



**2005**  
Annual Report  
Partners In Health



# Director's Message



In 1987, starting with a handful of volunteers and funding from a single donor, PIH launched a project in rural Haiti, with the aim of providing assistance to a community of refugees. Over the next 18 years, PIH grew slowly to include projects in five additional countries. In each case, PIH was invited by the community or the government to provide services in areas profoundly affected by poverty, violence and epidemics of disease. Before we began any new project we weighed the decision thoroughly, aware that PIH specializes not in short-term emergency interventions but in partnerships that we expect to last a lifetime and beyond.

As PIH expanded incrementally, the global AIDS pandemic exploded exponentially. We at PIH found ourselves confronting a new and daunting challenge – how to expand our work and make our model of care more widely available without sacrificing quality for quantity, principles for expediency.

In 2004, PIH was approached by the Rwandan Ministry of Health to see if we would bring our model for AIDS treatment and care to rural Rwanda. At the same time, we were offered funding from a new partner: the Clinton HIV/AIDS Initiative (CHAI). It proved to be an offer we could not refuse. In the face of a pandemic that kills more than 5,500 people a day in Africa and has already orphaned more than 12 million African children, we could not shy away from an opportunity to bring hope to tens of thousands of people and to subject our model of care to the acid test as an example of a community-based approach that could be scaled up, by ourselves and others, to save the lives and answer to the needs of millions. And so we laid the groundwork to begin our first new initiative in more than five years and our inaugural partnership in Africa.

The Rwandan Ministry of Health sent PIH to work in a remote and destitute area of eastern Rwanda. We immediately set to work to renovate a crumbling hospital and to recruit and train doctors, nurses and hundreds of community health workers. The results of our first year of work in Rwanda are outlined in these pages. I am sure you will feel as proud as we do when you see the significant number of patients involved and communities revived.

For the past 18 years, the guiding principles of PIH have been determined by the collective voice of the communities in which we serve rather than the moving targets of government policies and economics. Our goals and budgets have increased hand-in-hand, thanks to the growing cadre of funders who have supported PIH. Over the years, one patient has become ten, then ten thousand. This year PIH patient encounters reached over a million. And as the number of patients served has grown, so have our efforts to document and disseminate the best parts of our model of healthcare to new generations of clinicians, community health workers, patients and program managers.

Earlier this year, I was on a flight home from Kenya, where I had been visiting a project that assists orphans whose parents had died of AIDS. On the plane, I sat next to a woman who was also on her way home to the States. She asked me what I had been doing in Kenya. When I told her that Paul Farmer and I had been evaluating treatment programs in communities affected by AIDS, she interjected, “Oh, is there any hope?” Her question reminded me that many people are still not aware of the remarkable progress on many fronts over the last few years – progress in treatment, progress in mobilizing commitment and resources to make that treatment available to the poor, progress that means AIDS need no longer be an automatic death sentence.

Thanks to many partners and long associations with supporters and coworkers, my response was easy: “There is a great deal of hope, masses of hope, more hope than you could imagine.” These pages highlight reasons for hope and underscore PIH’s long-term reliance not just on hope but on a model of comprehensive healthcare that includes providing tools to improve the lives of people living with AIDS, tuberculosis and malaria and for countless others whose lives are distorted by the grim reality of genocide, poverty, hunger and landlessness and who often feel their suffering has gone unnoticed by the rest of the world. Here is the evidence.

