



PIH Bulletin

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Based in Boston, Mass., Partners In Health works hand-in-hand with its partners in Haiti, Rwanda, Peru, Russia, Lesotho, Malawi, Mexico, Guatemala, and Boston. Since 1987 we have dedicated ourselves to developing and implementing a unique model of health care, bringing an ethic of social justice to the practice of medicine.

Above photo: As their houses filled with water, many Haitians fled down flooded roads in search of refuge in the city of Saint-Marc, where Zanmi Lasante recently began operating a hospital.



After the storms

Bringing emergency relief and long-term recovery plans to flooded communities in Haiti

The poorest country in the western hemisphere was recently hammered by four hurricanes in devastating succession. Catastrophic floods and mudslides in the wake of the storms killed more than a thousand people and destroyed homes, crops, and even entire villages. Thousands of poor families who had little before are now left with nothing.

“The situation is very dire and catastrophic and sad and frustrating,” wrote Loune Viaud, Director of Operations of Zanmi Lasante (ZL), PIH’s partner organization in Haiti. She estimated that around 10,000 people were displaced due to floodwaters in the Artibonite Valley, where ZL recently expanded operations to six facilities. Almost 7,000, including about 1,000 patients and ZL staff, took refuge in the 25 makeshift shelters supported by ZL. The ZL team worked around the clock to supply these people with food, clean water, medical care, and basic living essentials, such as clothing and beds.

Although PIH had never intended to be an emergency relief organization, the team quickly discovered that we were one of the

only organizations able to quickly access, assess, and begin delivering relief to the flooded areas. “Our team is able to [assess the situation and immediate needs] because of the strong community network of social workers and community health workers, who are also living in the situation... We can get the kind of information that others have no access to,” said PIH Medical Director Joia Mukherjee.

Meanwhile, the PIH Boston team quickly began collecting and shipping the most desperately needed supplies, thanks to generous emergency donations from PIH supporters. Within days of the flooding, the PIH Boston team started procuring what would soon become over 15 tons of supplies, including food, medical supplies, mattresses, water filters and jugs, clothing, and blankets.

The ZL team is now turning its focus to strengthening the medical facilities in the areas hit by the storms, as they are now handling an influx of patients from neighboring communities that had their own health centers destroyed by the floods. The clinical team is also worried about outbreaks of waterborne diseases, as well as malaria. Although the

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Perspectives:

Reflections on maternal mortality

Progress, but still a ways to go

by Paul Farmer and Ophelia Dahl



“Obscene” is still the word that comes to mind when we think of maternal mortality—and it has been almost 25 years since we first witnessed death in childbirth. In 1983, as students in one of central Haiti’s fetid clinics, we prepared to celebrate a birth. Although we’d just met the young woman about to become a mother, her desperate expression as she began to hemorrhage haunts us still. Regional statistics could have predicted the outcome: a 1985 survey pegged Haitian maternal mortality at 1,400 deaths per 100,000 live births. By comparison, maternal mortality in the United States last year was 14 deaths per 100,000 live births.

Worldwide, 500,000 women die in childbirth every year; more than 90 percent live in Africa or Asia, and almost all are poor by any standard. Obscene though it is, death during childbirth isn’t the end of the story. In the world’s poorest areas, many orphaned children wind up destitute and on the streets within a few years of their mothers’ deaths, sometimes resorting to desperate or criminal measures for food, shelter, clothes or school fees.

One of the 12 U.N. Millennium Development Goals is to reduce maternal mortality 75 percent by the year 2015. But we are moving too slowly to meet this goal, the United Nations says.

Today, the maternal mortality rate in Haiti is less than half what it was a quarter-century ago. Across the broad swath of central Haiti where we work, we estimate the number to be well below 100 deaths per 100,000 live births—not good enough but a vast improvement, most of it occurring in the past decade. Change came largely for three reasons.

First, our nonprofit organization, Partners In Health, has worked closely with the Haitian Ministry of Health to strengthen public health infrastructure. We have rebuilt, equipped, staffed, and stocked hospitals and clinics; trained nurse-midwives and other personnel, including more than a thousand community health workers; linked villages and health centers to district hospitals by modern telecommunications and ambulance service; and established modern surgical services for obstetrical emergencies.


Second, we have broken the rule that high-quality health services are a privilege rationed by ability to pay, not a right. The case was made first for affordable medicines. Now it is being made for emergency Caesarean sections—an essential tool to reduce maternal mortality. Faced with evidence that

maternal mortality was greater where fees were higher, the district health commissioner for central Haiti announced last August that all prenatal care and emergency obstetrical services would henceforth be available free to all patients. He was later echoed by Haitian President René Préval.

Third, we have linked prenatal and obstetric care to an all-out effort to improve access to primary health care. The presence of functional, accessible public clinics and hospitals restores faith in the health system, motivates people to seek care before they are critically ill, and allows for preventive interventions such as prenatal care and family planning.

Consider Rwanda, another country where we work, which is rising rapidly from its ashes scarcely a dozen years after an appalling genocide. Rwandan maternal mortality rates in 1995, the year after the genocide, are unknown. But they are sure to have exceeded the 1,800 deaths per 100,000 live births reported that year in relatively peaceful Malawi. The situation has improved dramatically since then.

By helping to train and, importantly, pay community health workers, the Rwandan Ministry of Health is taking steps to link rural villages to health centers with the capacity to make routine labor safe. Rwanda is also seeking to make family planning available to citizens and to increase access to preventive and primary care through basic health insurance. Maternal mortality has dropped from more than 1,000 deaths per 100,000 live births between 1995 and 2000 to less than 600 today—still terrible but well below the average (940) reported for sub-Saharan Africa.

At the government’s invitation, Partners In Health launched efforts to strengthen AIDS treatment and primary health services in one region of rural Rwanda in 2005. Mindful of the lessons learned during two decades of work in rural Haiti—and of that young Haitian woman whom we watched turn abruptly from the anticipation of new life to a confrontation with death—we have made reducing maternal mortality and improving women’s health top priorities. And we have welcomed the opportunity to support Rwanda’s commitment to breaking the cycle of poverty and disease by including health care and education (especially for girls) in its vision of the future. It’s probably no coincidence that Rwanda also boasts the world’s highest percentage of women in parliament. 

This piece was originally published on May 11, 2008, in The Washington Post.

Heroes in Hinche

Zanmi Lasante staff do “whatever it takes”

In crises like the recent storms, it is the reaction that defines individuals and organizations. Two staff members from Zanmi Lasante (ZL) were among the many who sprang into action when the floodwaters reached the upper central plateau of Haiti.

