



KEEPING OUR PROMISES
PUSHING THE BOUNDARIES
ENSURING A SUSTAINABLE FUTURE



DIRECTOR'S MESSAGE

Dear friends,

We take deep pride and are profoundly grateful to be able to share with you Partners In Health's accomplishments over the past year. In broad strokes, they include more than two million patient visits, major infrastructure investments, extensive training, and significant expansion both of our programs and of the geographic areas where we work. This year, as in years past, we have grown dramatically, greatly extending the reach of our work.

Perhaps more exciting than these quantifiable measures of our achievements, however, are the transformations we can see in the people and communities we serve. In late 2007, I visited Haiti for the first time in almost a year. Returning after such a long absence, I was struck more clearly than ever by the results of what we consider both a partnership and a long-term investment. At our first site in Cange, once a destitute squatter community of landless peasants, I saw a population that is overwhelmingly healthy. Infants whom we vaccinated 20 years ago are now healthy, confident young adults who, unlike most of their parents, have gone to school, learned to read, had enough to eat, slept on beds instead of dirt floors, and had access to medical care when they were sick. Now their overriding concern is finding work.

The task of creating jobs for an educated young workforce represents a new and difficult challenge. More than a challenge, however, we regard it as an inspiring measure of progress in a community where two decades ago children died routinely for lack of clean water and rarely attended school because they could not afford the fees and uniforms. Even more inspiring is the evidence that many of these young people have embraced a spirit of solidarity and a commitment to health and social justice. At a moving ceremony this past August, hundreds of people packed the Bon Sauveur chapel in Cange to celebrate and give a rousing send-off for seven students who are going to medical school in the Dominican Republic and Cuba. All of the students have pledged to return to the Central Plateau to serve the destitute sick after they complete their training.



Stories like this give us the confidence to respond frankly when people ask whether we have an “exit strategy.” We don’t. But we do have a transition strategy. Our goal is not to see how quickly we can leave a community but to rebuild public health systems and infrastructure, provide training and support for local medical staff, and employ community health workers as agents of change to break the vicious cycle of poverty and disease. Over time, our success in achieving these goals reduces our role in providing direct service but not our commitment. We continue to provide valuable technical and financial support, to bring more resources to bear on the problems we see, and to focus on filling the gaps in services where we are needed most.

We know it is Partners In Health’s ability to keep our promises and to forge long-term partnerships, as we have in Cange, that has allowed us to push the boundaries at all of our sites around the world. We are proud that our work has played a part in resetting expectations for what is possible in global health and are determined to maintain our longstanding commitment to “accompany” patients, communities, and even countries through social and economic upheavals and natural and unnatural disasters. And we humbly recognize that we are only able to fulfill these obligations thanks to the many partners we have found along the way who share our ambitious vision. To this end, we have embarked upon a 25th Anniversary Drive to find new allies and support for our work. Together as individuals, communities, agencies, non-governmental organizations, and governments, we must build a concerted movement to advocate in the broadest sense for higher standards in global health, making the needs of people and communities suffering from the joint burdens of poverty and disease our top priority.

Sincerely,



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.

*PIH helped create the national
TB laboratory in Lesotho*

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BREAKING THE CYCLE

Over the past twenty years, Partners In Health has brought high-quality health care to more than two million of the world's poorest and most vulnerable people, has revitalized dozens of destitute communities, and has defied conventional wisdom to achieve breakthroughs that have transformed health policies and priorities worldwide.

Working with local partner organizations and ministries of health, we have built, equipped and staffed hospitals and clinics that treat patients regardless of ability to pay in Haiti, Peru, Rwanda, Lesotho and Malawi. We have recruited, trained and employed thousands of people from these communities as accompagnateurs (community health workers), who bring medicines and support to patients in their homes, and catalyze community solidarity and growth. We have provided food and built homes for families whose health was undermined by hunger and exposure to the elements. And we have used the power of example and the leverage of commitment to reshape policies and rewrite budgets that denied lifesaving treatment for diseases like HIV and drug-resistant tuberculosis in poor countries.

This globe-spanning record of service and success has grown organically out of a simple promise made more than two decades ago to a squatter community of displaced peasant farmers in Central Haiti, a pledge of solidarity summarized in our mission statement: "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."

Keeping that promise has repeatedly compelled us to push the boundaries of what is considered achievable and affordable in public health. And it has obliged us to put down deep roots and invest substantially in building the infrastructure, forging the partnerships and marshalling the resources that will be required to ensure a sustainable future for projects that have become the backbone of their communities.



A child reads at a school in rural Haiti

OF POVERTY AND DISEASE

When Dr. Jen Furin first saw Matsepiso, the 19-year-old woman was writhing in pain on a pile of rags on the floor of a one-room hut high in the mountains of Lesotho.

After three days of labor, Matsepiso had finally delivered a dead baby. But not before she had suffered a fractured pelvis and a double fistula — ruptures between her vagina and both her colon and her urinary tract. Without treatment, Matsepiso was almost certainly condemned to a life of unrelenting pain as a social outcast, exiled and shunned because of severe incontinence. A village health worker had hiked four hours to the health center in Ha Nkau to beseech the PIH team to visit and treat Matsepiso.

The PIH team succeeded in transporting Matsepiso by donkey, truck, wheelbarrow, and eventually a small plane to the main referral hospital in Lesotho's capital city, only to be told "there is nothing we can do." Dr. Furin refused to accept that verdict. With assistance from colleagues in Boston, she contacted the Hamlin Fistula Hospital in Ethiopia, which readily accepted Matsepiso for free care, provided PIH could get her there. Matsepiso could not fly on a commercial plane because she was unable to sit. So a group of PIH donors stepped up to pay for a medical flight that carried her the length of the continent to Addis Ababa. Six months later, after a series of successful surgeries, Matsepiso is back home and doing well.



But for PIH, that happy ending is not where the story concludes. It's where the real work begins. The lessons from Matsepiso's case are inescapable. Had prenatal care, a birthing center with skilled staff, and a common C-section been available to her, Matsepiso would not have suffered such devastating injuries and her baby would have lived. To prevent other needless deaths and suffering, we cannot expect or afford to transport individual patients across continents. Instead, we can build the infrastructure needed to make childbirth an occasion for celebration rather than the high-risk gamble that kills more than half a million women every year in poor countries and leaves over two million more scarred and stigmatized by fistulas and other preventable and treatable complications of childbirth.

We can build and equip operating rooms capable of performing C-sections within reach of poor and isolated communities; staff them with capable surgeons, anesthetists and nurses, preferably from the community; stock them with sutures, blood and other necessary supplies. We can acquire ambulances and construct lying-in centers close to clinics so that women don't need to travel for several hours on foot or muleback when they are in labor. We must expand our efforts to provide comprehensive prenatal care and labor management and to train traditional birth attendants to refer patients to the nearest health center or hospital. Looking further into the future, we must ensure that children are well-nourished today so that girls don't grow up with stunting that leaves them at high risk for obstructed delivery in the future. And we can redouble our research and advocacy efforts to make all of these interventions a budgeted priority, not just for our sites but for national health systems and international funding institutions.



Patients waiting at a health center in Rwanda

KEEPING OUR PROMISES

Partners In Health was founded on the belief expressed simply and eloquently in a common Haitian proverb—tout moun se moun or “everyone is human.” From that belief emanated the fundamental promises that have driven and guided our work: We will listen with respect to your needs and aspirations; we will act with urgency, joining with you to meet your needs and pursue your dreams; and we will persist in solidarity, sharing in both your struggles and your triumphs. Whatever it takes.

Keeping these promises has taken PIH in directions we could never have anticipated and rewarded us in ways we could never have imagined. When PIH consisted of a handful of people scuffling to establish a basic, one-room clinic, our patients in the destitute squatter community we served told us that what they really wanted was a hospital ... and an oven to bake bread. It took a few years, but the small clinic has now grown into a 104-bed, full-service hospital with three operating rooms. And the bakery that we established proved to be just the first of many projects that fall outside the normal boundaries of medical charities but are essential to improving the physical and economic health of poor communities.

Partners In Health now makes promises every day to more than two million people living in poverty who depend on us for access to quality health care and social services. More than 10,000 of them are currently receiving treatment for HIV/AIDS, tuberculosis, or both. We are committed to continuing their care for as long as is medically necessary. For HIV patients, whose survival depends on daily doses of antiretroviral drugs, this means for the rest of what we intend to make sure are long, healthy, and productive lives.

Examining a pediatric patient in Malawi

BREAKING THE CYCLE

More than 10 years ago, Denizard Wilson was diagnosed with AIDS. Soon he was too sick to continue working in Port-au-Prince, too poor to afford medical care, fearful that time was running out.

