 3,000 CHWs in the coming year.

Developed and disseminated training curricula for CHWs, clinicians, and program managers: In partnership with the World Bank and with local ministries of health, PIH began development of 12 primary health care modules for CHW training, covering topics such as family planning, reproductive health, malnutrition, and vaccinations. This year, 1,600 CHWs in Rwanda and 1,000 in Haiti received training in HIV/AIDS, TB, and primary health care topics such as malnutrition and vaccinations. The Program Management Guide was developed with support from the Bill & Melinda Gates Foundation to provide a PIH model for program planning and implementation. The guide was completed and launched on an interactive online platform in 2011. PIH also developed a training for maternal health workers, forming the basis for a program aimed at stemming maternal mortality rates across our Lesotho sites.



Advocacy & Policy

The Institute for Health and Social Justice (IHSJ) team continued to promote PIH's human rights-based approach to health and development with advocacy and policy-change strategies to increase funding for global health, improve socio-economic conditions in Haiti, and promote food security and health system strengthening.

Highlights of the Year

Exposed the inadequacy of food aid in Haiti: The IHSJ team co-authored *Sak Vid Pa Kanpe: The Impact of U.S. Food Aid on Human Rights in Haiti*, with the Center for Human Rights and Global Justice at the NYU School of Law, the RFK Center for Justice and Human Rights, and Zanmi Lasante. The report shows that while food aid provides partial nourishment to many people without reliable food sources, the way in which it is procured, delivered, and administered often interferes with basic human rights and erodes long-term food security. The report also recommends ways to improve US food aid to Haiti, including involving Haitians in the planning and implementation of aid programs, and increasing Haiti's capacity to produce food locally.

Continued building a movement for social justice and affecting policy change: IHSJ leadership gave over 75 talks, lectures, and presentations to educate and engage different communities around the globe. In addition, the team met with Congressional staff and members over 40 times in the past year to inform and influence global health policy.

Co-hosted events to highlight important healthcare issues: With resources swallowed by the fight against infectious diseases, the world's poor are often left to fight non-communicable diseases (NCDs) such as diabetes, heart disease, and cancer on their own. In March 2011, PIH and our partners at the Harvard Medical School Department of Global Health and Social Medicine organized and participated in a conference on the often-neglected non-communicable or chronic diseases of the world's poorest citizens. The conference was convened to raise awareness in advance of a high-level United Nations meeting on NCDs in September 2011.

Published a landmark article on women and structural violence: PIH staff authored an article detailing how reducing structural violence against women would improve progress in meeting the United Nations' Millennium Development Goals related to women's health and education. With examples from our Haiti and Lesotho projects, the article clearly demonstrates how women's lives can be saved and transformed by programs that combine quality health care with determined efforts to uproot structural violence and the social determinants of disease, especially poverty, sexism, and gender-based violence.

The Year In Review



*Solidarity celebration for Haiti
one year after the earthquake*

Research

To strengthen and leverage our community-based approach, PIH conducts rigorous research that can be used both to identify and remedy weaknesses and to prove its effectiveness and impact. This year, with our partners at Harvard Medical School (HMS) and Brigham and Women's Hospital (BWH), PIH published a variety of research including articles on cholera, tuberculosis, and the advantages of the community health worker model.

Highlights of the Year

Focused on cholera in Haiti: Researchers at HMS and BWH described the emergence of cholera in Haiti, and proposed a series of interventions to reduce its spread and impact. Led by members of PIH's Haiti team, this work led to the publication of a joint statement on cholera prevention and care that was endorsed by a global panel of experts. In ongoing work, Louise Ivers, a BWH physician and PIH's Senior Health and Policy Advisor, partnered with a team of cholera researchers to seek funding for continued research into the epidemiology and management of cholera in Haiti.