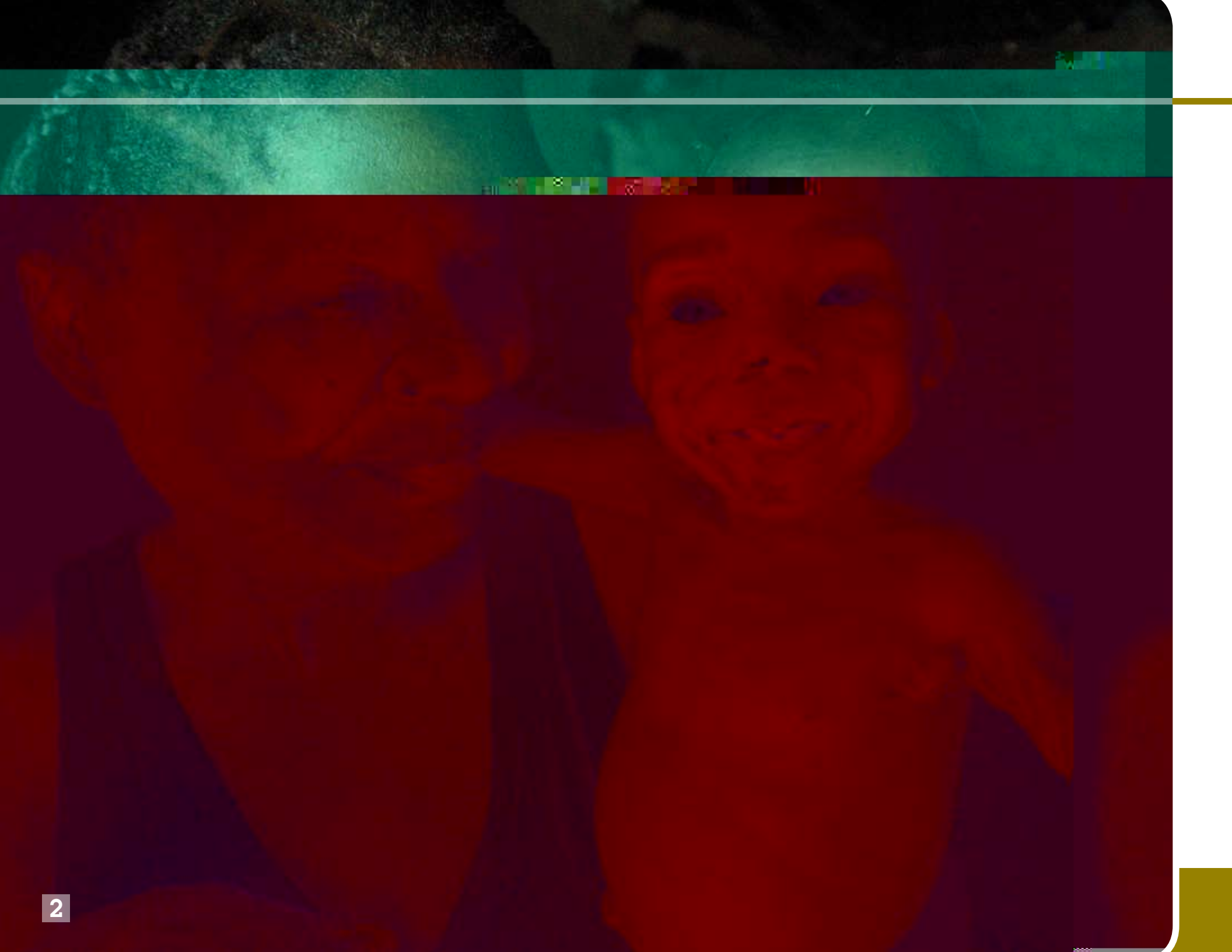
Ophelia Dahl



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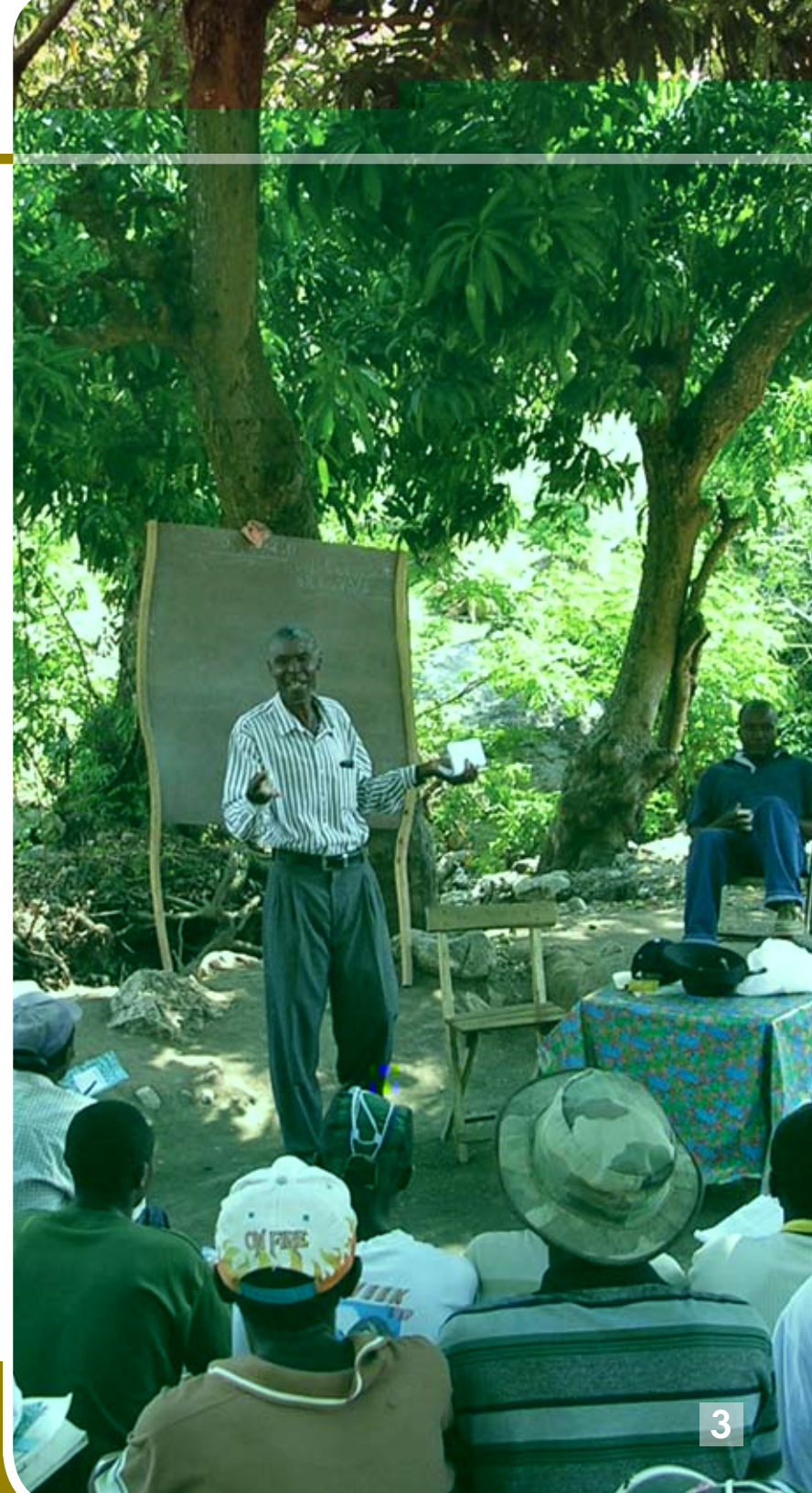
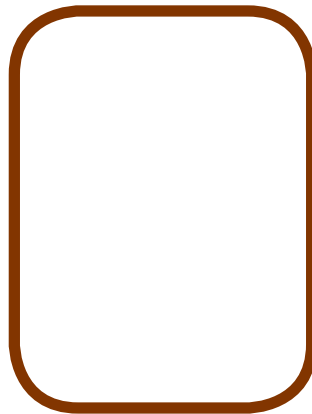






# Our Mission

*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.*





# Confronting a global crisis...



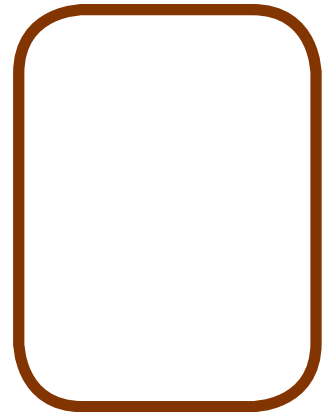
*The numbers are mind-numbing, the depth of human suffering unfathomable, the failure of human compassion and solidarity unforgivable.*

In 2005, more than 15 million people died of diseases that we know can be prevented and treated. Those numbers include three million people who died of AIDS. Another two million killed by tuberculosis. And more than 10 million children who died before they reached their fifth birthday, mostly from common, treatable infectious diseases like diarrhea, pneumonia, measles and malaria.

Ten million children under the age of five. That's about half the total preschool population of the United States. Imagine every pre-k girl (or boy) in the country dead in a single year.

But of course very few of the 10 million children who die each year come from the United States ... or from Western Europe ... or from Japan. Almost all of them live and die in poor, developing countries. More than half would not have died if they had not also suffered from hunger and malnutrition that left them too weak to fend off common ailments.

Like the overwhelming majority of adults who die of AIDS, TB and other diseases, these children die not so much because they were infected with a bacteria or a virus but because they are poor, because they live in poor countries, many of which have systematically dismantled their public health systems at the behest of international donors and financial institutions, and because of a lethal failure of imagination and compassion in rich countries where these same diseases are rarely contracted, routinely treated and almost never fatal.



*It doesn't have to be this way.*

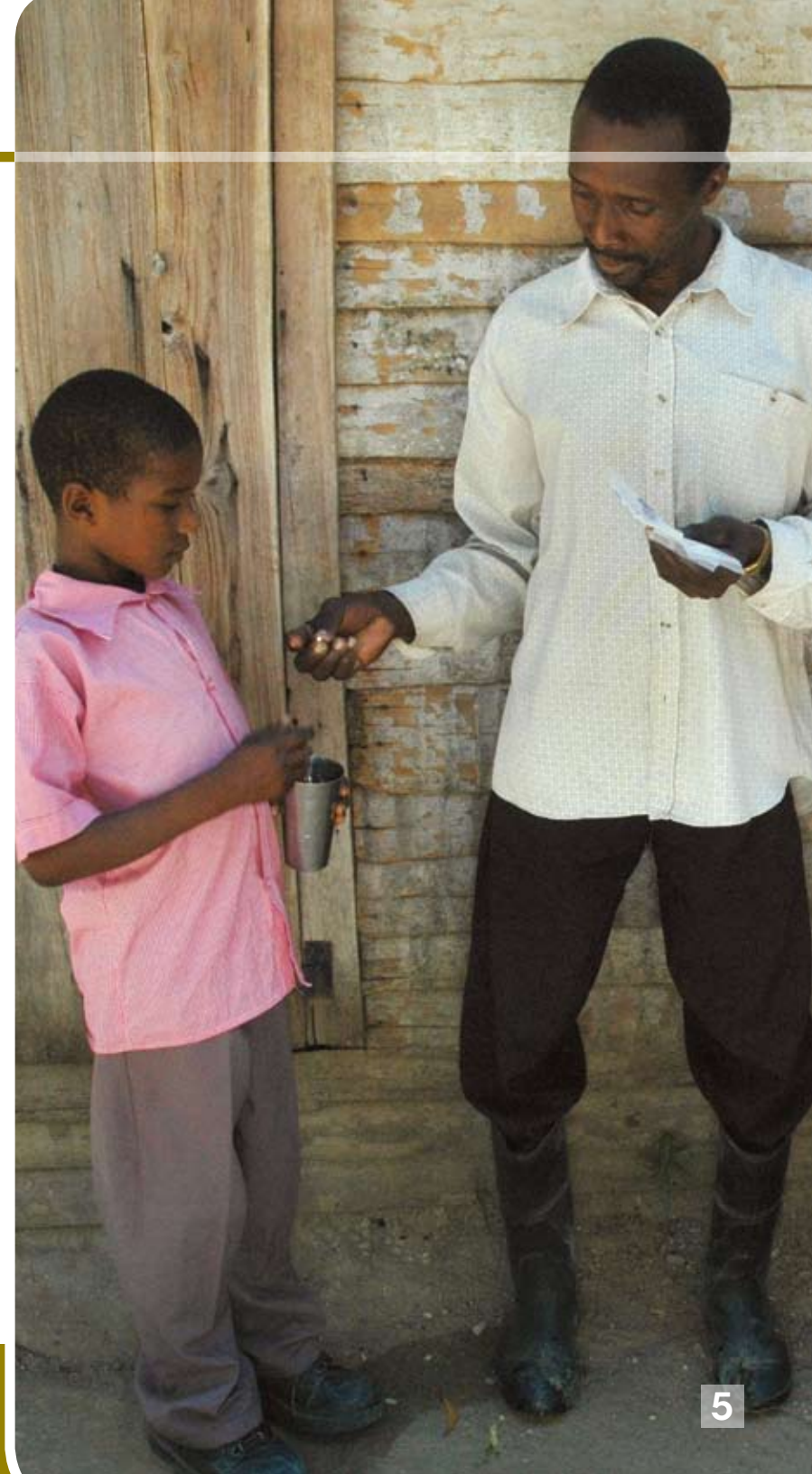
For almost two decades, working in some of the world's poorest countries, Partners In Health has proven that lives can be saved and hope can be rekindled, not just for individual patients but for entire communities.

It can be done ... if we don't allow the global tally sheets of millions of lives and billions of dollars to numb our minds, hearts and imaginations ... if we start with the expressed needs of individual patients, the conditions in the villages and neighborhoods where they live and the unwavering commitment that they deserve the same quality of healthcare that we would expect for our own families.