Then he heard about PIH's Haitian partner organization, Zanmi Lasante (ZL), moved back to his hometown in the Central Plateau and enrolled in treatment. As one of the early patients in ZL's HIV Equity initiative, Wilson received free antiretroviral drugs, daily visits from an *accompagnateur*, and literally a new lease on life.

"Since I have been with Zanmi Lasante, I have never been sick again—not the kind of sickness I had known," Wilson says.



ZL's support for Wilson extends far beyond delivering medicine. Wilson had arrived back in the Central Plateau sick and destitute. His family needed a decent home. ZL's Program on Social and Economic Rights built them a sturdy new house. He needed work so that he could provide for his family. Today he is employed by ZL as a motorcycle messenger, carrying patient blood samples over dirt roads, and tracking down patients who miss appointments.

And wherever he goes, despite the stigma often attached to HIV, he offers advice for young people—"Go to school before you enter into sexual relations"—and encouragement for fellow HIV patients—"As long as we are alive and have access to drugs, there is hope."

"The only way I would be scared would be if Partners In Health did not exist," Denizard says. "As long as they are here, I am alive. And as long as I am alive, I will have hope. And as long as I have hope, I will continue to spread this message."



OF POVERTY AND DISEASE

PUSHING THE BOUNDARIES

In order to keep our fundamental promises to our patients, Partners In Health has had to find innovative ways to deliver treatments and solutions that had been deemed too complicated and too expensive for poor communities. When we started treating multidrug-resistant tuberculosis (MDR TB) in Peru, official World Health Organization policy decreed that “MDR TB is too expensive to treat in poor countries.” When we began providing free antiretroviral treatment (ART) to HIV patients in Haiti, health experts warned that patient default rates “could be as high as 60%.” Defying accepted wisdom, we proved that daily accompaniment by community health workers could yield cure rates for MDR TB equal to programs in the United States and ART adherence rates well above 95 percent.

Our experience has taught us that we must push beyond the traditional boundaries of health interventions to take on the conditions of poverty that breed disease and despair. Often, for example, we see children returning to our clinics over and over again, suffering from malnutrition or diarrheal diseases. Medical judgment and economic calculations suggest, and our experience confirms, that providing access to adequate food and clean water can save lives, reduce the burden on medical facilities, and improve the prospects of entire communities by allowing children to attend school regularly and their parents to tend to their jobs and fields instead of their ailing children.

PIH has leveraged its success to catalyze transformations in international policy and reallocation of global resources. The success of our pioneering treatment programs for HIV/AIDS and MDR TB helped pave the way for unprecedented new funding and attention to the diseases of the poor, including the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). More recently we helped convince these and other major funding institutions to recognize that food and paid community health workers are essential for successful prevention and treatment programs.

BREAKING THE CYCLE



*Collecting clean
water in Haiti*

The surgical team was prepped and the operating room was ready when the ambulance arrived at the hospital in Cange, Haiti. Orderlies rushed to bring in the patient, a pregnant 45-year-old mother of 11 who was hemorrhaging badly. Dr. Eddy Jonas, a Haitian surgeon, examined her and found that she was suffering from placenta previa, a life-threatening complication in which the placenta blocks the cervix. Almost immediately, she was wheeled into the operating room, where Dr. Jonas performed a delicate and dangerous emergency Caesarean-section, backed by an entirely Haitian team of nurses and nurse-anesthetists.

The successful operation was observed and filmed by a camera crew from CBS's 60 Minutes. After it was over, correspondent Byron Pitts turned to PIH co-founder Paul Farmer and asked, "That same woman, same circumstances, 25 years ago—what would have happened?"



Farmer's answer was short and unambiguous. "She wouldn't have made it." Twenty-five years earlier, there would have been no ambulance to transport her, no operating room to transport her to, no trained surgeon and surgical staff able to perform a C-section within a day's journey.

Farmer pointed out a simple lesson—"If you set your sights high and stick with it, you can make real progress." And as other events confirmed, if you keep pushing the boundaries, if you keep delivering and demanding quality care for poor patients, you can help bring change on a wider scale.

Weeks before Dr. Jonas performed the emergency C-section, Cange hosted another dramatic event—Zanmi Lasante's thirteenth annual forum on health and human rights. Dr. Raoul Raphaël, the head of Haiti's Ministry of Health in the Central Department, brought the crowd to its feet when he declared, "As Health Commissioner of this region, it is my pledge that all pregnant women will have free access to prenatal care. And we will work to increase access to free Caesarean sections as they are life-saving operations that **cannot** be sold as you would sell a side of beef or a goat."

A few months later, with backing from the World Health Organization and the Canadian government, Haiti launched a national program of free obstetrical care, reinforced with reimbursements to cover the costs of transportation and help mothers obtain prenatal care, deliver their babies in hospitals, and return for follow-up at post-natal clinics that are an important entry point for family planning services.



OF POVERTY AND DISEASE

ENSURING A SUSTAINABLE

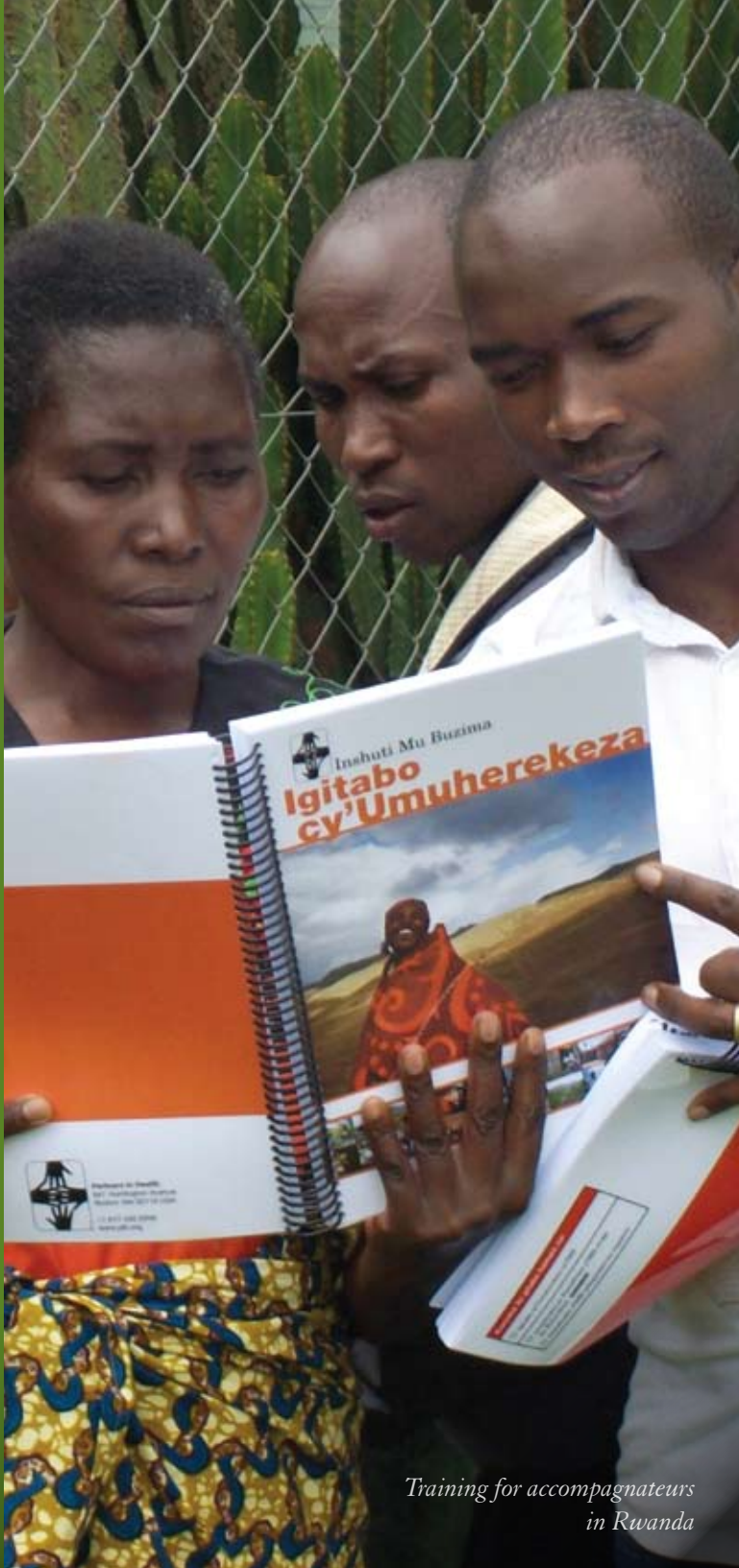
While recognizing that the ultimate measure of sustainability for our projects will be their ability to carry on without further assistance from us, PIH views sustainability in a different light.