Studied the impact of innovations in care delivery at PIH sites across the globe: Louise Ivers described the impact of shifting tasks among doctors, nurses, and community health workers in Haiti. Rwandan Minister of Health Agnès Binagwaho and collaborator Paulin Basinga evaluated the effect of performance-based financing of primary health care in Rwanda. Jen Furin described the role of traditional healers in caring for HIV patients within the PIH sites in Lesotho. Sonya Shin and others focused on the impact of microfinance programs for impoverished persons living with HIV in Peru. Paul Farmer led a group of experts that called for an expansion of cancer care and prevention to developing countries. The group highlighted PIH programs in Haiti and Rwanda.

Continued to study the transmission and treatment of multi-drug resistant tuberculosis: Mercedes Becerra of HMS described the burden of drug-resistant TB within households of patients in Lima, Peru. Ted Cohen and Sonya Shin of BWH developed tools to track and predict the spatial spread of drug-sensitive and resistant TB. Sonya Shin also studied the impact of a targeted drug-resistance testing strategy for multidrug-resistant tuberculosis detection in Lima.



Researchers from a tuberculosis study in Peru
© SES

Selected Publications

Books

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A man wearing a white hard hat and a light blue patterned shirt is crouching on a dirt mound at a construction site. He is carefully planting a young green sapling into the ground. In the background, there are several buildings under construction, a red container, and a small tractor. The landscape is hilly with some greenery and mountains in the distance under a clear sky.

Finance & Governance

*Tree planting at Mirebalais
construction site*

Financial Review

As we approach the twenty-fifth anniversary of our founding, we reflect with a great deal of humility on the tremendous progress we have made accompanying the poorest of the poor in 12 countries. Along the way we have learned many lessons, formed valuable partnerships, increased our supporter base, and extended the depth of our programmatic efforts. Our work in fiscal year 2011, as reflected by our financial performance and position, was no exception.

In fiscal year 2011, we generated revenues of \$88 million, representing a \$24 million or 18 percent compounded annual increase compared to normalized revenues of \$63 million in fiscal year 2009. Partly supporting this growth were 15,000 individuals who became new PIH donors during the most recent fiscal year. This base of new donors alone outpaces the total number of donors in fiscal year 2009, reflecting the benefits of our careful decision to bolster investments in development. Even with this increased investment in development efforts, the vast majority of our funding continues to directly support program activities; administration and development account for just 6 percent of total expenditures.

We ended fiscal year 2011 with \$117 million in expenses, creating a deficit for the year of \$28 million. The deficit was intentional and part of our plan to spend down in fiscal years 2011 and 2012 the \$58 million remaining as of June 30, 2010 that we received to support rebuilding efforts in Haiti following the devastating earthquake in January 2010. We have made a number of investments in Haiti—including construction of a public teaching hospital highlighted in this report—that we believe will generate lasting benefits for our patients and partners. We expect to draw down on remaining Haiti funds of \$30 million, included in our net assets of \$62 million, by the end of fiscal 2012.

Looking forward to fiscal year 2013 and beyond, after the additional funds for Haiti are expended, we plan to reduce overall spending to levels consistent with anticipated normalized revenues. While this will require difficult decisions, we remain committed to acting responsibly and strategically—keenly mindful of our moral and medical obligation to those we diligently serve. In addition, we will strive to ensure that our precious financial resources continue to reach the intended beneficiaries as efficiently and effectively as possible. This critical objective is reinforced by a recent internal change initiative that includes strengthening internal control processes and formalizing belief and boundary systems.

Thank you for continuing to stand with us and making our work possible.

Donella M. Rapier

Chief Financial Officer



Since 2003, Partners In Health has consistently earned Charity Navigator's highest rating, certifying our commitment to accountability, transparency, and responsible fiscal management. Only 1% of charities have received this distinction for eight consecutive years, placing Partners In Health among the most trustworthy charities in America. We are deeply committed to being good stewards of our donors' dollars, with 94 cents of every dollar donated going directly to our programs—directly to saving lives.