ZL driver Jean Benoit Isaac (“Ti Ben”) and Fritz Germain, an HIV and sexually transmitted infections prevention educator, both work with ZL in Hinche, an area shockingly devastated by the floods. Neighborhoods and houses disappeared entirely under water. The rooftops and tassels of corn stalks were all that could be seen. In living memory, Hinche had never experienced flooding, so no one was prepared for, or could have imagined, the level of destruction it would bring.

At 4:00 on Wednesday morning, Ti Ben and Fritz learned about flooding in Hinche. Needing little direction, they commandeered a ZL car and started out towards the low-lying areas. They found and shuttled the exhausted, wet, and shell-shocked flood victims to places of safety. They identified the need for food, clean water, and organization, and placed orders in various restaurants around town, leaving IOUs in their wake: 500 sandwiches, spaghetti for 200, rice and beans, 800 bottles of juice, hundreds of sachets and bottles of purified water.

By Wednesday afternoon, they were gathering food orders, throwing boxes of bottled liquids on the roof rack of the truck, and then unloading them at shelters. They made countless trips. They worked like machines.



Flooding destroyed entire communities in Hinche.

Neither had stopped all day. Neither had eaten.

Ti Ben is not from Hinche, but from Port-au-Prince, where his wife and young son live. The day before the Hinche flooding, his own home in the flats of Port-au-Prince had been entirely flooded. His family was safe but, like many Hinche residents, he too had lost everything. When asked about his family and home and his plans to return to Port-au-Prince, he looked incredulous.

“What’s done is done there and I know they are safe—that’s what matters. The roads are blocked but even so they need me here. I can’t leave. These people need to eat. Mothers and babies need clothes. This is my work now.”

At the first shelter, an empty school building, volunteers wearing helmets from a local relief organization were attempting to keep order and direct the

throng of hungry people streaming in. A crowd massed around the ZL truck, a cacophony of voices asking for help, food, water, answers.

Ti Ben jumped out of the car and quickly began injecting order into the chaos. He explained to people why ZL had come, what they had to offer, and how they needed to proceed. Order quickly came and distribution began. Small sandwiches to young children; the biggest to nursing mothers. Bottles of water to young children; sachets to everyone else.

That was the first of many stops followed by more food pick-ups and more deliveries. The sun set, twilight passed and true night fell. But Fritz and Ti Ben kept going. Over 500 people had been fed in a few hours because of them. At dawn, they would wake up and do it all again. ☸

Special thanks to PIH Interns Max Bearak, Melissa King, Sadie Richards, and Tom Spoth for their help in providing content for this issue of PIH Bulletin. To read more news about PIH’s programs and partners, please sign up for our monthly e-newsletter at www.pih.org/youcando/email.html.

Dealing with HIV and destructive floods

Zanmi Lasante social workers help patients cope

The floods in Haiti from the recent hurricanes left many HIV patients and their families with almost nothing. Zanmi Lasante social worker Ermaze Louis Pierre describes how PIH's partners in Haiti are working to fix this.

It was 4:00 in the morning on September 3rd when one of the assistant social workers called me to tell me that the city of Hinche was flooded. The first thing that ran through my mind was to get up and go search for our HIV patients, because the majority of our patients aren't able to live in nice, sturdy houses.

When we arrived at the part of the city where the flooding was, all we could see were the roofs of homes. With water levels reaching our chests, we began searching for all of our HIV patients and their families. Thankfully, all had had time to leave their homes, but they did not have time to save any of their belongings. The water took with it everything that they owned. We quickly located everyone and placed them in a shelter that we organized through Zanmi Lasante (ZL) to assure all patients were able to continue to take their medicines. In the shelter,



A ZL social worker in search of patients.

we also provided patients and their families with mattresses, warm cooked meals, clean water, soap, and clothes.

What really made me sad and upset was to see that these people were already facing a lot of difficulty (socio-economic as well as medical) before becoming victims of the floods.

Since the flooding, our social work team has been accompanying our patients, even after the closing of the shelters, to make sure that we are doing whatever we can to help them get back on their feet.

The only hope that most of these patients have is the ZL team. We are always there with them for their medical as well as social needs. In Hinche,

there are approximately 1,200 families who have lost their homes, animals, or farms. This emergency situation has made us double our efforts, working morning, noon, and night to help our patients, and all those affected.

Right now I feel happy knowing that we have helped patients start to return to their normal lives, little by little. I would like to say thank you to everyone who, in one way or another, has helped us to quickly respond to this devastating time we are now facing in Haiti. I hope that you will not become discouraged and keep us in your thoughts and prayers. 🙏

After the Storms

floodwaters have receded, countless pools of stagnant water still remain—the perfect breeding ground for mosquitoes and malaria, a potential public health disaster.

In addition to medical concerns, the team is working on longer-term relief plans, such as housing for the displaced. They have also been creating and distributing “resettlement kits” to help those who lost nearly everything. These kits include food supplies, cooking pots, stoves, water contain-

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Children at one of the 25 shelters supported by Zanmi Lasante.

ers and purification systems, clothes, shoes, and school fees and supplies for children.

The team is also working to bulk up microfinance, agricultural and food production projects, and local infrastructure to give the areas a real chance to build a prosperous and sustainable community.

“The work has just begun,” says PIH Executive Director Ophelia Dahl. 🙏

Scenes after the storms

Top right: Floodwaters from torrential rains inundated the streets of many communities in Haiti, forcing many people to flee to higher ground.

Middle left: With nowhere else to go, many sought refuge in overcrowded, poorly supplied shelters after being forced from their homes by the rising waters.

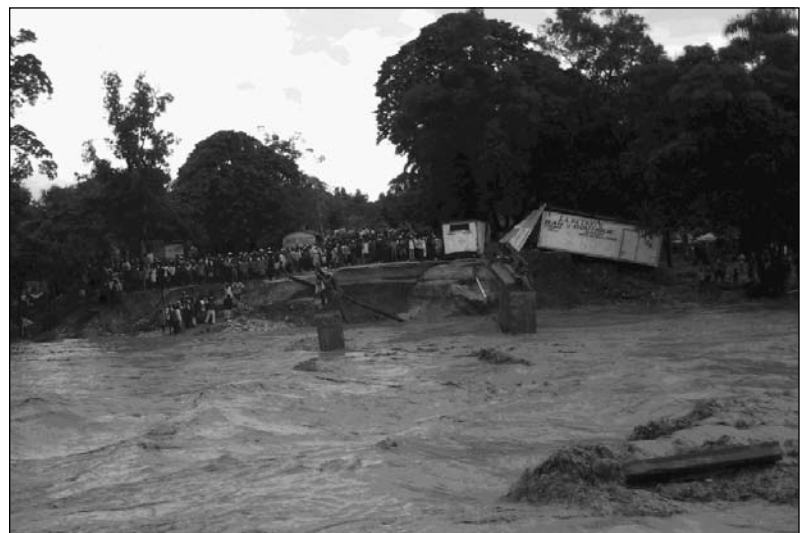
Middle right: Swollen from hurricane rains, the river in Mirebalais swept away the main bridge connecting the capital city of Port au Prince with the devastated Artibonite valley, effectively cutting off the area of Haiti most in need of emergency supplies.