Already Zanmi Lasante in Haiti, our oldest and strongest partner organization, has demonstrated that it can expand and improve medical and social services with an entirely Haitian team of doctors, nurses, social workers and nearly three thousand community health workers and non-medical staff. But Zanmi Lasante still receives and relies on technical, administrative and, especially, financial support from PIH. That support must and will continue in order to meet both medical needs and moral obligations. After all, the epidemics of deprivation and disease that plague poor communities in places like Haiti and Rwanda developed over the course of generations of exploitation and neglect. We cannot expect to eradicate them overnight.

We have shown that the vicious cycle of poverty and disease can be broken. Better yet, it can be converted into a virtuous cycle in which improved health yields increased productivity and prosperity, even as access to food, clean water, classrooms, and opportunities results in better health throughout the community. We realize, however, that accelerating this virtuous cycle in communities devastated by decades of deprivation requires not only local partnership and capacity building but also long-term injections of external support.

So while we continue to advance our work and maintain our ongoing commitments, we also recognize the importance of building infrastructure; of forging strategic alliances; of helping develop a new science of global health delivery to inform and inspire the next generation of global health practitioners; and of being fiscally responsible so that we can sustain our work for years to come.

BREAKING THE CYCLE



*Training for accompagnateurs
in Rwanda*

FUTURE

Patricie is a young, Rwandan widow with five children. Patrick Almazor is a young Haitian doctor who joined PIH's partner organization, Zanmi Lasante, when he completed his medical training in 2001. Early in 2008, Patricie's and Patrick's paths crossed at the Burera District Hospital in Rwanda.



Patricie was there because she was suffering from both advanced HIV/AIDS and disseminated tuberculosis. Patrick was there because PIH had enlisted him to spearhead technical support for the Rwandan government's ambitious drive to strengthen rural health systems throughout the country. The hospital itself was there because the Ministry of Health, with support from its partners in PIH and the Clinton HIV/AIDS Initiative, had chosen to launch its rural scale-up in Burera, one of only two districts in the country that previously lacked a true hospital.

To achieve its goals, the government of Rwanda has mapped out a comprehensive, community-based framework that incorporates core elements of the PIH model that are both familiar to Patrick from his work in Haiti and essential to liberating patients like Patricie from the stranglehold of disease and despair—daily visits by a trained accompagnateur; food for her and her malnourished children; support to rebuild her house and send her children to school; and an opportunity to earn a decent living for her family.

Working with the mayor of the district and local Ministry of Health authorities, PIH transformed a decrepit building at the Butaro Health Center into a 55-bed hospital with three wards and the first operating theater and radiology unit in the district. The hospital will provide inpatient care until construction is completed on a new district hospital in late 2009. PIH also helped recruit and pay doctors, nurses, and pharmacy and laboratory staff, and committed itself to provide training and salaries for 1,200 community health workers and supervisors elected by villages across district.

The Rwandan government is also looking to PIH and the Clinton Foundation to help raise the funds to get the program up and running. A study by the Clinton Foundation pegged the annual cost of the program at only \$27 per person. As the Rwandan economy grows, the government is committed to funding it entirely from the national budget.



OF POVERTY AND DISEASE



*A mother with her baby
shortly after delivery*

HAITI/ZANMI LASA

Zanmi Lasante (ZL) strengthened its programs, facilities, and staff dramatically, both across the Central Plateau, where we have been working for almost 25 years, and in the lower Artibonite Valley into which we started expanding in 2005. With this expansion, ZL is now the main provider of health care for central Haiti, serving a population of 1.2 million people in an area that extends from the border with the Dominican Republic to the coast.

HIGHLIGHTS OF THE YEAR

- **Improved Public Health Infrastructure:** With support from AmeriCares, ZL constructed a new 54-bed hospital in Lacolline. The hospital relieved overcrowding at the small, cramped clinic in nearby Lascahobas, where the number of patients had soared from a handful each day to as many as 400 since ZL started providing HIV treatment and comprehensive primary care. The Lascahobas facility has been renovated to serve as a women's health center and malnutrition clinic.
- **Improved Mother and Child Survival:** ZL's program for women's health (*Proje Sante Fanm*)—which has provided prenatal care, treatment of sexually transmitted diseases, and family planning

THE YEAR

services since 1990—faced both an opportunity and a challenge when the Haitian government launched a national program of free obstetrical care in April 2008, with support from the World Health Organization and the Canadian government. The number of women seeking *Sante Fanm* services increased sharply at all ZL sites and doubled at several. Attendance also grew rapidly at post-natal clinic, which historically has had very low attendance rates, presenting an opportunity to provide badly needed family planning services, cervical cancer screening, and testing for sexually transmitted infections.



■ **Expanded Agricultural Initiatives to Improve Nutrition and Provide Economic Opportunities:**

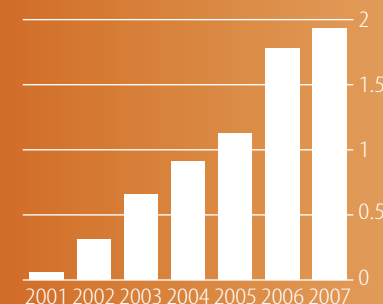


ZL began manufacturing its own locally-produced peanut-butter medicine to treat severely malnourished children. Production of *nourimanba* provides jobs for 23 local people and guarantees a market for local farmers who grow peanuts, corn, and beans. In addition, 240 families with malnourished children joined our Family Assistance Program, and received agricultural training, seeds, tools, fertilizer, a goat, and in many cases land to farm. Most importantly, ZL offered on-going support and home visits from agricultural technicians and community agriculture agents.

■ **Strengthened Surgical Capacity Through Training:** ZL continued its efforts to strengthen human resources, with an emphasis on building a strong surgical team. Three ZL nurses completed a rigorous 18-month anesthesiology training in Cange, through a partnership with Doctors Without Borders. The nurse-anesthetists have pledged to work for ZL for five years. In addition, three other ZL nurses traveled to Boston to receive advanced training in operating room nursing through a partnership with Regis College in Weston, Massachusetts.



1.9 MILLION patient visits



3,562 AIDS patients on antiretrovirals

13,647 HIV-positive patients monitored

6,395 children receiving educational assistance

3,325 adults receiving literacy training

9,315 students received free lunches at 27 schools

454 metric tons of food distributed to patients

419 births and 756 family planning visits per month at ZL facilities

Staff:

373 medical

1,190 non-medical

1,557 community health workers



An SES health promoter with an HIV patient

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. At the same time, SES also strengthened and expanded primary health care, mental health and social support services in the shantytowns around Lima and other poor communities.

HIGHLIGHTS OF THE YEAR

■ Continued Treatment for Drug-resistant TB:

The SES program continued to flourish as more than a thousand patients completed treatment and SES provided comprehensive support to even more patients through the two long years of extremely difficult treatment. As always, SES supported patients economically, by paying for medical exams, diagnostic tests, surgery, and medications to treat adverse reactions to drugs, and by providing housing, food, and transportation.



■ Expanded HIV/AIDS Care: In 2005, SES began a pilot program with HIV/AIDS patients, providing the

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same high level of social and economic support MDR TB patients have received over the last decade. Of the 108 original patients, 52 are still receiving accompaniment and regular support from a dedicated community health worker. Over one third are now clinically and economically stable enough not to require the intensive intervention they needed during initiation of antiretroviral treatment. These patients now work with a friend or family member to stay on track with their treatment, receiving only periodic follow-up visits from the SES HIV team.

- Strengthened Primary Care Services:** Primary health care continues to be a major priority for SES, particularly in the shantytown of Carabayllo and the surrounding areas on the outskirts of Lima. SES now operates 16 *botiquines*—small rural health posts that serve patients who would otherwise have no access to primary care. The *botiquines* are run by a team of 25 community health workers, who receive supervision from three district coordinators and ongoing training through workshops on topics ranging from early childhood development to nutrition and first aid.



- Expanded Mental Health Services for MDR TB and HIV Patients and Families:** Building on its successful therapy program in Carabayllo, SES extended both group therapy and one-on-one peer counseling options to the northern region of La Libertad and other areas where no services previously existed. SES also brought the department of mental health and the national TB program together; they now collaborate to provide vital mental health services to all MDR TB patients.

- Improved Academic Performance of At-Risk Children:** SES enrolled hundreds of children in a pilot program emphasizing the use of games and logic problems to improve math skills. Under the supervision of the SES education staff, the youth promoters of Carabayllo—adolescents and young adults between the ages 13 and 20—tutored 70 primary school children who had been identified by their teachers and parents as needing extra attention in order to perform at grade level. More than three quarters of the children involved showed a significant improvement in their academic performance.