First in Haiti, then in Peru, Russia, Guatemala, Mexico, Boston, and most recently in Rwanda, we have developed, adapted and refined a model of community-based care that attacks not only the diseases that bring people to our clinics but the underlying poverty and deprivation of which the diseases are a symptom.

The foundation of this model can be summarized in five fundamental principles:

- **Access to primary health care**
- Free health care and education for the poor**
- Community partnerships**
- Addressing basic social and economic needs**
- Serving the poor through the public sector**







## 1 Access to primary health care

*Prevention and treatment of specific diseases, such as AIDS, cannot be separated from the need for basic primary care. People seek medical care because they feel sick, not because they have a particular disease. And they are far more likely to go to a clinic that provides comprehensive services than to a facility that exclusively treats a dreaded and stigmatized disease like AIDS or tuberculosis. Providing quality health care fosters trust in the health system and encourages use of services both for general medical conditions and for more complex diseases.*

When PIH reopened Rwinkwavu Hospital in rural Rwanda, people flocked from miles around. Many came to be tested and treated for HIV/AIDS. That, after all, was what the Rwandan government had brought us there to do. But we had also come to apply the PIH model of care and the “four pillars” of the HIV Equity Initiative we had pioneered in Haiti — AIDS treatment and prevention in the context of primary care; advancing tuberculosis care; improving screening and treatment of sexually transmitted infections; and emphasis on women’s health.

Mothers brought children who were delirious and shaking from malarial fevers. We treated the malaria. We encouraged the mothers to be tested for HIV, particularly if they were pregnant. If they tested positive — and more than 10 percent of them did — we prescribed and administered antiretroviral therapy to keep their babies from getting infected during birth. We enrolled them in training for HIV-infected mothers and in a formula-feeding program to prevent mother-to-child transmission through breastfeeding. By the end of our first eight months in Rwinkwavu, more than 600 HIV-positive mothers had received training and kits containing formula, kerosene burners, fuel and baby bottles to reduce the risk of diarrheal diseases from formula prepared with contaminated water.



## 2 Free health care and education for the poor

*Charging fees to see a doctor or attend school has emptied clinics and classrooms in many poor countries, precisely where the burdens of poverty, illiteracy and disease weigh most heavily. Attaching a price tag transforms health care and education from basic human rights and public services for all to a privilege for the few. Because both health and education are essential for people to improve their lives and contribute to national development, it is counterproductive to charge user fees to those who need these services most and can afford them least. PIH works to ensure that cost does not prevent access to primary health care and education for the poor.*

Whether in Rwinkwavu, Rwanda, or in Cange, Haiti, indigent patients at PIH clinics pay nothing for doctor consults, hospitalizations, medicines or twice-daily home visits

from community health workers. For the first time, impoverished patients can afford to send their children to school, thanks in some cases to free PIH schools and in others to cash subsidies to help cover the costs of school fees, uniforms, books and other expenses.

When PIH arrived in Rwinkwavu, the derelict, fee-for-service district hospital had no doctors and no patients. Although people in the nearby villages suffered from high rates of HIV, tuberculosis, malaria and severe malnutrition, waiting rooms were deserted and the dilapidated beds were empty. Within weeks after PIH reopened the facility and started covering fees, the waiting areas, clinics

and wards were packed with patients. Many of them walked for hours and camped out overnight on the hospital grounds in order to be there when the clinic doors opened. Many also explained that they had not seen a doctor before because they could not afford it.





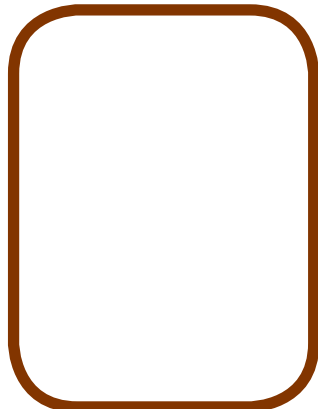
### 3

## Community partnerships

*A key to success for PIH has been our ability to forge strong partnerships, both with sister organizations of local health care providers and with the patients and poor communities we serve. Community members are engaged as full-fledged partners at all levels and phases of our health and socioeconomic interventions. PIH doesn't tell the communities we serve what they need. They tell us. Then they work with us to plan, implement and evaluate programs to meet those needs.*

Community health workers, whom we also call *accompagnateurs*, are the glue that holds these partnerships together. These community members, many of them patients themselves, are trained and paid to provide health education, to refer sick people to a clinic and to deliver medicines and social support to patients in their homes. They also serve as a living, thinking communications network, keeping patients informed and alerting medical and social service staff to ill patients, families with special needs and community concerns.

Many of the *accompagnateurs* are living with HIV themselves. They speak openly about their status and encourage community members to present for testing. In the words of Denizard Wilson (right), an HIV-infected man who helps deliver medications to other patients in central Haiti, "I am a motorcycle messenger for Zanmi Lasante. I carry patient blood samples over dirt roads, and doctors send me to find patients who stop coming in for appointments, or patients who think that an HIV-positive diagnosis means their life is over. I have a message for these patients, and for my family, and for everyone, infected or not: as long as we are alive and have access to drugs, there is hope."





## 4 Addressing basic social and economic needs

*Fighting disease in impoverished settings also means fighting the poverty at the root of poor health. People are far more likely to fall ill, for example, if they are chronically hungry and malnourished, as is the case with more than one of every three people in Haiti and Rwanda. Providing medical treatment may have little effect if the patients are too malnourished to absorb their medicines, if they are swallowing their pills with contaminated water, if they are living in shacks where the rains pour in, turning the dirt floors where they eat and sleep into mud puddles.*

Through community partners, PIH works to improve access to food, shelter, clean water, sanitation, education and economic opportunities. In Haiti, Rwanda and Peru, PIH provides monthly food packages to needy patients and their families. We replace tumble-down shacks made of sticks, mud and banana leaves with modest but sturdy homes with tin roofs and concrete floors. We build spring caps and fountains to provide reliable sources of drinkable water. We provide access to the financial support, supplies and training that patients need to return to their fields or to launch small workshops, businesses and other income-generating activities. Thousands of community members are trained and employed as community health workers or as staff at PIH facilities, helping to transform both the medical and economic health of their communities.

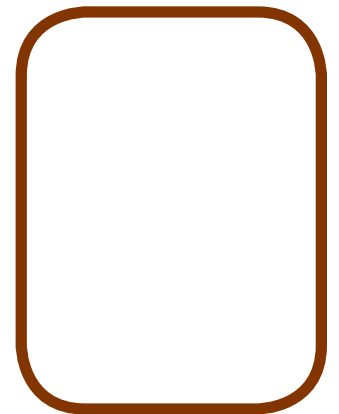


## 5 Serving the poor through the public sector



*Non-governmental organizations like Partners In Health can play an important catalytic role in developing new approaches to treating disease and combating poverty. But a vital public sector remains the best way to implement and expand successful models and to assure universal and sustained access for the poor. Rather than establish parallel systems, PIH works to strengthen and complement existing public health infrastructure.*

In Peru, PIH's sister organization Socios En Salud (SES) started out in the shantytowns outside Lima as a maverick NGO treating multidrug-resistant tuberculosis (MDR-TB) patients who had fallen through the cracks of the government's much-touted tuberculosis program. At first the Peruvian Ministry of Health resisted treating MDR-TB patients and accepting the PIH model of care. Not any longer. Today, MDR-TB treatment is carried out through Ministry clinics, with training and technical assistance from SES. And the SES model of community-based care and accompaniment has been adopted as the lynchpin of Peru's national programs to scale up treatment for MDR-TB and antiretroviral therapy for AIDS patients.





# Spreading the model and the message

The PIH model works. Over almost two decades, working with our partners in Haiti, Peru, Russia, Boston, Guatemala, Mexico and Rwanda, we have proven that it is possible to save lives, and transform communities by starting with the needs and basic human rights of individual patients. We have also shown that examples of successful action at the community level can have a ripple effect that changes assumptions and policies around the world. By defying the accepted medical wisdom of the 1990s that MDR-TB and AIDS could not be treated in resource-poor settings, we helped make “scaling up” and “universal access” the catchwords of the global health community today.

Now, if we want to scale up our own contribution to fighting global pandemics of disease and poverty, if we believe that our model of care has something special to offer and want to make it available to more of the millions of destitute patients and communities in need, we face the challenge of how to go about it. Several options present themselves:

- **We can do it ourselves** ... *by expanding to new communities and new countries, bringing with us our commitment to build strong local partnerships and to address both the medical and socioeconomic causes of disease;*
- **We can teach others to do it** ... *by pouring more energy and resources into training and technical support for government health services and other non-governmental organizations dedicated to bringing quality health care to the poor;*
- **We can create and disseminate tools to help other people do it** ... *by distilling the lessons of our experience into training materials, clinical manuals and systems for managing and monitoring community-based care; and;*
- **We can mobilize resources and advocate for policy changes to do it** ... *by galvanizing financial, technical and political support and helping to build a broad-based movement for health and social justice.*

Or we can do all of the above ... as we we have done for the past several years and with increasing urgency and notable impact in 2005.