Financial Review

Statement of Activities

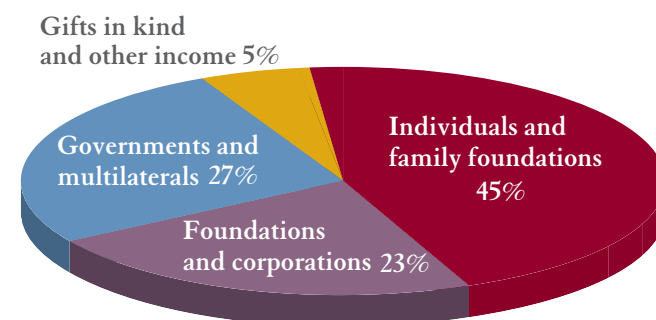
(dollars in thousands)

For the year ended June 30,

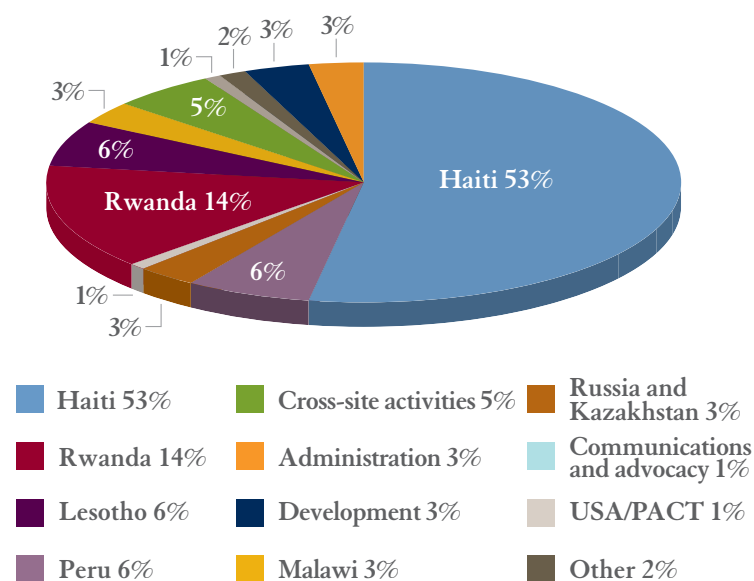
	2011	2010	2009
Revenue			
Contributions, grants and gifts in kind			
Individuals and family foundations	\$39,956	\$83,546	\$32,311
Foundations and corporations	19,900	46,039	14,915
Governments, multilateral & research institutions	23,220	17,428	14,468
Gifts in kind and contributed services	4,450	4,770	1,523
Other income	351	175	152
Total revenue	87,517	151,958	63,369
Expenses			
Program services	109,642	86,237	60,118
Development	3,793	3,042	1,590
Administration	3,153	2,507	2,227
Total expenses	116,588	91,876	63,935
Excess/(shortfall) of revenue over expense	(29,071)	60,082	(566)
Investment income/(loss)	1,446	569	(3,324)
Change in net assets	(27,625)	60,651	(3,890)
Currency translation adjustments	101	56	(59)
Net assets at beginning of year	89,434	28,727	32,676
Net assets at end of year	61,910	89,434	28,727

Note: Just 6% of total expenditures in FY11 went toward administration and development, with the vast majority of funding going directly to program activities.