Bottom left: The floodwaters have receded, but countless pools of stagnant water still remain—the perfect breeding ground for mosquitoes and a public health disaster: a massive outbreak of malaria.

Bottom right: The storms destroyed many of this season's crops in one of Haiti's most important agricultural areas. The country had already been suffering from acute food shortages.



To find out more about PIH's hurricane relief efforts and how you can help, please visit: www.pih.org.



The rocks in the sun

Report indicts U.S. government and Inter-American Development Bank for violations of the rights to clean water and health in Haiti

In 1998, the Inter-American Development Bank (IDB) awarded \$54 million in loans to the Haitian government to improve the country's crumbling public-water system. The money was supposed to bring clean water to people who for many years had been denied this basic human right. A decade later, this money still has not produced a single improvement to Haiti's water supply in the city designated to be one of the first recipients.

A report issued in June by Partners In Health (along with its Haitian sister organization Zanmi Lasante, New York University's Center for Human Rights and Global Justice, and the Robert F. Kennedy Memorial Center), reveals the U.S. government's clandestine efforts to ensure that political considerations took precedence over the rights of some of the planet's poorest people. In the 10 years since the loans were approved, the Haitian water system has actually gotten worse. In 2002, a water-poverty index released by the British-based Centre for Ecology and Hydrology ranked Haiti dead last out of 147 countries surveyed.

The report's title, "Wòch nan Soley," comes from a Haitian proverb that laments, "the rocks in the water don't know the suffering of the rocks in the sun," or the wealthy do not know the suffering of the poor. According to Loune Viaud, Director of Operations at Zanmi Lasante, this is precisely what needs to change. "We have to stand up for what's right," she declared at a press conference. "We must strive to hold our governments, and the institutions to which they belong, accountable. And we must commit to ensuring that the right to water is realized in rich and poor countries alike."

According to the report, the IDB failed to distribute loans and grants to Haiti. This violates its own charter, which prohibits politics from influenc-

ing IDB decisions. Internal documents from the U.S. Treasury Department and the office of the U.S. Executive Director at the IDB, obtained through the Freedom of Information Act, show that officials actively used American influence to block the loans in an attempt to destabilize the elected government led by President Aristide, who was ultimately overthrown in 2004.

International law also protects the human right to water, according to the United Nations' Committee on Economic, Social and Cultural Rights, as well as other international covenants and declarations. Thus, the U.S. government's actions can be construed as a violation of its international human-rights obligations.

These violations are the latest in a line of oppressive policies towards Haiti, which has been hamstrung by crushing foreign debt for virtually its entire existence. For example, it took Haitians more than 100 years to pay off a debt equivalent to \$21 billion USD today, imposed by France in 1825 to "compensate" for the value of lost "property," including the founders of

Haiti themselves—former slaves.

Massive debt has precluded spending on desperately needed infrastructure projects. In 2003, Haiti's debt service was \$57.4 million; the Haitian government's combined budget for education, health care, environment, and transportation was \$39.2 million. Haitians must endure crushing poverty and poor health, exacerbated by the inability to afford adequate amounts of potable water (often available only from the private sector). In order to purchase the World Health Organization's minimum standard of 20 liters of water per day, a Haitian family of four would have to spend approximately 12 percent of its annual income—the equivalent of asking a U.S. family living at the poverty level (\$20,444 per year) to pay nearly \$2,500 per year for water.

In Port-de-Paix, the Haitian city that was supposed to be one of the first beneficiaries of IDB loans, the private sector provides 80 percent of the drinking water, and 86.7 percent of residents surveyed reported that they are "always" or "sometimes" unable to pay for water. Over 80 percent also

The 87-page report "Wòch nan Soley: The Denial of the Right to Water in Haiti" states that:

- Public water systems are rarely available throughout the year and close to 70 percent of the population lacks direct access to potable water at all times;
- The percentage of the population without access to safe drinking water has increased by at least seven percent from 1990 to 2005;
- Infectious diarrhea was the second leading cause of death in Haiti in 1999, and gastrointestinal infection was the leading cause of mortality for young children. These preventable diseases result primarily from unsafe drinking water and poor sanitation.



WÒCH NAN SOLEY:
THE DENIAL OF THE RIGHT TO WATER IN HAITI



indicated that the water quality had gotten worse or not improved. Poor water quality is a major public health concern.

“I’ve been working in Haiti for more than a decade,” said Dr. Evan Lyon of PIH. “I have long been aware of the connection between lack of access to clean water and preventable disease. But surveying households in Port-de-

Paix opened my eyes to how essential clean water is to all facets of life, from cooking and washing to growing food. At one household, we perched on rickety chairs, ankle-deep in water. The family was literally bailing filthy water out of their yard while I asked them questions. When we tested water at the local hospital we discovered it was just as contaminated as the water that

makes people sick in the first place. The hospital’s water comes from the same dirty sources.”

“I bet most of the people in [the U.S.] do not think about this as a right,” Viaud said. “It is taken for granted. Just imagine one day without water in New York City. It would be a disaster—in the news around the world. It would be outrageous.” 📷

To Burera and beyond Health care and home visits in Rwanda

A young, widowed mother of five named Patricie was recently admitted to the Burera District Hospital. She suffered from both advanced HIV/AIDS and disseminated tuberculosis. Though there are an estimated 600 new cases of tuberculosis in the district annually, Patricie was only the second person to receive treatment this year. Just a few months ago, there was only one physician to serve a population of nearly 400,000. Many faced limited access to health care, and childhood malnutrition was rife.

“We have seen this before,” said Dr. Peter Drobac, a physician who works with PIH in Rwanda. Three years ago, Partners In Health, in partnership with the Clinton HIV/AIDS Initiative (CHAI), arrived in Rwanda to help the government rebuild health systems in two rural districts—Kayonza (Rwinkwavu) and Kirehe. Two hospitals and seven health centers later, hundreds of thousands of Rwandans have gained access to high-quality health care.