1,072 MDR TB patients completed treatment

2,792 patients received nutritional support

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

1,297 people obtained primary care services at *botiquines*

287 patients received group therapy

420 patients received housing support

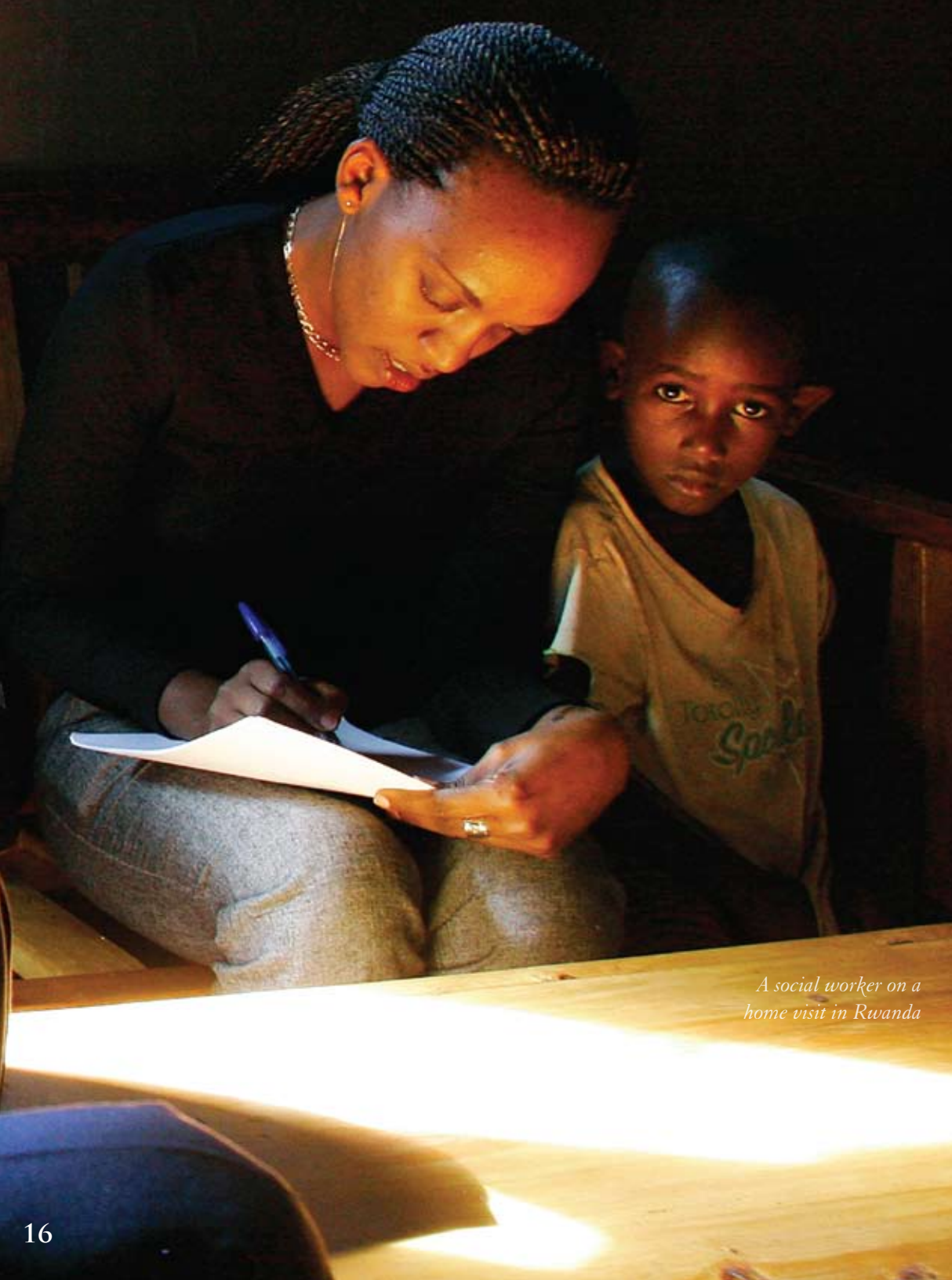
1,000 adolescents educated on HIV/AIDS prevention

Staff:

20 medical

123 non-medical

1,174 community health workers



A social worker on a home visit in Rwanda

RWANDA/INSHUTI

PIH and our Rwandan partner organization, Inshuti Mu Buzima (IMB), achieved several major milestones during our third year of operations. We 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.

HIGHLIGHTS OF THE YEAR

- **Helped Launch Rwanda's Rural Health Initiative:** Working within a government framework that incorporates key elements of the PIH model as well as other innovations from around Rwanda, IMB and PIH helped the Ministry of Health bring comprehensive care to Burera, a district in northern Rwanda whose 400,000 people had previously been served by a single doctor and no functioning hospital. We transformed a decrepit building into a 55-bed hospital, laid plans for a new district hospital, and worked with local Ministry of Health officials to recruit four new doctors, and hire 13 nurses, a pharmacist, and a laboratory technician. We also worked to harmonize the PIH *accompagnateur* model pioneered in Haiti with the Rwandan government's national community health worker program. PIH is committed to training and

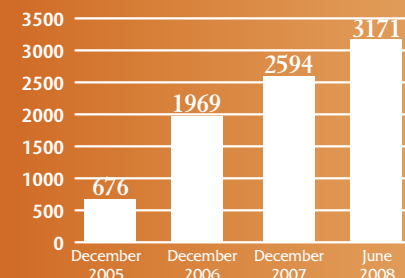
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compensating 1,200 community health workers elected by villagers throughout the district. Within a few months, more than 100 HIV patients were receiving daily visits from community health workers.

- **Improved Public Health Infrastructure in Eastern Rwanda:** With a population of over 260,000, Kirehe was one of the few districts in Rwanda without a functioning district hospital. IMB committed to help the Ministry of Health build a new facility. Phase one construction got underway in April 2007 and was scheduled to be completed in autumn 2008. In the meantime, IMB renovated the existing ambulatory health center and strengthened the staff, leading to an increase of patient visits to almost 200 patients per day. IMB also collaborated with UNICEF and other donors to construct a new pediatric building at Rwinkwavu Hospital. The new facility houses dedicated pediatric consultation and counseling rooms, rooms for family planning and prevention of mother-to-child transmission of HIV sessions, a large playroom, a pharmacy, and office space.
- **Provided Treatment and Training for Management of Chronic Disease:** IMB established chronic care clinics at seven sites that are now providing management of long-term illnesses such as asthma, diabetes, epilepsy, heart disease, and splenomegaly for almost 1,000 patients. Nurses who staff the clinics received specialized training, starting with seminars on diagnosis and management of asthma and diabetes. IMB is also developing protocols for the management of these illnesses, which will be put into a handbook for nurses and doctors working in hospitals and clinics in the developing world.
- **Expanded to a Seventh Site in Southeastern Rwanda:** IMB expanded to Ndego, making it the seventh site in the Eastern Province operated jointly with the Rwandan Ministry of Health. IMB moved quickly to upgrade the cramped and dilapidated health center facilities and collaborated with the Global Fund to Fight AIDS, Tuberculosis and Malaria to construct a new building with three consulting rooms, two laboratories and a bathroom. A new infectious disease clinic was established to improve care for patients with AIDS and tuberculosis. And IMB doctors began making weekly visits to support the infectious disease clinic, supervise rounds on hospitalized patients and provide testing, treatment and psychosocial support for HIV-positive children.



3,171 AIDS patients on therapy



26,704 patients tested for HIV

161,831 patient visits
(152,772 outpatient, 9,059 hospitalizations)

13,544 cases of malaria
diagnosed and treated

3,276 deliveries in seven health
facilities

1,100 food packets distributed
each month

747 children received secondary
school fees

Staff:

241 medical

369 non-medical

910 community health workers



LESOTHO/BO-MPH

During its second year of operation, PIH Lesotho (PIHL) expanded its rural initiative to bring comprehensive primary health care and HIV testing and treatment to five more remote mountain communities. And we launched a pathbreaking national program to provide community-based treatment for a devastating dual epidemic of drug-resistant tuberculosis and HIV/AIDS.