# Expanding to new areas and

The most direct way to bring the PIH model of care to more of the millions of people in need is to do it ourselves: to expand our operations and our partnerships to new communities that are afflicted by poverty and disease; to bring them quality healthcare in the broadest sense, including prevention and treatment for HIV/AIDS and TB, comprehensive primary care, and commitment to alleviating the conditions of poverty and social exclusion in which disease takes root; and to confront these problems by forging long-term partnerships with national and local government, with local medical staff, and with the communities and the patients themselves.

In recent years, PIH has done just that. We have responded to the increasing urgency of the global health crisis by expanding within the countries where we have been working and by taking the plunge into new countries. In Haiti, Zanmi Lasante (ZL) has spread its work and its influence from the squatter community where PIH was born in the 1980s across and beyond the Central Plateau. In just the past five years, the number of patient encounters at ZL clinics in Haiti has increased almost twenty-fold, from 60,000 per year in 2001 to more than 1.1 million in 2005.

In 2005, PIH took another bold step, bringing our community-based model of care to sub-Saharan Africa, the epicenter of the global AIDS pandemic. At the request of the Rwandan government and with support from the Clinton HIV/AIDS Initiative (CHAI), the Global Fund to Fight AIDS, Tuberculosis and Malaria and private donors, PIH launched an initiative in two districts in rural Rwanda.

With the move to Rwanda, the total population in areas served by PIH clinics has now climbed well past one million people. And growing.



## Replicating the model in Rwanda

In 2005, Partners In Health began working in two rural health districts in Rwanda, the most densely populated country in Africa and one of the poorest countries in the world, with an average life expectancy of only 38 years.

PIH's intervention in Rwanda consciously replicates the model that has proven successful in central Haiti. That model was what brought PIH to the attention of the Rwandan government ... who in turn brought PIH to Rwanda to kickstart the lagging rural component of their AIDS prevention and care program. And kickstart it we did. Within eight months, in districts where few people had been tested for HIV and virtually none were on treatment, PIH and our new Rwandan partner, Inshuti Mu Buzima (Kinyarwanda for Partners In Health), had tested more than 30,000 people and enrolled nearly 700 on antiretroviral therapy.

Our ability to hit the ground running owed a great deal to the experience and the model we brought with us from Haiti. From the outset, AIDS prevention, testing and treatment were embedded in the comprehensive array of services prescribed by PIH's model of care. The abandoned Rwinkwavu District Hospital was rehabilitated not as an AIDS testing and treatment center but as a full-service facility offering treatment for everything from child malnutrition to malaria and tuberculosis. By the end of 2005, it was seeing an average of 160 patients a day and every one of the 70 beds in four hospital wards was filled.

In keeping with our commitment to free health care and education for the poor, PIH provided stipends to destitute patients to cover payments to the Rwandan national health insurance system and the costs of school uniforms and supplies. Community partnerships strengthened quickly as we trained and hired hundreds of *accompagneurs*. Social support programs were also launched almost immediately, including distribution of food packages to all patients being treated for HIV or tuberculosis. And close cooperation with the Rwandan government ensured that the PIH intervention reinforced rather than undermined the public sector. More than two-thirds of the Rwandan staff hired by the end of 2005 were employed jointly with the Rwandan Ministry of Health. And Rwinkwavu soon became a regular site for training staff from other Ministry clinics.

PIH's Haitian doctors and nurses took a leading role in transplanting and adapting the PIH model to Rwanda. Several of them traveled to Rwinkwavu to train their Rwandan counterparts. The cross-fertilization worked both ways. When the Haitian doctors went home they took with them new "made in Rwanda" methods for enrolling, training and managing cohorts of patients and *accompagneurs*.



In addition to expanding its reach geographically, PIH has also scaled up its ability and commitment to provide training and technical assistance for other governmental and non-governmental organizations battling poverty and disease.

As the organization that pioneered the PIH model, Zanmi Lasante (ZL) has also taken the lead in providing training both to other PIH projects and as part of the Caribbean HIV/AIDS Regional Training Network. In 2005, ZL trained more than 200 people at its two National Training Centers in Hinche and Cange. Participants included doctors, nurses, lab technicians, pharmacists, administrative staff, community leaders, *accompagnateurs* and medical consultants from programs in Haiti and other Caribbean countries.

From the outset, training has also been highlighted as a central component of PIH's work in Rwanda. The stated goals of the project include strengthening national training and evaluation programs and developing a model for rural HIV care that can be adapted and replicated throughout Rwanda and in other African countries. Within weeks of enrolling its first cohort of HIV patients, PIH's Rwandan partner, Inshuti Mu Buzima, started training teams from elsewhere in Rwanda and other African countries, starting with Mozambique.

In Russia, PIH has worked with our Russian partners to use our experience and success with treatment of multidrug-resistant tuberculosis (MDR-TB) in Tomsk, Siberia, as a springboard for training and technical assistance to improve treatment capacity nationwide.



## Socios En Salud trains national MDR-TB and HIV programs

Since 1999, PIH's Peruvian partner, Socios En Salud (SES), has helped Peru scale up its national program to treat multidrug-resistant TB. Almost 3,000 people from the Peruvian Ministry of Health, including doctors, nurses, nurse technicians and more than 1,000 health promoters, have received training from SES. So when the Peruvian Ministry of Health ran into problems enrolling HIV patients for free antiretroviral therapy, they turned to SES for help.

At the end of 2004, eight months after the Peruvian National HIV Program began enrolling patients, only 1,000 people were receiving treatment. Clearly enrollment was falling far short of the 7,000 that had been projected for the end of the first year, putting continued funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria at risk.

Starting in January 2005, SES brought its experience in community-based treatment for MDR-TB to bear, first to analyze the barriers to enrollment and then to overcome them. Teams of SES nurses and community health workers consulted with medical staff, observed the process of patient care at all the major HIV treatment sites and pitched in to provide clinical and logistical support at hospitals where enrollment was lagging. Based on this experience, the SES teams were able to identify several major obstacles and to propose solutions. The solutions included many key elements of the PIH model of care, starting with the critical importance of paid community health workers or health promoters to help patients through the enrollment process, to identify and refer patients from the community, and to assist patients in adhering to treatment once they had been enrolled.

The solutions achieved dramatic results. Rates of enrollment increased sharply, from 124 patients per month to 226. By the end of August, just eight months after SES joined the effort, total enrollment had almost tripled. The goal set by the Global Fund to qualify for continued support was met and the partnership between SES and the Ministry of Health was strengthened.



# Creating and disseminating to

Recognizing the need to spread our model more widely, PIH has also stepped up efforts to document our approach and to produce manuals and training materials that can be used by doctors, nurses, program managers, administrators, community health workers and patients.

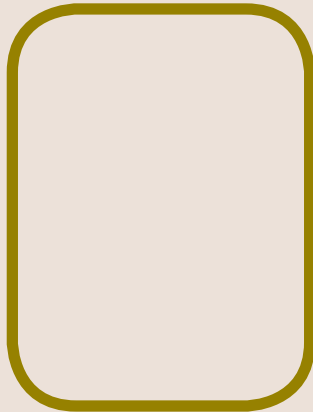
PIH's pocket-sized guides for community-based treatment of HIV and multidrug-resistant tuberculosis (MDR-TB) have been widely distributed. The MDR-TB guide has been adapted for the Russian setting and translated into Russian as well as Spanish. The HIV manual has been extensively revised and updated for a 2006 edition in English, French and Spanish.

PIH has also developed, tested and refined training programs for all the key participants in community-based care. Patients are given a thorough understanding of their diseases and treatment regimes. *Accompagnateurs* learn to spot symptoms and refer patients, to administer medications and recognize possible side-effects, and to keep an eye on living conditions and provide psychosocial support when needed. With support from the Bill & Melinda Gates Foundation, PIH is now standardizing the curricula for these courses and packaging them for distribution.



## PIH's Electronic Medical Records System

With its emphasis on directly observed therapy monitored by an extensive network of community health workers, the PIH model of care has a lot of moving parts. Monitoring them all to keep track of patient care, treatment regimens and inventories of medications is not easy. High-tech facilities in rich countries invest millions of dollars in computer systems to help with the task. But when PIH looked into these systems, we found that none of them really met the needs of community-based care in resource-poor settings, where electricity and network connections are often interrupted, where human resources are scarce and overstretched, and where many of the key participants may start out with limited literacy and familiarity with computers.