The Government of Rwanda soon proposed an ambitious program to strengthen rural health systems throughout the country utilizing many of the core elements of the PIH/CHAI model. The first step was to replicate the successes of the Rwinkwavu collaboration, and other health delivery approaches in use in the country, in one of the two remaining Rwandan health districts without a district hospital—Burera.

The partnership quickly began working in Burera, and this spring, doctors made the first official home visit to a patient in Burera—Patricie.

Those familiar with the philosophy of PIH know that home visits are an integral part of our work. “There is no substitute for the opportunity to sit with a patient in his or her home in an effort to understand the social, economic, and structural forces that shape lives and contribute to illness,” said Dr. Drobac. “For this reason, the first home visit in Burera felt like an inauguration of sorts.”

Dr. Drobac joined Dr. Patrick Almazor—the recently appointed PIH Burera District Director (and a Haitian physician with years of experience working with Zanmi Lasante,



Dr. Patrick Almazor visiting Patricie at her home in rural Burera, Rwanda.

PIH’s partner organization in Haiti)—for two hours of steady climbing up volcanic hills to reach Patricie’s home, a stone’s throw from the Ugandan border.

Patricie and her five children live in a two-room shack with a thatched roof and a mud floor. Their home is nestled near a picturesque hilltop surrounded by lush fields of sorghum, corn, beans, and vegetables. Yet Patricie’s land is hardly bigger than the poor little house itself—none of those crops are hers. She has scraped out a living by working her neighbors’ land in return for a small share of the crop yield. Due to her illness, she was unable to work at all for several months. Her husband had died years earlier of AIDS. As a result, her five children (though thankfully HIV-negative) clearly suffered from malnutrition and parasitic infection.

The Rwandan government’s framework provides Patricie with more than medicines alone. She is visited daily by a trained accompagnateur from her own village, who provides a critical link to the health center. Patricie and her family receive both medical and nutritional support. “We hope to someday help rebuild her house and help get her children to school, as has been done for hundreds of other destitute families near Rwinkwavu, and at other PIH sites around the world” added Dr. Drobac. 📷

One house at a time

Malawi program constructs social and economic equity

The truck turned down a small rocky path, which only grew smaller and more rocky. Soon, its tires began mowing through tall reeds, grasses, and small shrubs. The driver finally pulled into a small clearing next to a weathered pile of straw and sticks leaning up against a tree—the home of the Felesiano family.

Chimfuka Felesiano, a thin, middle-aged man, slowly shuffled towards the truck. With each step, a hollow-sounding rattle wheezed in and out of his lungs as he fought to breathe. Noticing his struggle, Edwin Kambanga and his coworkers immediately hopped out of the truck and rushed to his aid.

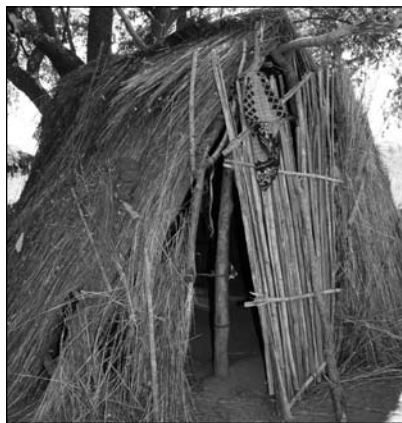
Edwin has seen many extreme cases of poverty through his work in the rural Neno district of Malawi, one of the poorest countries in Africa. He is the

coordinator of POSER—the Program on Social and Economic Rights for APZU (Abwenzi Pa Za Umoyo, PIH’s partner organization in Malawi). POSER initiates projects that directly address the factors that put PIH’s patients at increased risk of disease—poverty and social inequalities.

Poverty was both the cause and result of the severe, debilitating cardiovascular condition that plagues Chimfuka, said Edwin. Unable to afford a sturdy house, he and his family were forced to live in a damp, drafty hut, which affected his breathing. Unable to afford medical fees to treat his breathing problems, they grew worse, eventually rendering him unable to repair and maintain the walls of his hut. As his house deteriorated, so did his health and his ability to work and support his family.

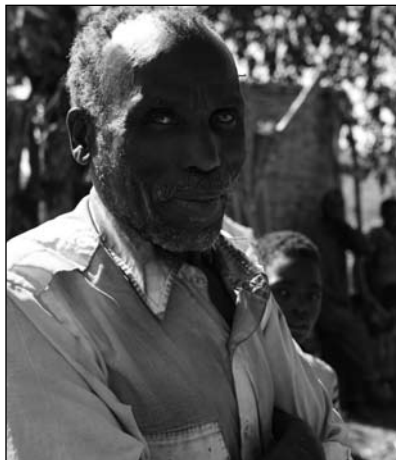
Earlier this year, the roof and a wall of the hut crumbled during a rainstorm. With his medical condition, there wasn’t much Chimfuka could do to rebuild the house, and he couldn’t afford to pay someone from his village to help. So his wife and their young son did the best they could to cobble together a shelter to help the family endure the torrential downpours of Malawi’s rainy season—a small lean-to made of straw and sticks piled up against a tree. No floor but the muddy ground, and no walls or roof but a straw stack that looked like it would collapse if anyone other than Chimfuka puffed at it. In this “house,” Chimfuka’s physical (and financial) condition only grew worse.

Although APZU is only a year old, Edwin and his POSER team are already making a difference for people like



Top left: Chimfuka Felesiano's house caved in during Malawi's rainy season.

Top right: Unable to rebuild the house, Chimfuka's wife and small son created a lean-to out of straw and sticks.



Bottom right: POSER constructed a new house for Chimfuka and his family.

Bottom left: Chimfuka was all smiles the day the POSER team came to see him move into his new home.



Mary Chichera cuts fabric to make a shirt at the Chiyanjano tailoring program.



A new building constructed by POSER houses a local community-based organization. The organization's old building is on the right.

Chimfuka. After visiting his family, the team immediately decided that a new house was desperately needed, and construction of a modest two room house with a metal roof, brick walls, and cement floor quickly began on a small plot of land a few feet away from both the crumbling hut and the makeshift straw lean-to. In this warm, dry house, Chimfuka now has a chance to grow strong enough to help provide for his family.

Over the past year, POSER has helped give 19 patients and their families new homes, and plans to continue constructing houses for two patients each month.