HIGHLIGHTS OF THE YEAR

- **Expanded the Comprehensive Healthcare Program in Rural Areas:** Building on our success at a single site in 2006, PIHL expanded to a total of six rural health centers in four mountain districts serving a population of more than 300,000 people. The Rural Initiative upgraded or replaced clinic buildings, staffed them with doctors and nurses, stocked them with essential supplies and equipment, and installed solar power and satellite communications at four sites that previously had no electricity or telecommunications capability. All of the sites now provide testing and treatment for HIV and tuberculosis, programs to prevent transmission of HIV from mothers to children, vaccinations and clinics for children under the age of five, women's health services, and trauma care.

Community-based care for an MDR TB patient in Lesotho

THE YEAR

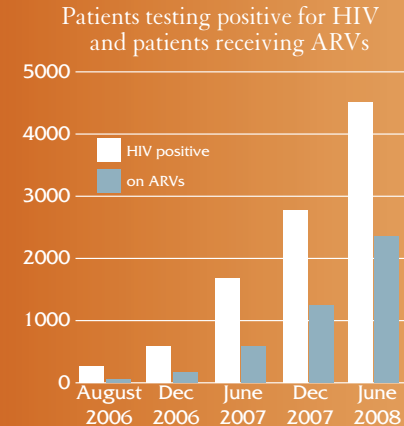
ATO LITŠEBELETSONG TSA BOPHELO

- Established a National Treatment Program for Drug-Resistant TB:** With support from the Open Society Institute, PIHL responded to a major epidemic by launching a community-based program to treat multidrug-resistant and extensively drug-resistant tuberculosis. The program is now treating patients in all 10 districts of Lesotho. Patients are hospitalized only until they are stable enough to go home or move into small houses rented by PIHL near the hospital. There they receive daily visits from treatment supporters trained and employed by PIHL, as well as food, transportation and other social supports. To date, not a single patient has defaulted from the arduous two-year course of treatment.



- Strengthened Public Health Infrastructure:** PIHL transformed an old leprosy hospital into a state-of-the-art tuberculosis facility, complete with negative air-pressure and ventilation systems to prevent cross-infection. Working with the Foundation for Innovative New Diagnostics (FIND) and the Lesotho Ministry of Health and Social Welfare, PIHL also refurbished the National TB Reference Laboratory and provided on-the-job training in microscopy and culture testing for the lab technicians. For the first time, the laboratory is now performing culture and first-line drug sensitivity testing.

- Provided Food for the Hungry:** Confronted by an alarming increase in the number of malnourished children, with help from the government of Ireland, PIHL launched a supplementary feeding program to provide nutritional support to all malnourished children in the mountains. The family of every child enrolled in the program receives a monthly package containing 60 kilograms of maize meal, nine kilograms of beans, four liters of cooking oil, and six kilograms of a nutritious corn-soy blend to help them gain weight. In addition, all severely or moderately malnourished children older than six months receive a special high-protein, high-energy peanut butter fortified with vitamins, milk powder, and sugar.



13,887 patients tested for HIV, of whom 4,521 tested positive

2,354 HIV patients receiving antiretroviral therapy

790 cases of TB diagnosed of whom 75% are co-infected with HIV

117 MDR-TB patients receiving treatment

3,485 households receiving food supplements

900 community health workers trained (as of June 30, 2008)

Staff (as of Dec. 31, 2007):

17 medical

75 non-medical

740 community health workers



*A mother weighs her baby
at a clinic in Malawi*

MALAWI/ABWENZI

In February 2007, PIH launched Abwenzi Pa Za Umoyo (APZU) in Neno, a rural district in southern Malawi. Building on the momentum created by providing care for HIV patients, APZU undertook a wide variety of infrastructure and staffing improvements to strengthen the overall health system and launched programs to provide social and economic support for the surrounding communities. These led to more than 100,000 patient visits in the district during this time.

HIGHLIGHTS OF THE YEAR

- **Scaled Up HIV Testing and Treatment:** APZU hit the ground running by training 20 new HIV testing counselors, who were quickly deployed throughout the district. More than 12,000 people were tested in 2007 alone, and the number of HIV patients receiving antiretroviral therapy (ART) increased from less than 200 to more than 1,100. A second ART clinic was opened in the populous Lisungwi area of the district, which also contributed to the rapid expansion of patients enrolled on ART. In addition, all new patients were enrolled in a six-month food support program, receiving monthly household food packages to support the nutritional needs of the patients themselves, and the members of their households.
- **Addressed the Health Worker Shortage:** APZU trained and employed 300 full-time community health workers (CHWs) to provide support to patients at the four busiest health centers in the district. The CHW program contributed

THE YEAR

to the rapid enrollment of new patients and was a major factor in APZU's impressively low rate of patients lost to follow up (less than 2 percent). APZU also focused on retaining medical staff working for the Ministry of Health by renovating and building improved staff housing; initiating a performance based salary top-off for all MOH staff working with APZU; and providing opportunities for weekly training. MOH staff have cited these training opportunities and increased resources, including stocking of sufficient pharmaceutical and lab supplies, as a source of increased job satisfaction.



- **Built Health Infrastructure:** When APZU arrived in Neno, most of the district's 10 health centers had not been maintained in the last 20 to 30 years. APZU initiated renovation and construction projects at eight of the ten facilities. Four of these major renovation projects had been completed by the end of June 2008. The centerpiece of APZU's infrastructure improvements was construction of a new district hospital in Neno, complete with inpatient wards for women, men and children, a pediatric intensive care unit, a laboratory, blood bank, two surgical theaters, a pharmacy, and an emergency room. By the end of June 2008, the facility was more than 90 percent completed.
- **Launched a TB Program:** Tuberculosis is the leading cause of death for HIV patients in Africa, making testing and treatment for TB essential to achieving good outcomes for patients on ART. After obtaining permission from Malawi's National Tuberculosis Program, APZU launched a TB registration site in January 2008. Over the next six months, APZU diagnosed and treated more than 200 TB patients with a standard of care that includes Directly Observed Therapy, food packages, as well as close monitoring and follow-up.
- **Built Community Centers, Homes, and Hope:** APZU's Program on Social and Economic Rights (POSER)



worked closely with six different community-based organizations to tackle the conditions of poverty that lead to disease and to provide support to patients with HIV, as well as orphans and vulnerable children. POSER helped build community centers, established new vocational training programs, and provided support for agricultural activities. In addition, the program built new homes for 15 patients, and provided money for tuition, school uniforms, and school supplies for 100 children. POSER also helped identify poor people who desperately needed employment, so that APZU could provide full-time jobs to some of the most vulnerable people, especially those affected by HIV.

12,000 patients tested for HIV

1,100 HIV patients receiving antiretroviral therapy

200 patients treated for TB during first six months of 2008

4 major renovations completed at health centers

51 housing units renovated or constructed for staff

15 houses built for families of patients

100 children receiving tuition support

300 community health workers trained

Staff (as of June 30, 2008):

87 medical

191 non-medical

300 community health workers

RUSSIA/Партнеры во имя Здоровья

PIH Russia expanded both its services to improve treatment and outcomes for TB patients in Tomsk Oblast in Siberia and its training and technical support for doctors treating multidrug-resistant TB elsewhere in Russia and in other countries in Eastern Europe and Central Asia that had been part of the former Soviet Union.

HIGHLIGHTS OF THE YEAR

■ Expanded Services to Improve MDR TB Care and Outcomes in Tomsk Oblast:

With support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, PIH Russia created and expanded several programs to improve TB treatment and outcomes in Siberia's Tomsk Oblast. New services included: TB screening for HIV-positive patients and prophylactic TB treatment for more than 160 HIV patients with latent TB infections; psychological and social support for the estimated 50 percent of TB patients who are addicted to alcohol; an early TB detection program to screen for cases among high-risk groups including the unemployed, homeless and ex-prisoners; expansion of the *Sputnik* program that provides home-based treatment for high-risk patients and has raised adherence rates from 52 percent to more than 90 percent.

■ **Provided MDR TB Training for Doctors from Former Soviet Republics:** Working with colleagues from the Tuberculosis Office and the Penitentiary System of Tomsk Oblast, and with financial support from the Eli Lilly Foundation, PIH provided intensive training for 93 doctors representing the majority of the former Soviet Union countries. During the seminars, participants were instructed by Russian and international experts on proper treatment of patients with MDR TB, took part in case-based clinical discussions, and shared best practices.

■ **Provided Technical Assistance for Other Regions of Siberia:** In February 2008, PIH/Russia started providing intensive Technical Assistance to two Russian territories in Siberia—Novosibirsk and Altay Kray. PIH staff visited the territories several times and consulted with TB doctors on MDR TB program implementation.