So we decided to create our own. Meet the PIH Electronic Medical Records (EMR) system, now being used at more than 150 clinics in Peru, Haiti and Rwanda. The web-based system maintains patient records, alerts doctors to drug resistance and laboratory results, and highlights serious changes in a patient's health. It also allows pharmacists to predict patient drug usage a year in advance, monitor supplies and avoid stockouts that could disrupt treatment.

Use of the system is not limited to PIH projects or even to countries where PIH operates. Both the Rwandan and Peruvian governments have seen what the system can do and have decided to adopt it for use nationwide. The system has also been deployed at an HIV clinic in the Philippines and will soon be rolled out in Kenya.

Others working to provide and manage health care in poor communities have seen demonstrations of the EMR and have recognized that it addresses their needs. Several groups around the world have joined with PIH to define requirements and collaborate in developing EMR 2.0, a more powerful and flexible open-source system scheduled to be completed in 2006.



## Mobilizing resources and

From its earliest years, Partners In Health has insisted that pandemics of disease and poverty cannot be conquered without challenging the growing inequality between rich and poor. Nor can inequality be confronted effectively without recognizing that extreme wealth among the few and extreme poverty among the many are intimately connected, products of a system in which wealth and power rarely “trickle down” so much as they are syphoned away from those who have the least to those who have the most.

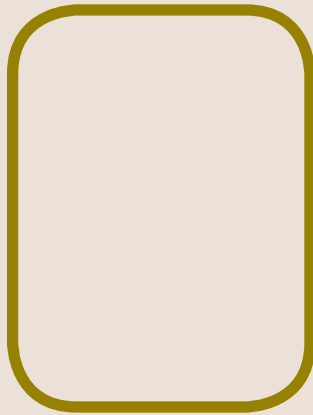
On a small but increasing scale, we at PIH have made it our business to reverse this flow. By working in partnership with poor communities to prove what can be done in resource-poor settings and advocating for changes in policies and priorities at the international level, PIH helped pave the way for unprecedented new funding and attention to the diseases of the poor, including the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the World Health Organization’s “3x5 Campaign” that helped increase the number of AIDS patients receiving antiretroviral therapy in Africa eightfold in just a year and a half.

Our affiliations with Harvard University and the Brigham and Women’s Hospital give us access to valuable expertise, technology and research capabilities. They have allowed us to redirect at least some of these resources toward meeting the needs of destitute communities and toward conducting research that serves both to improve the treatment and health of our patients and to reinforce our advocacy efforts on their behalf.



## Mobilizing support to replicate the model

By demonstrating and documenting that our model works, Partners In Health has been able to leverage support from a growing number of major foundations and donors specifically for the purpose of replicating that model more widely.



The Clinton Foundation's HIV/AIDS Initiative (CHAI) has provided major financial and programmatic support for PIH's move to Rwanda as the first expression of a partnership aimed at bringing the PIH model to the continent hardest hit by both disease and poverty. CHAI's partnership with PIH is distinguished by shared commitment to a comprehensive approach to medical and socioeconomic needs.

The Bill & Melinda Gates Foundation, an early and important supporter of PIH's work with MDR-TB, has more recently earmarked a grant explicitly to expand PIH's capacity to provide training and technical assistance. The grant is being used to improve training facilities, to prepare and test training materials, and to launch new research that will help us document and disseminate results and lessons from our work.

The M•A•C AIDS Fund, created by M•A•C Cosmetics and financed through sales of VIVA GLAM lipsticks, has emerged as an important supporter of the PIH model by channeling resources targeted specifically for food, social support and other essential needs and services for HIV patients.

The Eli Lilly and Company Foundation has supported a comprehensive training initiative in Russia, aimed at replicating the PIH model of treatment for MDR-TB nationwide and institutionalizing training within the Russian health system.

# Haiti / Zanmi La



*For Zanmi Lasante (ZL), 2005 was a year of daunting challenges and inspiring achievements. In the aftermath of the coup that forcibly removed President Jean-Bertrand Aristide, political instability and deteriorating security prevented Boston-based staff from traveling to Haiti for most of the year. Across Haiti, the already decrepit public health infrastructure disintegrated. Yet Zanmi Lasante not only survived but thrived, expanding its operations and impact dramatically. In the process, ZL proved conclusively that the PIH model of care succeeds not so much by the intervention of dedicated medical personnel from the United States but by empowering our partners on the ground – the local medical staff, the accompagnateurs, the patients themselves and, ultimately, the impoverished communities in which they live.*

## Highlights of the year

- Constructed, equipped, staffed and opened a new hospital in Cerca La Source complete with two large wards, a pharmacy, a drug warehouse, a laboratory, x-ray equipment and offices.
- Increased the number of patient visits at its hospitals and clinics to more than 1.1 million for the year, four times what the total had been just three years earlier.



- Provided antiretroviral therapy to more than 2,000 AIDS patients, a 30 percent increase from the previous year. That figure included the first patients enrolled outside the Central Plateau, in the coastal town of St. Marc, as

part of ZL's technical assistance to Ministry of Health clinics in the Artibonite region.

- Expanded and strengthened its training capabilities and programs, both for ZL staff and for people working to prevent and treat HIV/AIDS all across Haiti and the Caribbean, as part of the Caribbean HIV/AIDS Regional Training (CHART) Network. More than 530 people, 40 percent of them from outside the ZL system, benefited from training sessions conducted at ZL's two National Training Centers in Hinche and Cange.

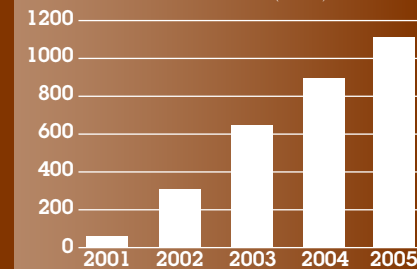
- Expanded social and economic support activities, by providing school fees for more than 5,000 orphans and vulnerable children, constructing or repairing spring caps, fountains and kiosks to bring clean drinking water to nearly 9,000 people, building more than 100 houses and providing nutritional assistance to more than 4,600 AIDS patients.

- Improved data collection and reporting by hiring and training data clerks, revising patient intake and follow-up forms and adding tools to the Electronic Medical Records (EMR) system to improve analysis of patient status, calculation of drug requirements and management of pharmacy supplies to avoid stockouts of medications.

## 1.12 million patient visits

Number of ZL patient visits in Haiti, 2001-2005

number of visits (1000s)



**2,019** AIDS patients on antiretrovirals

**6,000** HIV-positive patients monitored

**6,865** children receiving educational assistance

**3,000** adults receiving literacy training

**110** houses built

**4,607** people receiving nutritional assistance

**1,100** people receiving seed money for small commercial enterprises

Staff (as of March 31, 2006):

**207** medical

**878** non-medical

**1,156** community health workers

**\$10,719,782** budget

# Rwanda/Inshuti

*2005 was PIH's first year in Rwanda. When the year began, PIH's Rwandan sister organization, Inshuti Mu Buzima (IMB), did not exist, the district hospital in Rwinkwavu was all but abandoned and virtually nobody among the more than 400,000 people in the Rwinkwavu and Kirehe districts was being tested or treated for HIV/AIDS. By the end of the year, all that had changed dramatically.*

## Rwanda 2005: Before and after

**Before:** the district hospital in Rwinkwavu was a derelict shell, with no doctors, no electricity or running water, broken beds and windows, crumbling, unpainted walls and only a trickle of ambulatory patients.

**After:** the hospital has been repaired, refurbished and restaffed. Walls have been plastered and painted. Four wards have been opened with 70 new beds that have been consistently filled. Ambulatory visits have increased to almost 200 per day.

**Before:** there were no patients receiving antiretroviral therapy for AIDS.

**After:** by the end of 2005, 676 patients had started supervised therapy.





**Before:** hundreds of school-age children were not attending school because they could not afford to pay for school uniforms, books and other fees.

**After:** financial support from IMB was helping 1,436 children attend school.

**Before:** many of the patients examined, tested and treated at PIH facilities reported or exhibited distinct signs of malnutrition.

**After:** all patients on AIDS and TB treatment were receiving monthly food packages and food supplements.

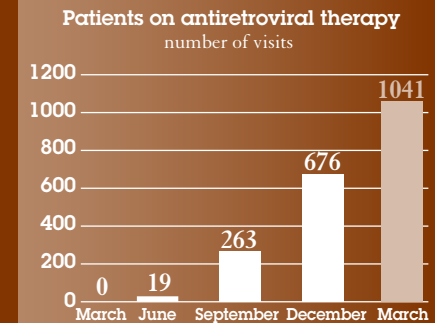
**Before:** most HIV-infected mothers did not know their status. Even if they did, they did not have access to the antiretroviral drugs and infant formula needed to reduce the risk of mother-to-child transmission of HIV during pregnancy and breast-feeding.