In addition to building houses for the poorest of the poor, Edwin and his team work to bolster other factors that can help patients and their families out of poverty—including education, job skills training, food, farming supplies, and even employment (some of POSER's houses were built by APZU patients with HIV).

Not far from Chimfuka's sturdy new house is another small house, literally filled with children. A dozen of them, ranging in age from 6 to 17, live here along with their mother, Mary Chichera.

A tiny but feisty woman with dancing eyes and a warm smile, Mary cares for all of them by herself—six are her own children, six are orphans who lost their parents to the village's AIDS epi-

demic (one local leader estimated over 600 AIDS orphans in this village alone). A disease that disproportionately affects the poor, HIV/AIDS can also trap those living with the disease with the burden of poverty—both those infected by HIV, as well as those caring for a patient or a child orphaned by the disease.

It's easy to supply each of the kids with love and attention, said Mary. "It's a very hard life trying to support all the children and get them enough food, blankets, paraffin, school materials, and everything," she said as Edwin translated. "This makes many heartbreaking situations." For example, one of her children was accepted into a prestigious private school—an opportunity to escape poverty. Pausing to wipe her eyes, Mary explained how she was forced to choose between this promising future for her child, or food for the rest of her children.

POSER is working to eliminate these kinds of difficult choices that people affected by HIV so often face. Partnering with a local community-based organization called Chiyanjano, Edwin and his POSER team helped create a clothes-making co-op for women who are either living with HIV themselves, or are caring for HIV patients or orphans. With training from experienced tailors, supplies, cloth, and sewing machines donated by POSER, Mary explained how 30 of her neighbors are now working together to sew

clothes. She glowed with pride as she showed off some of their products—brightly colored dresses, shirts, and jackets. These products are then either given to AIDS patients and orphans struggling with poverty, or sold in the market to provide an income to help Mary and the other women support their families.

POSER has also commissioned the co-op to produce an order of school uniforms for poor students in the district, as well as uniforms for APZU staff and curtains for the local hospital. Edwin and his team plan to help the women sell their products overseas in the US and the UK in the near future. "We are really being empowered," Mary smiled.

"Due to the growing number of HIV patients and orphans, we were so desperate," added Ezra Dzomodva, the director of Chiyanjano. "And then [POSER] came to our rescue."

In addition to Chiyanjano, POSER has partnered with five other community-based organizations throughout the Neno district to implement income generation programs and vocational training, childcare centers, community gardens, and support groups for people living with HIV/AIDS. By coupling these programs with the local health centers supported by APZU, Edwin and the POSER team hope to attack HIV and other diseases of the poor—medically as well as economically. ☒

Studies confirm XDR-TB can be cured

Extensively drug-resistant tuberculosis (XDR-TB) is curable with intensive and specialized care, concluded two recent studies published in the *New England Journal of Medicine (NEJM)* and the *Lancet*.

When XDR-TB burst into the headlines in 2006, it was widely portrayed as a virtually incurable disease. An outbreak of XDR-TB in South Africa in 2006, in which 52 out of the 53 patients infected died, lent credence to fears that being diagnosed with XDR-TB was an effective death sentence.

Multidrug-resistant or MDR-TB strains are resistant to at least the two main first-line drugs, isoniazid and rifampin. XDR-TB strains are resistant to isoniazid and rifampin as well as at least three of the six classes of second-line drugs.

Between 1999 and 2002, patients in Peru with MDR-TB were treated with an aggressive treatment protocol. The authors of the *NEJM* study demonstrated that of the 651 patients entering the program, 603 had MDR-TB, and 48 actually suffered from XDR-TB. Fully 60 percent of the patients with XDR-TB were successfully treated and cured, a cure rate only slightly lower than the 66 percent achieved with the MDR-TB patients.

The study adds urgency to the debate on drug-resistant strains of TB, said the *NEJM* study's lead author, Carole Mitnick, a PIH research associate and an Instructor for Harvard Medical School's Department of Global Health and Social Medicine. She added that she hoped this report would help doctors move away the treatment protocol that has been used unsuccessfully to treat MDR-TB for 15 years.

That unsuccessful protocol calls for a standard six-month regimen, known as DOTS (Directly Observed Treatment, Short Course), of first-line TB drugs. If unsuccessful the first time, the regimen is repeated. Although highly effective on TB strains that are not drug resis-

tant, this protocol is ineffective on patients with drug-resistant TB from the start, and can only make the problem worse.

"The mentality needs to change," said Mitnick. "A one-size-fits-all method doesn't work for some groups of TB patients. Specialized interventions need to be adopted."

She suggests that in places where drug-resistant strains of TB are widespread, at the first diagnosis of TB, patients should be tested to determine whether their particular strains are resistant to the first-line drugs. This could make it possible to start effective treatment with second-line drugs immediately, thus increasing the chance of curing patients and reducing both fatalities and transmission of the resistant strains.

This treatment protocol was applied in the study published in the *Lancet*. Here, PIH and collaborators treated patients in the Russian province of Tomsk, following 608 patients with MDR-TB, 29 of whom had XDR-TB. After testing a patient for drug-resistant strains of TB, an individualized treatment program was designed to provide at least five drugs that the strain was susceptible to, or if five could not be found, then providing drugs that the patient had not used before.

With this regimen, the study reported outcomes similar to those achieved in Peru. About half of the patients diagnosed with XDR-TB were cured (compared to 67% of MDR-TB patients).


"Our study is novel because it shows that XDR-TB can be treated under regular program conditions as part of an integrated TB program," added Salmaan Keshavjee of Harvard Medical School and the report's lead author. Although patients generally underwent the first six months of the treatment (the most intensive phase) in hospitals, the remainder of the treatment (about 18 months) was delivered on an outpatient basis. "This is



MDR-TB patient in Tomsk, Russia.

very important, in the setting of some countries wanting to keep patients with MDR-TB and XDR-TB under quarantine," said Keshavjee, who also works with PIH's TB programs in Tomsk and Lesotho.

"The fact that our findings are similar to [the *NEJM* study] supports the fact that aggressive treatment regimens, aggressive adverse-events management, and community-based delivery of care are part of a package that works for MDR-TB and XDR-TB," said Keshavjee. "This doesn't mean that we don't need new drugs as soon as possible. Instead it means that with the existing drug regimens delivered appropriately, we can save many more lives now."

The studies were conducted by researchers from the Department of Global Health and Social Medicine at Harvard Medical School, the Division of Global Health Equity at Brigham and Women's Hospital, *Socios En Salud* (PIH's partner organization in Peru) and PIH, in cooperation with other organizations. 