BY THE NUMBERS

856 new TB patients
and 171 new MDR TB
patients enrolled

Default rates reduced to
1.2% for TB and
9.7% for MDR TB

1,235 TB and
MDR TB patients
received nutritional
support

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

Staff
6 medical
11 non-medical

THE YEAR IN REVIEW

USA/PACT

The Prevention and Access to Care and Treatment (PACT) Project strengthened its health promotion and directly observed therapy services for marginalized HIV/AIDS patients in Boston and moved to make its model of community-based care more widely available in other cities and to adapt it to patients suffering from diabetes and other chronic diseases.

HIGHLIGHTS OF THE YEAR

- **Adapted the PIH Model of Community-Based HIV Care to Diabetes:** PACT took several important steps toward adapting its model of accompaniment by community health workers to support diabetes patients who have difficulty adhering to treatment. The PACT team mapped community needs, researched existing best practices of diabetes care, interviewed patients to learn about their needs, and figured out how the PACT model could be tailored to address them. PACT also developed a partnership with a local health center to pilot the model.
- **Improved Directly Observed Therapy (DOT) to Reach More Patients:** After a thorough review of its Directly Observed Therapy (DOT) program, PACT was able to offer services to more patients by optimizing DOT appointment times and travel routes. Additional slots were opened by giving patients the option of receiving DOT either seven or five days a week, depending on their needs and preferences.
- **Built a Replication Team to Support Similar Projects:** PACT responded to frequent requests to replicate its model in other US cities by creating a team to provide training and support. PACT has already trained and collaborated with four programs in New York City and three others in Miami, Cincinnati, and Norfolk, Virginia.

BY THE NUMBERS

147
patients received
community-
based care

86
new patients
enrolled on
treatment

43
patients served with
Directly Observed
Therapy (DOT)

7,217
DOT visits and
2,975 health
promoter visits
made

299
total patients
served since the
program was
started

Staff
1 medical
19 non-medical
2 contracted



*A PACT DOT specialist
with a patient*

CHIAPAS/EAPSEC

Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC) increased the quality and breadth of Community Health Promoter (CHP) training by providing physician supervision of hands-on primary care, offering workshops from international residents and students, and tailoring training to unique challenges such as epilepsy and tuberculosis. In addition, EAPSEC helped bring together CHPs from across Chiapas for quarterly conferences and collaborated on creating a new community health certificate program.

HIGHLIGHTS OF THE YEAR

- **Provided Medical Training for Health Promoters:** Community Health Promoters (CHPs) took part in over 500 primary care training experiences, in which physicians accompany and advise them as they treat and educate people in their communities. In addition, medical students from Tec de Monterrey (one of Mexico's finest medical schools), Harvard and the University of Washington, as well as residents from Harvard's Brigham and Women's Hospital, led training workshops for CHPs and accompanied them on primary care visits.
- **Provided Training and Medicines to Take on Epilepsy and MDR TB:** In response to an alarmingly high rate of epilepsy in the municipality of Siltepec, CHPs and families received access to anti-seizure medications for the first time as well as training in how to manage the disease. PIH and EAPSEC also worked with local NGOs and international groups to secure treatment from the federal Mexican TB program for a young father suffering from untreated MDR TB. This case is a pilot for MDR TB treatment in the state of Chiapas. In addition, PIH and EAPSEC met with representatives from the Pan American Health Organization and Chiapas Ministry of Health, which contributed to the certification of a local independent hospital for TB laboratory testing and treatment.
- **Helped Create a Certificate Program for Community Health Promoters:** EAPSEC collaborated with a state university and other NGOs to launch an innovative certificate program in Collective Health with concentrations in Multiculturalism or Determinants of Health.



THE YEAR IN REVIEW

ELECTRONIC MEDICAL RECORDS

The PIH informatics team continued to develop OpenMRS, an open source electronic medical record system (EMR), in collaboration with a growing number of programmers from around the world. Use of OpenMRS expanded to new sites in Rwanda, Malawi and Lesotho, and the programming team developed a number of new tools to improve patient care and reporting capabilities. Additionally, the team organized the Electronic Health Records track of the Rockefeller Foundation's Making the eHealth Connection conference, bringing together 25 leading members of the medical informatics field in Bellagio, Italy.

HIGHLIGHTS OF THE YEAR

- **Designed Software to Improve Patient Care:** With support from the World Health Organization, a comprehensive new software module was built to support the care of MDR TB patients within OpenMRS. This module allows clinical staff to easily track complex drug regimens, bacteriology data and DST results and provides tools for reporting and drug forecasting. Programmers also developed software to allow data synchronization, so that patient data can be viewed instantaneously at all clinical sites in a country.
- **Expanded to New Sites:** The informatics team installed a new, OpenMRS-based system in Malawi, where it is partnering with a local organization, Baobab Health. A touch screen interface was developed through this collaboration that is now used to enroll and monitor patients in the HIV program in Neno. In Lesotho, the EMR team installed satellite internet at six clinical sites and data is now being entered from mountain sites.
- **Scaled Up Existing Implementations:** Use of e-Chasqui, a web-based laboratory information system that tracks TB tests, was expanded to over 300 clinical sites in Peru, covering a population of 3.1 million people. A study of the system showed that it decreased the communication time of lab results by 50 percent and reduced errors in delivering these results. In Rwanda, the EMR team started producing reports to identify HIV patients who were missing visits, whose weight and CD4 counts were too low, or who defaulted.



TRAINING

With funding support from the Bill & Melinda Gates Foundation, as well as other donors, PIH has invested heavily in strengthening and expanding our training program. Most notable over the past year have been efforts to build dedicated training teams and capacity in Boston and our country sites, the opening of a training facility in Rwanda, and the production and dissemination of our new curriculum for training accompagnateurs.

HIGHLIGHTS OF THE YEAR

- **Produced and Pilot Tested a Training Curriculum for Accompagnateurs:** *Accompagnateurs* (community health workers) are the backbone of PIH's model of community-based care. Producing and sharing a new curriculum for *accompagnateurs* gives PIH a powerful tool for strengthening that backbone and enabling other organizations to adopt our model. The curriculum consists of a facilitator's manual, a participant's manual, and visual aids that include flip charts, PowerPoint slides, and posters. Using simple text, profuse illustrations and engaging activities, the curriculum covers a broad range of topics, including HIV/AIDS, TB, stigma and discrimination, human rights, psychosocial skills, and the roles and responsibilities of *accompagnateurs*.
- **Completed Construction of a Training Center in Rwanda:** The Rwanda Training Center is situated on the grounds of Rwinkwavu Hospital, our main district hospital site in Rwanda. It includes a 150-seat auditorium, two training rooms, a computer lab, a library, offices, dormitories, and a cafeteria with full kitchen facilities. The state-of-the-art complex will host training sessions for all levels of staff, both nationally and internationally. PIH and the Rwandan government plan to make it the leading training site for HIV treatment in Rwanda and for neighboring countries in central and eastern Africa.
- **Launched an Online Warehouse of Tools and Resources:** The PIH Model Online (model.pih.org) was launched early in 2008, showcasing the way we work and sharing tools that others can use to strengthen community-based care. PIHMO currently hosts our training materials, including the new *accompagnateur* curriculum, and provides details about our programs for community health workers, food and nutrition, procurement and electronic medical records. Since PIHMO was launched, people from 93 different countries have visited the website.



ADVOCACY

PIH dramatically increased the scale, scope, and impact of its advocacy work aimed at influencing policies, increasing funding, and building a movement for global health equity. With vigorous new leadership and funding support from the Skoll Foundation, our advocacy and policy arm—the Institute for Health and Social Justice (IHSJ)—focused on four key initiatives and achieved significant progress on all of them.

HIGHLIGHTS OF THE YEAR

- **Responded to the Health Care Worker Crisis:** PIH provided vital research and drafting support for new World Health Organization (WHO) guidelines that endorse important elements of our model of community-based care as keys to overcoming the catastrophic shortage of trained health personnel in poor countries. WHO's recommendations explicitly call for training and paying community health workers, "who are providing essential health services."
- **Mobilized Awareness and Action for Food Security:** In October 2007, the IHSJ hosted a major two-day conference on "Integrating health, nutrition, and food security" attended by more than 120 representatives of non-governmental, academic and international organizations. A statement issued at the end of the conference called for united action in three areas: ensuring good nutrition for all children during the "window of vulnerability" under the age of two; providing access to adequate and nutritious food for people suffering from HIV and TB; and addressing micronutrient needs through supplementation, agricultural planning and production, and integration into health programs.
- **Made the Case for Increased Funding for Global Health:** PIH played an active role in the successful drive to reauthorize the President's Emergency Program for AIDS Relief (PEPFAR) with increased funding and a broader mandate. PIH also helped draft key language that will allow recipients to use PEPFAR money to pay salaries for community health workers, provide nutritional support for HIV patients, and build public health infrastructure.
- **Supported Socioeconomic Development in Haiti:** PIH and Zanmi Lasante collaborated with the RFK Memorial Center and the Center for Human Rights and Global Justice to produce a report documenting the devastating consequences for public health of US government action to block disbursement of \$54 million in already improved loans from the Inter-American Development Bank to improve Haiti's crumbling water system. PIH also teamed up with other organizations to push for passage of the Jubilee Act, including an amendment urging international financial institutions to relieve Haiti immediately of debt payments amounting to more than \$1 million every week.