**After:** more than 150 women a week were being tested in prenatal clinics. Women who tested positive received treatment and nearly 400 infants born to HIV-infected mothers were enrolled in a formula-feeding program to prevent mother-to-child transmission.

**Before:** many patients were living in tumble-down, mud-walled shacks with leaky thatched roofs and dirt floors.

**After:** in December 2005, IMB built its first new house for a patient's family, complete with a concrete foundation and a tin roof to keep out the rain ... the first of many to come.

## 676 AIDS patients on therapy



## 17,332 patients tested for HIV

5,973 patient visits  
(July-December 2005)

4,090 malaria tests, of which  
1,937 positive (July-December 2005)

4,609 women who received prenatal  
counseling (July-December 2005)

700 food packets distributed/month

1,436 children receiving educational  
support

Staff (as of March 31, 2006):

66 medical

140 non-medical

510 community health workers

57 Ministry of Health employees

\$1,355,183 budget

# Peru / Socios En



*For Socios En Salud (SES), 2005 was an important year of transition. In November, SES stopped enrolling new patients for treatment of MDR-TB, as financial support from the Global Fund came to an end. But that hardly marked a repudiation of the model of care that SES has pioneered or a decline in our impact on treatment and care in Peru. Far from it. As SES scaled back on enrolling additional MDR-TB patients at its own clinics, it scaled up training and support for Ministry of Health health centers, laboratories and staff. Through its partnership with the Ministry, SES is now helping to extend the model of community-based care for MDR-TB nationwide and has assumed a leading role in the national campaign to roll out antiretroviral therapy for HIV/AIDS.*

## Key SES accomplishments in 2005

- Expanded and improved infrastructure for MDR-TB treatment and testing, including setting up tuberculosis treatment facilities at more than 200 health centers and establishing six reference laboratories to test for sensibility to first-line drugs and establishing six reference laboratories to test drug sensitivity for first-line drugs and one for second-line drugs.
- Provided food baskets, transportation, lodging and other social support to an average of 325 patients per month. Each patient's needs are determined based on an extensive interview and evaluation. Needs are reviewed at least once a month through follow-up visits.



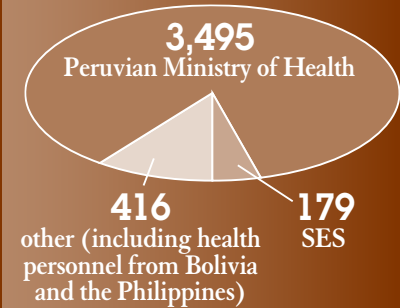
- Began providing care to the growing number of HIV-infected people in Lima and the surrounding areas. The TARGA-Plus program replicates the MDR-TB model of care by providing both antiretroviral therapy and the economic and social support that is essential for treatment adherence and success. Enrollment of the first cohort of patients began in November 2005 and is continuing through 2006.

- Conducted training courses attended by more than 4,000 people, including doctors, nurses, community health workers, health promoters and patients. The courses covered a wide range of topics, from DOTS-Plus treatment for MDR-TB and HIV to child health. More than 2,500 health staff were trained to provide DOTS-Plus treatment for MDR-TB.

- Opened three new *botiquines* (neighborhood clinics) that offer basic primary care, including maternal health and obstetrical care, as well as height and weight checks for children. Children who are underweight or at risk for malnutrition are monitored regularly. Many receive nutritional supplements or are enrolled in programs that provide nutritious breakfasts or lunches. SES now operates a network of 11 *botiquines* and three outposts, many of them located in rural and isolated areas.

- Provided opportunities for women to generate income as members of a cooperative workshop that participated in crafts fairs in Peru and sold handicrafts as far away as Japan and Switzerland.

4,090 people trained



219 Health centers equipped with TB treatment facilities

6 reference laboratories established to test for resistance to first line TB drugs

11 community health centers opened (plus 3 "outposts")

3,689 patients enrolled in national HIV Program with SES support

325/month patients receiving socio-economic support (food baskets, lodging, transport, etc.)

13,405 patient records in PIH Electronic Medical Records system

Staff (as of March 31, 2006):

12 medical

95 non-medical

695 community health workers

\$5,175,739 budget

# Russia

*In Russia, PIH continued on the twin tracks of strengthening the MDR-TB treatment program in Tomsk Oblast, Siberia, and providing training and technical assistance to improve treatment throughout Russia. In Tomsk, PIH's Russian partner organization scaled up enrollment of MDR-TB patients, increased social support services for TB patients and improved TB facilities. On the training front, PIH conducted a clinical and epidemiological workshop in St. Petersburg for high-ranking officials from the Russian medical system. The workshop laid the groundwork for a series of five comprehensive training sessions on the management of MDR-TB that will cover the entire country between 2006 and 2007.*

## Highlights of the year

- Increased enrollment in the MDR-TB treatment program in Tomsk, Siberia, to nearly 400 patients.
- Provided daily nutritional support, social support and hygiene sets to more than 1,600 TB and MDR-TB patients in Tomsk.
- Equipped four medical TB facilities with modern ventilation systems.
- Developed plans for nationwide training with the Russian Federal Tuberculosis Research Institute.

## BY THE NUMBERS

**635**  
MDR-TB  
patients enrolled

**201**  
prisoners

**434**  
civilians

**750**  
patients  
receiving  
nutritional  
support

Staff (as of March 31, 2006)  
**6** medical  
**10** non-medical

Budget  
**\$3,438,614**



# USA/PACT

*The Prevention and Access to Care and Treatment (PACT) Project in Boston expanded both its health promotion and directly observed therapy (DOT) services for marginalized HIV/AIDS patients and its harm reduction and HIV prevention work with vulnerable youth and Latinos with a history of substance abuse. The Health Promotion program increased its outreach to provide directly observed therapy and social support for HIV patients who were failing treatment because of mental health problems, substance use, housing instability or domestic violence.*

## Highlights of the year

- Enrolled 25 new AIDS patients in the Health Promotion program and eight into antiretroviral treatment.
- Expanded the PACT referral network to include health centers north of Boston, including Chelsea, Everett, East Boston and Revere.
- Received a three-year grant from the National Institute of Mental Health to study the long-term effects of a one-year course of directly observed therapy in the PACT Health Promotion program.
- Developed a curriculum and manual for health promoter training that are used with new participants entering the program and will allow further expansion and replication of the program.
- Expanded peer prevention training for Latinos in early recovery from substance use, increasing to more than 250 the number of men and women trained through Fuerza Latina to accompany and assist their neighbors as they struggle with the dual epidemics of HIV and substance abuse.

## BY THE NUMBERS

**52**  
patients  
receiving  
health  
promotion  
services

**15**  
patients  
on directly  
observed  
antiretroviral  
therapy

**215**  
total  
patients  
served  
since  
program  
started

**30**  
Spanish  
language  
training  
sessions  
conducted  
through  
2005

**250**  
Latino  
men and  
women  
trained  
through  
2005

**9,000**  
safe sex kits  
distributed  
through  
2005

*Staff (as of March 31, 2006)*  
**3** medical  
**32.5** non-medical  
**4** contracted

*Budget*  
**\$360,493**

# Mexico (Chiapas)

*Until early October, 2005 was a year of steady and impressive growth for the work PIH has been doing since 1989 in the southern Mexican state of Chiapas, alongside the Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC). Substantial progress could be measured in the number of community health promoters trained and deployed, the number of patient visits at village clinics, and the number of workshops conducted in impoverished indigenous communities. Then Hurricane Stan struck Chiapas with torrential rains, triggering floods and mudslides that swept away entire communities of thatch-roofed huts, washed out roads and left thousands of people without access to shelter, food, potable water and health care. PIH and EAPSEC sprang into action, sending out teams of health promoters and doctors, setting up temporary clinics in two of the worst-affected communities, and mobilizing donations of medicines and equipment from as far away as France, Switzerland and the United States.*

## Highlights of the year

- Provided financial, technical and medical assistance in the four regions of Chiapas where EAPSEC trains and supervises health promoters. PIH assistance included physician trips to clinic sites, development of training materials and assistance with health promoter training.
- Expanded and reinforced the work of the clinic opened in Amatán in 2004, providing treatment for a wide range of common ailments, including respiratory illnesses, gastrointestinal conditions, sexually transmitted infections, malnutrition, trauma, mental health issues and eye and skin infections.
- Helped train health promoters and staff clinics with resident physicians on rotation from the Brigham and Women's Hospital's Global Health Equity residency program.
- Opened emergency clinics in Belisario Domínguez and Honduras, two of the communities hit hardest by Hurricane Stan.