Revenue by Source FY2011

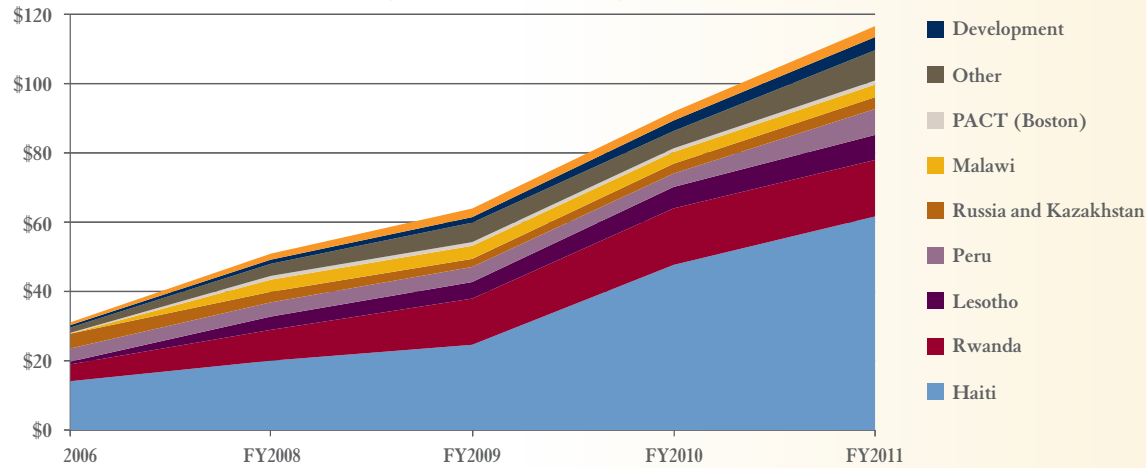


Program Costs FY2011



Expenses, 2006-FY2011

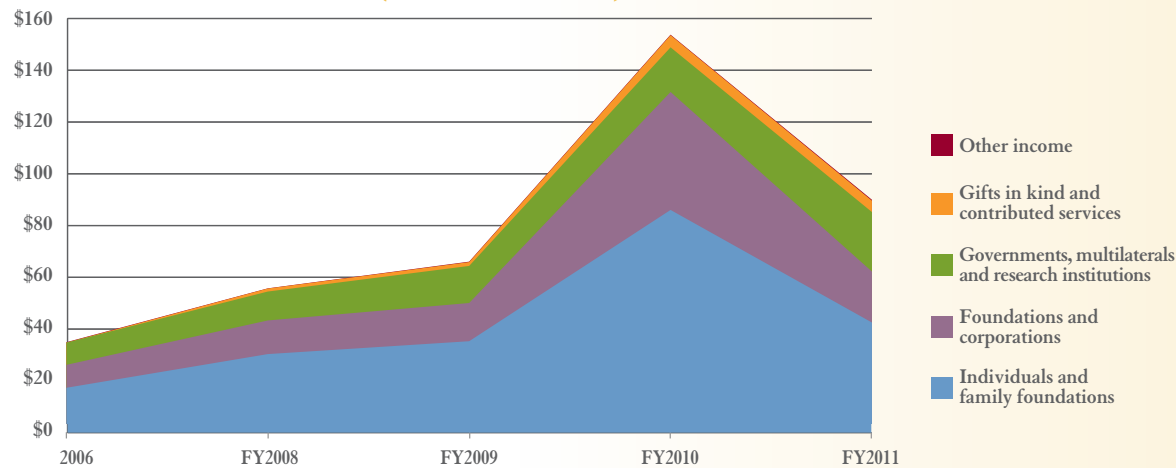
(dollars in millions)



Note: Other includes academic initiatives, medical informatics, training, monitoring and evaluation, communications, advocacy, as well as cross-site clinical staff and procurement. In 2007, PIH changed from a calendar year end to a fiscal year ending June 30. As a result, we have excluded 2007 due to only 6 months of operating results in that fiscal year.

Revenue by Source, 2006-FY2011

(dollars in millions)



Notes: Revenues in FY10 reflect generous donations for Haiti earthquake relief. In 2007, PIH changed from a calendar year end to a fiscal year ending June 30. As a result, we have excluded 2007 due to only 6 months of operating results in that fiscal year. Through 2004, PIH relied almost solely on one major foundation grant and a single major gift benefactor. In FY2011, PIH received gifts from 170 foundations and corporations and over 45,000 individual donors.



Nurse consults patient records in Lesotho

Financial Review

Balance Sheet

as of June 30,

(dollars in thousands)

	2011	2010	2009
Assets			
Cash and cash equivalents	\$7,899	\$4,476	\$5,218
Contributions receivable	825	2,106	2,362
Grants and other receivables	7,687	11,687	5,199
Prepaid expenses and other assets	535	311	142
Investments, at fair value	46,971	71,510	15,649
Property and equipment, net	2,886	3,047	2,725
Total assets	66,803	93,137	31,295
Liabilities and net assets			
Liabilities			
Accounts payable and accrued expenses	4,380	3,312	2,322
Amounts owed – fiscal agencies	513	391	246
Total liabilities	4,893	3,703	2,568
Net assets			
Unrestricted			
Currency translation adjustments	399	298	242
Undesignated	8,165	9,687	7,093
Thomas J. White Fund	17,374	15,382	13,641
Total unrestricted net assets	25,938	25,366	20,976
Temporarily restricted	35,972	64,068	7,751
Total net assets	61,910	89,434	28,727
Total liabilities and net assets	66,803	93,137	31,295