Slaying the monster

Lesotho's national multidrug-resistant TB program

In Botsabelo Hospital in Lesotho, a 12-year-old girl is very sick with multidrug-resistant tuberculosis (MDR-TB). Her right lung has been completely destroyed. But the disease has not affected her love of drawing. One day, she drew a picture of a big monster towering over a little insect, labeling the monster “MDR,” and the insect as the girl herself.

“Why are you so small?” Dr. Hind Satti asked her. “That’s the way I feel,” she answered. In many ways, the drawing symbolizes the public health nightmare faced in the tiny country of Lesotho, says Dr. Satti, PIH Lesotho’s (PIHL’s) MDR-TB Program Director.

Treatment for MDR-TB is long (usually lasting at least two years), arduous (subjecting patients to 30 to 40 pills plus at least one injection every day) and often accompanied by painful and debilitating side effects. Lesotho is also confronted simultaneously by an epidemic of HIV (with roughly one quarter of the adult population infected), which weakens immune systems, leaving patients highly vulnerable to diseases like MDR-TB.

Not long ago, patients in Lesotho

infected with the disease faced almost certain death. Today they and their families have reason to hope for a better prognosis.

For the past year, PIHL has been working hand-in-hand with Lesotho’s Ministry of Health and Social Welfare (MOHSW) and other partners (including the Open Society Institute, Foundation for Innovative New Diagnostics and the World Health Organization) to build up the basic infrastructure, expertise and technical support needed to test and treat patients for MDR-TB.


The national program now encompasses a state of the art MDR-TB hospital, complete with advanced negative-pressure and ventilation systems to prevent transmission of the air-borne disease; and a refurbished national laboratory to test for drug-resistant strains of the disease. These facilities are fully staffed and complemented by a team of treatment supporters who provide personalized, in-home patient care.

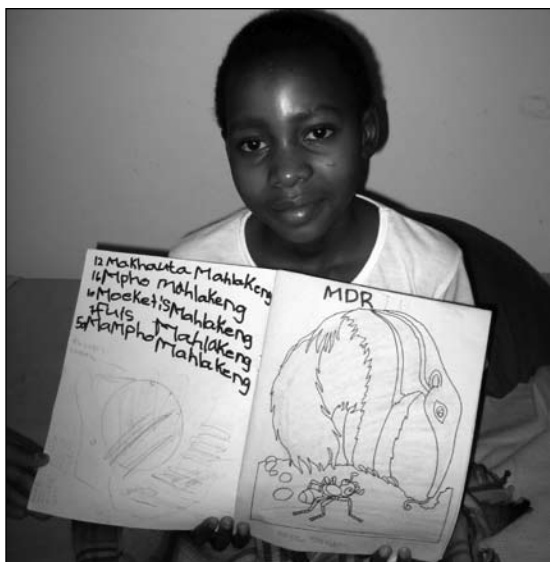
The little girl who draws pictures is one of more than 170 patients who are now receiving treatment for MDR-TB or the even more deadly extensively drug-resistant tuberculosis (XDR-TB). This number is growing rapidly and is

expected to reach 280 by the end of the year, and 450 by the end of 2009.

Most of the MDR-TB patients are able to receive treatment in their homes. Community health workers (a.k.a. treatment supporters) visit each patient twice daily to administer medication, provide psychosocial support, screen and counsel family members, and/or accompany extremely sick patients to the hospital in Botsabelo.

PIHL also trains “expert patients” who become an integral part of the community-based model. These are out-patients who have often returned to health from the brink of death to take on roles similar to those of the treatment supporters. They identify new potential patients, combat stigma associated with the disease, visit patients at home, provide health education on TB, HIV, and sexually transmitted infections, and provide psychosocial support to other patients and their families.

As Satti attests, they are “the living, breathing example of the success that can be reached in treating MDR-TB” through community-based programs. They carry the hope that the monster of MDR-TB will one day no longer burden their communities. 



A patient shows her picture of MDR-TB.



Dr. Hind Satti (center) and her team in the new state-of-the-art MDR-TB hospital.

A tale of two communities

Greenwich, Connecticut, and Rukira, Rwanda, are separated by more than 7,000 miles and an even wider gulf in wealth, health, and living conditions. Greenwich ranks as one of the most affluent cities in the world's richest nation. Rukira is a poor village in a country where most people live on less than \$1 per day. Yet for the past three years, a community in Greenwich has been united with Rukira by a shared commitment that has turned what looked like an abandoned building in Rukira into a thriving health center.

To Ed Cardoza, Vice President for Development at PIH, the Greenwich-Rukira relationship represents a model of "a community of concern." By that he means "a group of individuals on this side of the equation [the wealthy global north] who commit to work in solidarity with a community on the other side of the equation. They agree to learn from and provide for that community so that there's transformation on both sides."

The Greenwich community of concern started with a book and a handful of people. "What started it all was reading *Mountains Beyond Mountains*," recalls Lesley King, one of the founders of the group. "I was totally intrigued and inspired by it." She proceeded to introduce the book and the work of PIH to others she knew through a women's group and Trinity Church, a new non-denominational congregation.

In the summer of 2006, several members of the emerging community visited Rwanda to evaluate all the non-governmental organizations working there as potential partners. When they met with PIH, King recalls, "Everything clicked. Our visions were very similar. Like PIH, we were determined to treat the poor with dignity, not just with band-aids."

The Greenwich community pledged to provide a lot more than band-aids—\$500,000 a year for three years



Manzi Anatole with a patient at the Rukira health center.

to allow PIH's Rwandan partner organization, Inshuti Mu Buzima (IMB), to expand to a new site.

That site turned out to be Rukira. Robin Kencel of Greenwich recalls that when she first visited the health center, "I thought it was an abandoned place. There were no signs of life. And all the rooms looked the same, except the 'operating room' had a flat metal bed and a pail in a corner, and the 'patient rooms' had torn up mattresses. The 'kitchen' was a stone fireplace with a few battered utensils lying around."

But the dismal facilities did not discourage Kencel's companion on the visit, IMB nurse Manzi Anatole. "He proudly showed me the first improvement to the clinic—an electrical source to supply partial light and energy. Manzi's enthusiasm and focus were all the assurance I needed to convince me that the clinic was on its way to being a place of care and solace, reminding me that ultimately, we invest in people and not just projects."


The investment in Rukira has yielded a dramatic transformation. The battered wards are hardly recognizable, with mattresses on the beds and brightly painted murals on the walls. The roofs no longer leak. A well-equipped kitchen provides nutritious meals for patients who formerly had to rely on

their families to bring food. Step outside and the transformation continues. The health center is now surrounded by flower beds, a fish pond, a playground, and an arbor that has become a popular backdrop for wedding photos.