*Taste-testing guavas,
a rich source of
micronutrients, in Haiti*



RESEARCH

Research has long been an integral and invaluable part of PIH's work. Our programs are strengthened by studies that examine the medical and epidemiological challenges we face and measure the impact of our efforts. Research results documenting the benefits of community-based care have also reinforced our advocacy efforts and helped us work with other organizations to change global health policies and priorities.

HIGHLIGHTS OF THE YEAR

- **Measured the Impact of Nutritional Support on HIV Treatment:** A study conducted by PIH in Haiti found that targeted food assistance for people living with HIV was associated with increased body mass index and significantly better food security. Based on these findings, PIH has assembled a multidisciplinary team, with experts from Brigham & Women's Hospital, Massachusetts General Hospital, and the Friedman School of Nutrition Science and Policy at Tufts University. The team will evaluate specific nutritional needs in the areas we work and will design a tailored food basket to address those needs, rather than distributing a standard, one-size-fits-all dry ration. The study will evaluate the household-level impact of that assistance on food security, HIV outcomes and economic status.
- **Documented Success in Treating XDR TB:** Researchers from PIH, Socios En Salud, Harvard Medical School, and Brigham & Women's Hospital demonstrated that extensively drug-resistant tuberculosis (XDR TB) can be cured with intensive, specialized care. XDR TB strains are resistant not only to the two main first-line drugs used to treat drug-sensitive TB but also to at least three of the six classes of second-line drugs used for multidrug-resistant or MDR TB. Since it was identified as a major threat to public health in 2006, XDR TB has often been portrayed as a new and virtually untreatable disease. Reviewing the records of patients treated for MDR TB in Peru and Russia prior to 2006, researchers found that a significant number met the definition of XDR TB. Fully 60 percent of the patients with XDR TB were successfully treated and cured, a cure rate only slightly lower than for the other MDR TB patients.
- **Evaluated the Benefits of Accompaniment and Socioeconomic Support:** With financial support from the Doris Duke Charitable Foundation, a team of clinicians and researchers in Rwanda measured the clinical, psychosocial, and adherence benefits associated with two models of delivering antiretroviral therapy. The study compares outcomes among patients receiving community-based care at a PIH-supported site—where care includes daily accompaniment, nutritional support and other support designed to mitigate the medical, psychosocial, and socioeconomic hardships faced by HIV patients—with outcomes among patients in another rural area who receive clinic-based care without daily accompaniment and socioeconomic and nutritional support.

THE YEAR IN REVIEW

SELECTED PUBLICATIONS

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*Reading up on the
grounds of Zanmi Lasante
in Cange, Haiti*

FINANCIAL REVIEW

Thanks to the generosity of a growing number of supporters, Partners In Health has been able to expand and extend its activities in desperately poor communities around the world. Revenues of \$52.7 million in Fiscal Year 2008 (FY08) were deployed to strengthen healthcare operations, train and develop a growing workforce, and provide important social services to help break the cycle of poverty and disease.

Our three primary revenue streams all remained strong in FY08. Gifts from individuals grew robustly to \$27 million, providing 50 percent of our revenues for operations and 2 percent for longer term support in the Thomas J. White Fund. Grants from foundations and corporations totaled \$13 million, 25 percent of the total. Grants from governments and multilateral organizations comprised \$11 million, providing 21 percent.

Out of \$48 million of investments in programs, \$20 million funded work in ten hospitals, and surrounding clinics, villages and patient homes across the central plateau of Haiti, our largest and most mature project. Rwanda follows at \$9 million as we scale up operations there. Between \$3 to \$4 million went to each of our programs in Peru, Lesotho, Malawi and Russia; and \$1.1 million was invested in our U.S. Program for Access to Care and Treatment (PACT). Spending on development and administration remained under 6% of total expenditures.

As we look ahead, we do so in the midst of an unprecedented series of economic events. We are especially concerned about the potential impact on those who are likely to suffer most from this turmoil — the poor and vulnerable. Our healthcare operations are already dealing with the effects of rising costs for food and fuel. At the same time, the instability in the U.S. economy may affect fundraising as individuals and foundations may feel constrained due to investment losses and economic uncertainty.

The inspiring news so far is that contributions to PIH have not slowed even in this financial crisis. Rather, we have seen our donors rise to the occasion. Over the past 21 years, we have come to understand that our donors are a special and committed group of people. We will continue to rely on them to sustain the vital work we do in so many places on behalf of the poor—those who need us now more than ever.

On behalf of our patients and communities around the world, we thank you ever so much for your continued interest in and support of Partners In Health.

Donella M. Rapier

Chief Financial Officer



FINANCIAL REVIEW

STATEMENT OF ACTIVITIES

(dollars in thousands)

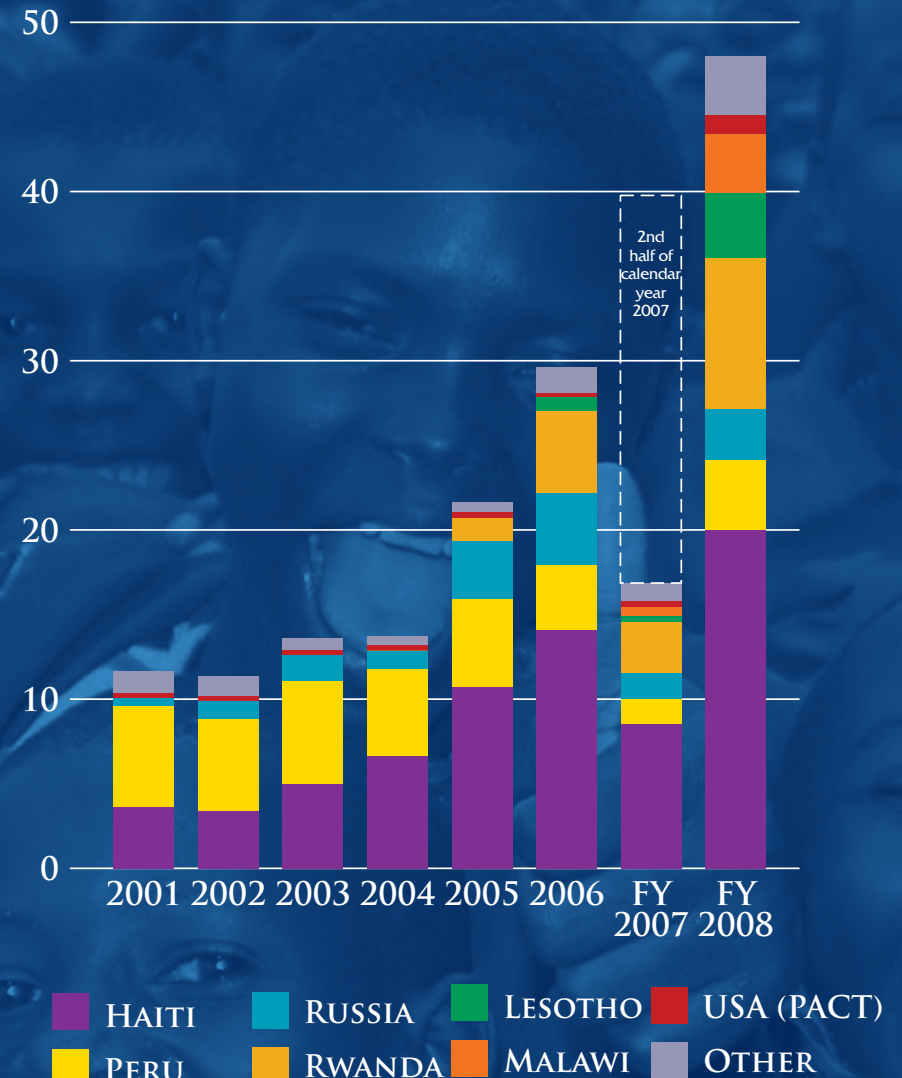
For the year ended
June 30, 2008

SUPPORT AND REVENUE	
Individuals and family foundations	\$27,284
Foundations and corporations	13,130
Governments and multilateral organizations	11,279
Gifts in kind	1,196
Investment and other income	(199)
Total support and revenue	52,690
EXPENDITURES	
Haiti	20,010
Rwanda	8,896
Peru	4,099
Lesotho	3,835
Malawi	3,497
Russia	3,058
USA (PACT Project)	1,082
Other ⁽¹⁾	3,499
Subtotal – Programs	47,976
Development	1,189
Administration	1,734
Total expenditures	50,899
NET ASSETS	
Change in unrestricted assets	1,523
Change in restricted assets	36
Change in Thomas J. White Fund	232
Total change in net assets	1,791