*Digging the foundation
for Mirebalais Hospital*

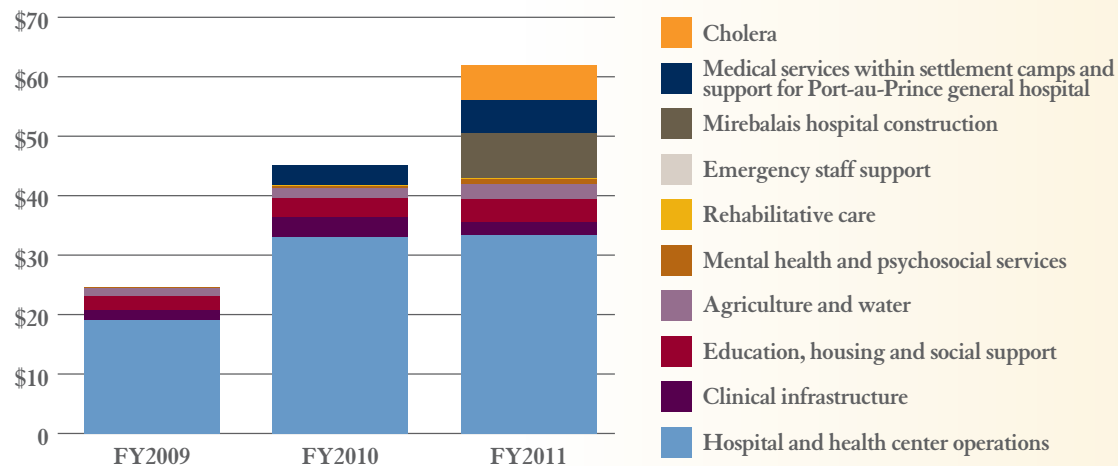
Earthquake relief and reconstruction in Haiti

The earthquake in January 2010 was a transformative event that continues to require an equally impactful and comprehensive response. In our deep commitment to the people of Haiti, we have responsibly exhausted much of the funds donated in response and expect to complete spending by the end of fiscal year 2012.

Following the devastating earthquake and the outpouring of support from generous donors, our intentions have been clear: leverage two decades of experience and existing infrastructure (e.g., hospitals, health centers, and a trained, dedicated workforce that now numbers over 5,400), expand current services complementary to the response and recovery, strengthen the public health system, and accelerate relevant new projects. While these efforts are ambitious and challenging, we have made substantial strides. Due to the significant overlap of our core Haiti operations with the earthquake response and recovery efforts, disentangling spending for the earthquake alone is not an easy task. However, the graph below provides a constructive view of how the reach and depth of operations expanded in response. As the graph shows, through fiscal year 2011, we have spent \$60 million above the spending level in fiscal year 2009, and this will increase to over \$90 million through fiscal year 2012.

More specifically, and consistent with the parameters we set for ourselves last year, we have provided much needed care in settlement camps, increased rehabilitative medicine and mental health services, and accelerated and expanded our plans for a national teaching hospital in Mirebalais. The hospital, scheduled to open in 2012, is the cornerstone of our efforts to rebuild Haiti's systems for public health and the education of health professionals.

Spending in Haiti, FY2009–FY2011 (dollars in millions)



Earthquake amputee with prosthesis participates in rehabilitation program



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*Pygmy children receiving
school supplies in Rwanda*

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*Zanmi Ben's blessed friends
share a joke with Bill and Daisy
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Malawian mother receives school supplies for her children



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*Patient at Rwinkwavu
Hospital in Rwanda*



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Cover Photos:

*Front left: A former HIV patient, now
a PIH motorcycle messenger*

*Front right: Construction workers building
Mirebalais National Teaching Hospital*

*Back: Patients waiting at Mamohau
Hospital in Lesotho*