The changes at the health center are far more than cosmetic. The number of nurses on staff has doubled. An IMB doctor now makes weekly visits. An ambulance was purchased. A water project was implemented to provide running water for the first time.

The Greenwich community put up all the money needed for these improvements. They also helped out with some of the work. During the summer of 2007, 11 members of Trinity Church traveled to Rukira, rolled up their sleeves, and picked up paint brushes and garden tools to help with the makeover.

"The community just keeps growing and changing," Lesley King remarked. "Not everybody makes a big donation. Some people have become ambassadors for PIH. Others have focused on related projects. We consider them all part of the community of concern as long as they are bringing attention and resources to the area."

That they are doing—proving, in Lesley King's words, that "we're two communities with one concern." 

Support for PIH takes many different forms

Each year, we are impressed and deeply touched by the many ways our friends reach out to help support our programs. From running marathons to organizing dance marathons, the creativity and dedication displayed in these projects are as inspiring as the donations are appreciated. Below are just two recent examples. To find out other ways you can help support PIH, please visit: www.pih.org/inforesources/news/support_pih.html

FACE AIDS stages a dance dance revolution

A 24-hour dance marathon organized by students at Stanford University and FACE AIDS raised over \$110,000 for PIH earlier this year. With no caffeine or sitting down allowed, hundreds of dancers had to rely on their commitment to social justice (and jugs of gatorade) to keep their bodies moving and grooving into the wee hours of the morning and beyond.

“Dance Marathon provided a powerful statement from Stanford students that they believe letting millions of people die from a preventable and treatable disease is unacceptable, that we know that we can do better,” said FACE AIDS Director Dave Ryan.


Since 2005, FACE AIDS has made a difference both on campuses in the

U.S. and in villages in Africa. The organization started by a handful of Stanford students has recruited 150 high school and university chapters, and has helped to support over 170 individuals affected by HIV in Zambia and Rwanda. This year, FACE AIDS passed a major milestone by reaching its goal of raising \$1 million for PIH programs in Africa.

“The impressive fundraising is empowering for students because it shows them that they have the power to make a real and direct impact in the fight against AIDS and the fight for global health equity,” said Ryan. “Dance Marathon and events like it not only provide direct support for PIH’s work on the ground in Rwanda, they inspire students to become advocates

for the cause of global health equity, and social justice more broadly.”

About 100 student leaders representing over 30 FACE AIDS chapters from schools all across the country are expected to take part in the organization’s third annual Fall Conference, taking place November 14 and 15 at Stanford. The students will participate in workshops on conducting creative and effective campaigns to raise awareness about inequity in global health and to raise funds for PIH in Rwanda. Students will also attend panel discussions featuring leaders in global health, including Paul Farmer and other representatives from Partners In Health.

To learn more about FACE AIDS, please visit www.faceaids.org. 

10-year-old sells candy to feed Haitian children


Eliza Forrest was troubled. She had heard about food shortages and rampant poverty in Haiti. A young friend had told her about how she had gotten very sick while visiting family in Haiti, did not have access to medical care, and had to fly back to the U.S. without even seeing a doctor. Eliza realized that her friend was lucky, that millions of Haitians don’t have the option of coming to the US if they are sick or hungry. Eliza’s heart went out to them, and she decided to take action. But as a 10-year-old fifth-grade student, what could she do? How could she help hungry children in Haiti?

On a Friday morning this spring, the staff at the Boston PIH office was surprised when a small, smiling girl in



Eliza Forrest presenting PIH with her fundraising efforts.

a bright pink sweater popped in with a candy box stuffed with money. The enterprising Eliza had single-handedly fundraised \$160 by selling bubble gum and lollipops at her church and school in Somerville, MA. As it costs about 25 cents to provide a child with a warm school lunch in Haiti, Eliza’s donation provided 640 meals to students who would otherwise have gone without, said Christine Hamann at the PIH development office.

“To see a student like Eliza realize that a project feasible for a fifth-grader could make a significant difference in the lives of our patients in Haiti is inspiring,” said Christine. “We’ll be very lucky if other kids her age become engaged in social justice issues.” 

Dateline PIH: Project updates from all over

Promotores juveniles become valuable resources for communities and families in Peru

Socios en Salud (SES), PIH's partner organization in Peru, teaches youth health promoters (*promotores juveniles*) valuable communications skills, tutoring skills, and health information to help other children in their communities.

Community Health Workers in Carabayllo, a shantytown on the outskirts of Lima, Peru, have been dedicated activists in bringing comprehensive health care to their neighbors since SES began work there in 1994. Following in the footsteps of these community activists, a similar network of *promotores juveniles* is evolving into a powerful local resource for children and families in the area.

The group of *promotores juveniles* is composed of local adolescents between the ages of 13 and 20 who receive



Youth health promoter tutoring a younger student.

special training from SES's Child Health Team to mentor young children. The teens, many of whom participated in SES programs in primary school, help supervise SES-

crafted education programs in participating public schools as well as in after-school activities and homework help at SES's Lois and Thomas White Community Center.

In addition to their time with the children, the youth promoters help organize community fund-raising activities and bring up other issues of concern within the community or among peers. As teenagers in situations of poverty are often faced with the responsibilities of adulthood at an early age—feeding and supporting their families, taking care of younger family members, etc.—they are also exposed to adult pressures of drug and alcohol use, sexual exploration, and gang membership. By arming youth promoters with the information and support networks they need to confront these kinds of situations, SES hopes to foster a sense of social responsibility that will sculpt their roles in the community.

PACT project takes on diabetes in Boston

PIH's *accompagnateur* (community health worker, CHW) model of care has proven its effectiveness in treating infectious diseases like tuberculosis and HIV. In a new collaborative effort, the Prevention and Access to Care and Treatment (PACT) project in Boston is adapting the model to treat a chronic disease: diabetes.

As countries become more affluent and their people adopt richer diets and more sedentary lifestyles, chronic diseases impose an increasingly heavy burden in death, disability, and medical costs. PACT hopes that their new initiative, which will provide services to patients as part of a randomized controlled study, will eventually show that the *accompagnateur* model can be successfully used to improve treatment of diabetes.

The new project will target high-risk patients, many of whom suffer from other conditions that increase the risk of treatment failure, such as obesity, mental health issues, and poverty. Many of these patients have also failed to adhere to treatments in other programs. The initiative is partnering with the Codman Square Health Center, which serves neighborhoods with some of the highest rates of diabetes-related deaths in the Boston area—Mattapan, Dorchester, and Roxbury.