## BY THE NUMBERS

150  
training sessions for  
health promoters

282  
health promoters  
trained, of whom

132  
women

150  
men

1641  
patient visits



# Guatemala

*Since 1998, PIH has been working with the Equipo Técnico de Educación en Salud Comunitaria (ETESC) to help highland communities in Guatemala heal from decades of brutal oppression by uniformed soldiers and state-sponsored death squads. At the request of surviving family members, we have assisted in locating, exhuming, identifying and reburying many of the hundreds of thousands of people who were killed or “disappeared,” allowing the dead to rest “with their eyes shut” and the living to mend some of their emotional and psychological wounds. PIH’s support for this work continued in 2005, despite heightened political tension and security concerns in the affected communities that prevented regular communication and reporting.*

## Highlights of the year

- Continued work at exhumation projects in three communities in the Huehuetenango region.
- Identified new mass graves and filed official petitions to exhume them. The Human Rights arm of the Archdiocese of Guatemala is supporting these petitions, and the government has committed to performing visual inspection of the sites.
- Conducted follow-up community support groups and educational sessions on the rights and responsibilities of the families of the deceased in each of these communities.
- Developed a national plan to coordinate and

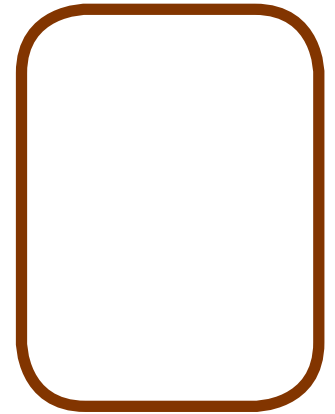
educate the communities of Huehuetenango about these ongoing projects and discuss how new sites can be effectively integrated into the network of existing sites.



## Research and Advocacy

*Partners In Health amplified the impact of its work to save lives and improve livelihoods through advocacy aimed at changing minds, transforming policies and building a movement for health and social justice.*

PIH and our sister organizations sent a team of 18 people to the Second People's Health Assembly in Cuenca, Ecuador, in July. The Assembly brought together more than 1,500 people from 80 countries to share knowledge and experience and build a movement supporting the demand "health for all." The PIH contingent included physicians, anthropologists and community health workers from Haiti, Peru, Chiapas and Boston. They made a big impact, with interventions ranging from a plenary address by Arachu Castro to a joint presentation by community health workers from Peru and Boston on "Community Involvement: the Engine for Structural Changes." Haitian *accompagnateur* Autensia Guerrier Gracia (a.k.a. Margarete, right) brought down the house as one of five people invited to address the closing session of the conference.



PIH also made its presence felt and the voices and needs of our patients heard at major scientific meetings and public events focused on global health, including the Pan American Health Organization's first Technical Advisory Committee in HIV/AIDS – chaired by Paul Farmer – and the Time Magazine Global Health Summit, where Farmer and fellow PIH co-founder Jim Yong Kim shared the spotlight with a cast of international luminaries that included Kofi Annan, Bill Clinton and Bill Gates.

Both our service in impoverished rural communities and our advocacy on behalf of healthcare and social justice for the poor were reinforced by research that documented the need, monitored the impact and demonstrated the benefits of community-based care. PIH staff researched and wrote numerous articles for influential journals in 2005 on subjects ranging from the impact of HIV/AIDS care on stigma and testing to implementing electronic medical records systems in developing countries.



## Selected 2005 publications

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Castro A. Adherence to antiretroviral therapy: Merging the clinical and social course of AIDS. *PLoS Medicine*. 2005;2(12):e338.

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Drobac PC, del Castillo H, Sweetland A, Anca G, Joseph J, Furin, Shin S. Treatment of multidrug-resistant tuberculosis during pregnancy: long-term follow-up of six children with intrauterine exposure to second-line agents. *Clinical Infectious Diseases*. 2005;40(11):1689-1692.

Farmer PE. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. 2nd ed. Berkeley (CA): University of California Press; 2005.

Fraser HSF, Biondich P, Moodley D, Choi S, Mamlin BW, Szolovits P. Implementing electronic medical record systems in developing countries. *Informatics in Primary Care*. 2005;13(2):83-96.

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Kim JY, Shakow A, Mate K, Vanderwerker C, Gupta R, Farmer P. Limited good and limited vision: multidrug-resistant tuberculosis and global health policy. *Social Science and Medicine*. 2005;61(4):847-859.

Laserson KF, Thorpe LE, Leimane V, Weyer K, Mitnick CD, Rieckstina V, Zarovska E, Rich ML, Fraser HSF, Alarcon E, Cegielski JP, Grzemska M, Gupta R, Espinal M. Speaking the same language: treatment outcome definitions for multidrug-resistant tuberculosis. *International Journal of Tuberculosis and Lung Disease*. 2005;9(6):640-645.

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Shin S, Naroditskaya V, Sloutsky A, Werner B, Timperi R, Bayona J, Farmer P, Becerra M. rpoB gene mutations in clinical isolates in multidrug-resistant *Mycobacterium tuberculosis* in Northern Lima, Peru. *Microbial Drug Resistance*. 2005;11(1):26-30.

Smith Fawzi MC, Lambert W, Singler JM, Tanagho Y, Léandre F, Nevil P, Bertrand D, Claude MS, Bertrand J, Louissaint M, Jeannis L, Mukherjee JS, Goldie S, Salazar JJ, Farmer PE. Factors associated with forced sex among women in rural Haiti: implications for the prevention of HIV and other STDs. *Social Science and Medicine*. 2005;60(4):679-689.

Solis L, Shin SS, Han LL, Llanos F, Stowell M, Sloutsky A. Validation of a rapid method for detection of *M. tuberculosis* resistance to isoniazid and rifampin in Lima, Peru. *International Journal of Tuberculosis and Lung Disease*. 2005;9(7):760-764.

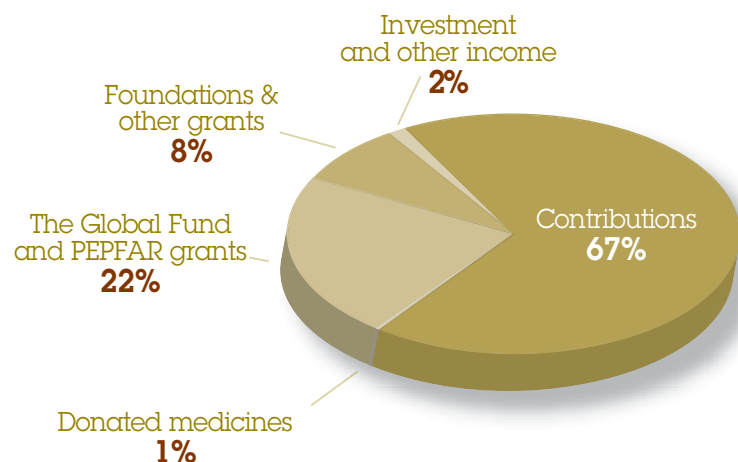
Timperi R, Han LL, Sloutsky A, Becerra MC, Nardell EA, Salazar JJ, Smith Fawzi MC. Drug-resistance profiles of *Mycobacterium tuberculosis* isolates: Five years experience and insight into treatment strategies for multidrug resistant tuberculosis in Lima, Peru. *International Journal of Tuberculosis and Lung Disease*. 2005;9(2):175-180.

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# Financials

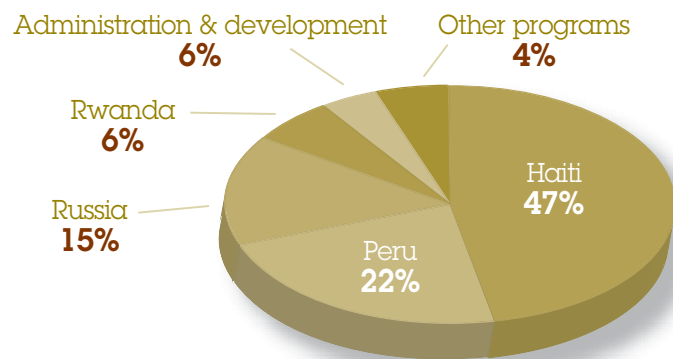
## 2005 Total support and revenue

Category	Amount
Contributions	\$ 24,647,378
Donated medicines	\$ 102,453
<i>Total contributions</i>	<b>\$ 24,749,831</b>
The Global Fund to Fight AIDS, Tuberculosis and Malaria; U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	\$ 8,096,506
Foundations and other grants	\$ 2,872,308
<i>Total grants</i>	<b>\$ 10,968,814</b>
Investment and other income (net)	\$ 483,839
<i>Total support and revenue</i>	<b>\$ 36,202,484</b>