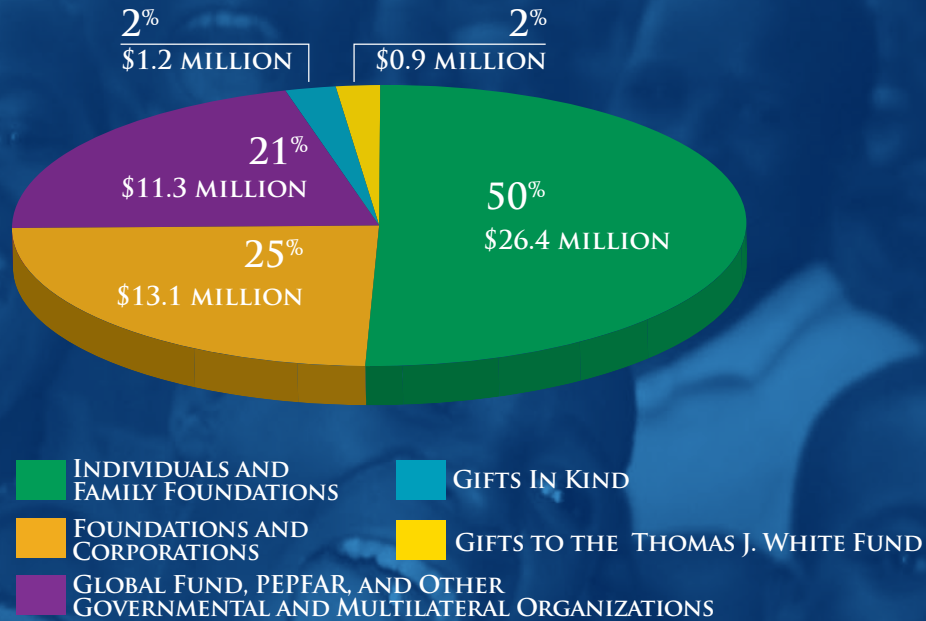
(1) Other includes the Institute for Health and Social Justice; Chiapas, Mexico; Guatemala; Training; Electronic Medical Records; Communications; and the international dissemination of the PIH model.

PROGRAM COSTS 2001-2008

(dollars in millions)

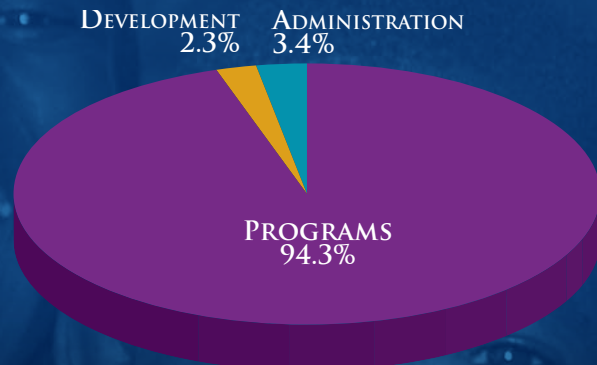


REVENUE BY SOURCE 2008



Through 2004, PIH relied almost entirely on one major foundation grant and a single major gift benefactor. In FY2008, PIH received gifts from 55 foundations and more than 11,000 individual donors.

EXPENSE COMPONENTS 2008



BALANCE SHEET

(dollars in thousands)	as of June 30,	
	2008	2007
ASSETS		
Cash and cash equivalents	\$3,923	\$7,566
Accounts receivable	766	635
Contributions receivable	234	–
Grants receivable	3,940	530
Prepaid expenses and other assets	112	212
Investments	23,063	23,466
Property and equipment, net	2,615	815
Total assets	34,654	33,224
LIABILITIES AND NET ASSETS		
<i>Liabilities</i>		
Accounts payable and accrued expenses	1,978	2,472
<i>Net assets</i>		
Currency translation adjustments	301	168
Unrestricted	10,021	8,498
Temporarily restricted	6,088	6,052
Thomas J. White Fund	16,241	16,009
Permanently restricted	25	25
Net assets, end of year	32,676	30,752
Total liabilities and net assets	34,654	33,224

FINANCIAL REVIEW

STATEMENT OF CASH FLOWS

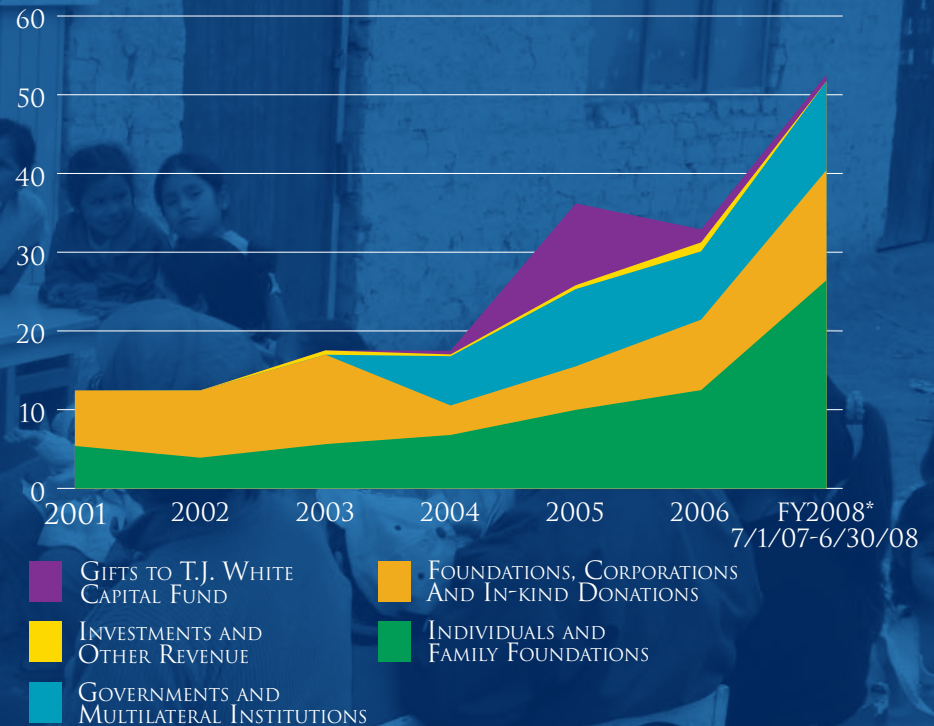
(dollars in thousands)

For the year ended
June 30, 2008

CASH FLOWS FROM OPERATING ACTIVITIES	
Change in net assets	\$1,791
<i>Adjustments to reconcile change in net assets to net cash used in operating activities</i>	
Depreciation and amortization	274
Net realized and unrealized losses on investments	1,084
Currency translation adjustments	133
<i>Changes in</i>	
Accounts receivable	(131)
Contributions receivable	(234)
Grants receivable	(3,410)
Prepaid expenses and other assets	99
Accounts payable and accrued expenses	(494)
Net cash used in operating activities	(888)
CASH FLOWS FROM INVESTING ACTIVITIES	
Additions of property and equipment	(2,074)
Sales of investment securities, net	(681)
Net cash used in investing activities	(2,755)
Net change in cash and cash equivalents	(3,643)
Cash and cash equivalents at beginning of period	7,566
Cash and cash equivalents at end of period	3,923

REVENUE BY SOURCE CY2001–FY2008

(DOLLARS IN MILLIONS)



* 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.

PARTNERS CIRCLE

FOUNDATION AND CORPORATE DONORS

Anonymous
4204 Design
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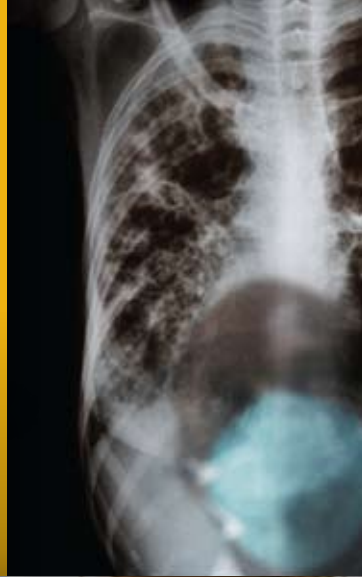
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