Like PACT's HIV/AIDS program, *accompagnateurs* in the new diabetes project will visit about 90 patients in their homes and deliver medical services, social support, and education

on diabetes, nutrition, and exercise. The project will also work to improve access to affordable healthy foods and exercise opportunities in the community, and help the health center provide more activities for their diabetic patients (such as exercise groups and snack clubs). A control group will receive standard care at their health center.

"Ultimately we hope not only to positively impact those patients in the program and study, but also to contribute data to local and national movements to improve the working conditions of CHW's and the sustainability of CHW-based programming," writes Leah Jacobs, the project's coordinator.

Multimedia Haiti and Lesotho

The Harvard News Office recently reported on a sampling of efforts by Harvard University and its affiliated institutions to improve health around the world. Partners In Health projects in Haiti and Lesotho were among those featured.

Check out this impressive package of heartbreaking and inspiring stories, photos, and videos at: www.news.harvard.edu/worldmedia.



Justin Ide, Harvard News Office

A building to build skills in Rwanda

PIH's partners in Rwanda recently built a new training center to aid efforts to strengthen the country's health care workforce.

Constructed with support from the Bill and Melinda Gates Foundation, the center includes a large auditorium, library, cafeteria, classrooms, offices, a computer room outfitted with 30 laptops, and a dormitory that accommodates about 70 people, and has already been put to use for a week-long training for community health workers (CHWs).

Participants were very

enthusiastic about the new facility. "[The training center is] very professional, [it] makes us feel serious," said one participant.

This fall, the training center will host more CHW trainings, and will begin holding regular staff meetings, clinical sessions for staff, and trainings in electronic medical records and computer literacy.

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.



A classroom in the new training center, prepared to host a training session for community health workers.

Support groups for children and their HIV-positive parents in Haiti

Smiling radiantly, a two-year-old child follows her HIV-positive mother to the clinic. As long as the child is cared for and fed, she is oblivious to the struggles of her parent. Yet developmentally, the indomitable spirit of youth is soon eroded by the stresses and anxieties of their parents. As adolescents, such children often become isolated by the loss of their parent(s), the inability to

go to school, and the economic collapse of their families.

Zanmi Lasante (ZL) recently began implementing a curriculum for psychosocial support groups for adolescent children living with this heartbreaking reality. The project, "Tout timoun se moun" (every child is a person), was designed to reach out and provide intensive social support for children affected by HIV.

The first groups consisted of HIV-positive parents discussing ways of coping with their own illness, emotions, and relationships with their families, and how they can better support their children. Soon after, their children (ages 10-17) began attending groups of their own to discuss ways that they can better cope with their parents' illness. Over the next year, ZL hopes to expand

these groups and provide opportunities for more children and their parents to become involved. Currently about 220 children who were deemed most "at risk" of severe levels of depression and anxiety are involved in the groups. An additional 270 children enrolled in the study are receiving individual follow-up from social workers at six of ZL's hospitals.

School-children and neighbors joined a network of community health workers to help distribute thousands of bednets.



Blanketing Malawi with mosquito bednets

Last year, the rural Neno District of Malawi reported more than 52,000 cases of malaria. The disease was responsible for hundreds of deaths and was the most common diagnosis in the outpatient clinics.

In October, PIH's partner organization in Malawi, Abwenzi Pa Za Umoyo (APZU), worked with the Ministry of Health to distribute over 26,000 insecticide-treated mosquito nets (ITNs) to the households with those at most risk of contracting the disease (young children, pregnant women, and people living with HIV/AIDS).

As the species of mosquito that carries malaria is most active at night and tends to bite people as they sleep, ITNs have been proven as a safe, effective, low-cost way of protecting against bites from malaria mosquitoes, thus preventing the disease.

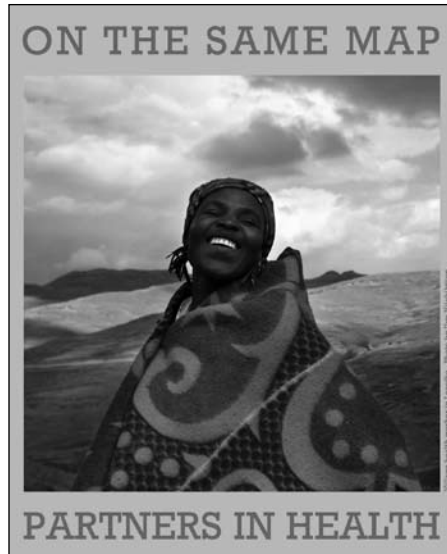
The Against Malaria Foundation and Together Against Malaria donated 26,000 ITNs, and by the end of the year, APZU and its comprehensive network of community health workers will have distributed 34,000 nets throughout the district.

On the same map: A 20th anniversary photo exhibit comes to Chicago

To mark the 20th anniversary of its founding, Partners In Health assembled a photography exhibit depicting our work to combat the epidemics of AIDS, tuberculosis, hunger, poverty and injustice.

"If a picture is worth a thousand words," wrote PIH Executive Director Ophelia Dahl, "these images are worth millions for what they have to say about human dignity in the face of intolerable suffering and criminal indifference, about solidarity, and ultimately about hope."

The exhibit will be on display in Chicago at the Loyola University Museum of Art (820 North Michigan Avenue) from November 29, 2008, to January 4, 2009. For information about how you can bring this inspiring exhibit to a venue near you, please contact info@pih.org.



"...our privileges are located on the same map as their suffering, and may—in ways that we prefer not to imagine—be linked to their suffering, as the wealth of some may imply the destitution of others..."

*-Susan Sontag,
Regarding the Pain of Others*

Pushing boundaries: Past, present, and future

Partners In Health held its 15th annual Thomas J. White Symposium on October 4, in Cambridge, MA. The theme this year was "Pushing boundaries: past, present, and future."

The program featured a panel of HIV patients who shared their stories of being provided with life-saving antiretroviral drugs by PIH's partner organization in Haiti, Zanmi Lasante. Another panel highlighted activists who have used the PIH model and philosophy of social justice to create their own programs to provide health care to the poor and inspire the next generation of social justice activists. PIH co-founders Paul Farmer, Ophelia Dahl, and Jim Yong Kim were also featured speakers. To view the video of the event, please visit: www.pih.org/inforesources/news/TJW_symposium_2008_video.html.

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Over 20 years of health and social justice