## 2005 Total expenditures

By program	Amount
<b>HAITI:</b> Program expenses	\$ 8,248,589
Medicines	\$ 2,471,193
<i>Subtotal Haiti</i>	<b>\$ 10,719,782</b>
<b>PERU:</b> Program expenses	\$ 4,224,522
Medicines	\$ 951,217
<i>Subtotal Peru</i>	<b>\$ 5,175,739</b>
<b>RUSSIA:</b> Program expenses	\$ 3,175,630
Medicines	\$ 262,984
<i>Subtotal Russia</i>	<b>\$ 3,438,614</b>
<b>RWANDA:</b> Program expenses	\$ 1,142,734
Medicines	\$ 212,449
<i>Subtotal Rwanda</i>	<b>\$ 1,355,183</b>
All other programs	\$ 931,082
Administration and development	\$ 1,200,268
<i>Total expenditures</i>	<b>\$ 22,820,668</b>
<i>Increase in net assets</i>	<b>\$ 13,381,816</b>



# Partners Circle

## Foundation Grants

Alvin and Fanny Blaustein Thalheimer Foundation, Inc.  
Anonymous  
Baobab Fund  
Baton Rouge Area Foundation  
The Bill & Melinda Gates Foundation  
Blue Cross Blue Shield of Massachusetts Foundation  
The Boston Foundation  
Boston Scientific Foundation, Inc.  
Centers for Disease Control Foundation  
Charles Engelhard Foundation  
Clinton Foundation HIV/AIDS Initiative  
The Conrad N. Hilton Foundation  
Conservation Food & Health Foundation, Inc.  
Eli Lilly and Company Foundation  
Fledgling Fund  
The Ford Foundation  
Frank B. Mazer Foundation  
Friendship Fund  
George and Patricia Ann Fisher Foundation  
Grace Jones Richardson Trust  
Hess Foundation  
Inavale Foundation  
Juniper Networks Foundation Fund at the Community Foundation of Silicon Valley  
The Kohlberg Foundation, Inc.  
M-A-C AIDS Fund  
MADRE  
Norcross Wildlife Foundation, Inc.  
Partners HealthCare System, Inc.  
Ralph and Gail Cassell Charitable Fund of the Legacy Fund  
Community Foundation  
Reginald F. Lewis Foundation  
Robert Earl McConnell Foundation  
Shifting Foundation  
Starr Foundation  
Sunshine Foundation  
Wallace Global Fund

## Government, Multilateral and Other Grants

Brigham and Women's Hospital  
Caribbean HIV/AIDS Regional Training Network (CHART)  
Center for AIDS Research (CFAR)  
Centers for Disease Control and Prevention  
Fogarty International Center

Global Fund to Fight AIDS, Tuberculosis and Malaria  
International Training and Education Center on HIV (I-TECH)  
Partners HealthCare System, Inc.  
Pittsfield Anti-Tuberculosis Association  
President's Emergency Plan for AIDS Relief (PEPFAR)  
Tropical Disease Foundation  
United Nations Development Program  
United Nations Research Institute for Social Development  
World Health Organization

## Matching Gifts

Adage Capital Management  
Aetna Foundation, Inc.  
Altria Group, Inc.  
American International Group, Inc.  
Amgen Foundation  
Arthur J. Gallagher Foundation  
Bank of America  
Bank of Canton  
Cingular Wireless  
Clorox Company Foundation  
CNA Foundation  
Computer Associates International  
Cyberlore Foundation  
Deutsche Bank Americas Foundation  
Doris Duke Charitable Foundation  
Dun & Bradstreet Corporation  
Matching Gifts Program  
Eli Lilly and Company Foundation  
Fannie Mae Foundation  
Gift Center  
Fleet Financial Matching Gifts Program  
FM Global Foundation  
Ford Foundation Matching Gift Program  
Gannett Foundation-GannettMatch  
Gillette Company  
Google Matching Gifts Program  
Harcourt, Inc.  
Harris and Eliza Kempner Fund  
ING Foundation  
Intuit  
John Hancock Financial Services  
JP Morgan Chase Matching Gifts Program  
Juniper Network Matching Gifts Program  
Kerry Inc.  
L.E.K. Consulting LLC  
Lehman Brothers

## Individuals, Family Foundations, and Organizations

**\$100,000 and above**  
Anonymous  
The Estate of Jocelyn Ruth Edelman  
J. Christopher Flowers and Mary White  
Mary and Robert Heine  
Hershey Family Foundation  
John & Mary Corcoran Family Foundation  
Diane E. and Albert J. Kaneb  
Malcolm McComb  
River Street Development Foundation  
Waterfall Foundation

**\$50,000 - \$100,000**  
Anonymous  
Bethany and Hank Cardwell  
Cathedral of the Sacred Heart of Jesus  
Ophelia Dahl

Merck Partnership for Giving  
Meredith Corporation Matching Gifts Program  
Microsoft Matching Gift Program  
National Grid Matching Gifts Program  
Open Society Institute  
Outten & Golden LLP  
PepsiCo Foundation  
Pfizer Foundation  
Pitney Bowes Corporation  
Prudential Foundation Matching Gifts  
Sallie Mae Fund  
SourceMedia Employee Matching Gifts  
SPX Corporation  
Starbucks Matching Gifts Program  
State Street Matching Gift Program  
Sun Microsystems Matching Gifts Program  
Thrivent Financial for Lutherans  
Tycos Matching Gifts Program  
UnumProvident  
Verizon  
Wachovia  
Watermark Estate Management Services  
Wellington Management Company, LLP  
Wyeth  
Zais Group, L.L.C.

**\$10,000 - \$25,000**  
Anonymous  
Eric Bauer  
Birmingham Foundation  
David Blair and Linda Marsella  
Peter Bloom and Janet Greenfield  
Philip and Maureen Bonanno  
Cadenhead Walters Charitable Foundation  
Jean Carper  
Jay Cashman  
Church of the Redeemer  
Buck Close  
Marjorie and William Coleman  
Corcoran Construction Corp.  
Beverly Cowart  
Paul Cravedi  
Gerald and Jeanne Curtis  
Felicity Dahl  
Phillippe Daniel  
Guido and Hennie Deboeck  
Virginia Deknatel  
Becky Dewey  
Gordon and Karen DuGan  
ElectricAid  
Steven and Marilyn Emanuel  
Evans Skidmore Family Trust  
Leslie Fleming  
Michael and Mary Fox

DeLaCour Family Foundation  
Annie Dillard  
Rupert Everett  
Paul Farmer and Didi Bertrand  
John and Margarette McNeice  
Project Medishare

**\$25,000 - \$50,000**  
Anonymous  
The Arcturus Fund of the Kalamazoo Community Foundation  
Paul and Catherine Bittenwieser  
Andrew and Katherine Constan  
Cullen-Martin Family Foundation  
Glenn Hadden and Cynthia Gray  
Lesley and William King  
Anna Lane  
Logical Innovations, LLC  
Nancy McCormack  
Paul F. and Elenor M. Wilkinson Trust  
Michael Sherman  
St. Anne's Parish - Glace Bay  
Sterling Stamos Capital  
Management LP  
Mallory Walker  
White Flowers Foundation  
Stephen and Melissa White  
Paul Zintl and Lisa Frost

**\$1,000 - \$10,000**  
J. Cooper Abbott  
Active Network, Inc.  
Charles C. Adams, Jr.  
Audrey Ades  
Susan Adler  
AIDS Action Committee  
AIDS Action Taskforce of Columbus, IN  
Alexander Family Foundation  
Jessica and Eric Allina-Pisano  
Altman-Stiller Foundation  
Patrick and Jeannine Alwell  
Victor Ambros  
Lizzie Americo  
Keith Amidon  
Mary and Thomas Amory  
Sally and John Amory  
Amy Mandel and Katrina Rodis Fund  
Scott and Nicole Andersen  
Elizabeth Good Angle and Frank King  
Anna and Emanuel Weinstein  
Family Foundation  
Anonymous  
Armand Antommarrina and Cali Matheny  
Susan and Michael Anzaldi  
Roberta Apfel and Bennett Simon  
Rex Armstrong and Leslie Roberts  
Edwin and Iris Arnowitt  
Aronson Foundation  
Drew and Diane Asson  
Gwendolyn Atwood  
Benjamin Auspitz  
Alfred and Patricia Austin  
Lynne Austin  
Paul and Sally Austin  
Sonia G. Austrian  
John Ayanian and Anne Fox  
Cynthia Ayres  
Lenore Azaroff  
Nat Bacon  
Carolyn Baek  
Roberto Bajandas  
Nick and Maura Balaban  
Ann and Charles Balch  
Matthew and Margaret Baltaris  
Baltins Family Fund of the Minneapolis Foundation  
George Bard  
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