



PIH Bulletin

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In This Issue

COVER STORY
Why Rwanda? 1

FOCUS: WOMEN'S
HEALTH IN HAITI
Preventing the Jènm
Maladi 4
Expanding the Proje
Sante Fanm 6

ALSO IN THIS ISSUE
New Clinic in Amatan. 10
TB Training in Russia. . . 12
PACT Relocates 13
1000 x 1000 Update. . . . 14
Recent Events 15

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Based in Boston, Massachusetts, PARTNERS IN HEALTH works hand-in-hand with its partners in Haiti, Peru, Russia, 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.

Why Rwanda? PIH to Launch New Project in Africa

Partners In Health's response to the global AIDS epidemic has been constrained only by the limits on our resources. The advent of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, founded only three years ago, changed our prospects, as did the publicity that followed the publication of Tracy Kidder's Mountains Beyond Mountains. These developments, along with improved fundraising and administrative capacity in the Boston office, have allowed us to revisit the possibility of expanding and to ask the hardest question: given the enormous need in so many of the countries that have approached us, and given the many promising partnerships suggested, how would we go about choosing the one place to set down new, deep roots in proper PIH style?

Over the past several years, Partners In Health has grown significantly. We've more than doubled the size of our staff in several of our partner projects; in Haiti, Peru, and Russia we have served in one way or another in major public health initiatives financed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In central Haiti, where the great majority of our patients are, Zanmi Lasante now runs, in concert with the Ministry of Health, five new public health centers. We've grown here in Boston, too: most PIH doctors are now also part of the Brigham and Women's Hospital's pioneering Division of Social Medicine and Health Inequalities, and our teaching and research efforts through the Department of Social Medicine at Harvard Medical School have also expanded.

Of our project sites, even the newest—our successful efforts within the prisons of Tomsk, Siberia—is now four years old. Why have we not undertaken “new” commitments in “new” settings in recent years? It hasn't been for lack of requests: during the past two years, especially, we've been inundated with appeals for technical assistance and more from Ministries of Health, non-governmental organizations, universities, and medical schools around the world.

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PIH medical director Joia Mukherjee with children in Rwanda. UNAIDS estimates that there are up to 240,000 AIDS orphans in the country.

Why Rwanda? continued

Scores of these requests have come from Africa, a continent designated by our board—and by epidemiological burden—as the priority setting for any future PIH endeavors.

Partners In Health has always had two chief reasons for caution in taking on truly new commitments. First, we decided years ago that any partnerships we established would be long-term. Almost all of the major projects we initiated in the 1980s and 1990s are still on-going. A second reason for caution is driven home every day in Haiti: the poorer the setting, the more comprehensive the response required. In central Haiti, it is impossible to only have “an AIDS project” when AIDS is just one of several serious health problems faced by those living in dire poverty. And so, although many compelling requests for assistance came to us from poor countries in Africa, places to which all of us felt drawn, the time was not yet right for PIH; we did not want to make promises that we couldn’t keep. With our expansion in Haiti just beginning, and with thousands of patients under our supervision there as well as in Peru and Russia, we worried that expansion into Africa would mean having to scale back many of our projects for lack of funding—something we would not do.

Three years ago, we received one of our first invitations to work in Rwanda, a country that had been torn, like Haiti and Guatemala, by great violence. Indeed, Rwanda is like Haiti in many ways—a small, overcrowded, ruggedly mountainous country. Like Haiti too, Rwanda is beset by social problems stemming from a history of political unrest that culminated in the 1994 genocide, and by a significant AIDS epidemic. Just

Over 800,000 Rwandans were slaughtered during the 1994 genocide—the fastest mass killing of civilians in recorded history. A brutal colonial legacy, deepening poverty and inequality, and longstanding ethnic tensions all contributed to the horrific outpouring of violence, but the genocide was not simply an uncontrollable manifestation of rage by a people consumed by “ancient tribal hatreds.” Rather, the genocide resulted from the deliberate choice of a modern political élite to foster hatred and fear in order to keep itself in power.

The U.N. peacekeeping force in Rwanda played an especially painful role in 1994: that of impotent spectator to the mass slaughter of civilians. The role of France, the United States, Belgium, and other governments were similarly ignominious. At a point when Rwanda was literally overflowing with corpses, U.S. and U.N. officials dithered over the semantics of the word “genocide” and opposed the provision of critical manpower and supplies. In the end, it was the Rwandan Patriotic Front, a rebel army led by current president Paul Kagame, that captured Kigali and halted the genocide.

During and after the genocide, between one and two million Rwandans were displaced in refugee camps in neighboring countries, mainly Zaïre.

how significant is not known: estimates vary widely, but most believe that between 8 and 13 percent of the population is infected with HIV. Less disputed is the number given for life expectancy at birth: although Rwanda’s GNP is pegged as higher than Haiti’s, average life expectancy at birth is only 38 years, a decade less than in Haiti. The leading causes of death are infectious diseases—the very ones PIH seeks to prevent or treat in our current programs.

So when renewed invitations followed—coming not only from the Rwandans but from a partner organization, the Clinton HIV/AIDS Initiative, we began to see a way for PIH to work, at last, in Africa. The stars seemed aligned: there is clearly, in Rwanda, a good deal of what is called in the jargon “political will.” The current government has even created a cabinet-level AIDS position—something that few other countries have done—and set bold goals for access to antiretroviral therapy (ART) for those who need it.

Indeed, thousands of patients—most of them in the capital city, Kigali—are already enrolled in treatment. We had made good friends within the Rwandan Ministry of Health and were impressed, during the course of trips made in 2003 and 2004, by their desire to integrate TB and HIV care; by the technical competence of those in charge of the national programs; and by the existing health infrastructure, even in rural areas. We were also eager for the opportunity to work with the Clinton Foundation, which had been one of our partners in the global campaign to lower the costs of antiretroviral therapy and press the case for expanding access to AIDS treatment. Thinking ahead to the transport of staff, supplies, and medications, the existence of decent roads in Rwanda makes travel across the country far easier than what we are accustomed to in, say, Haiti. Finally, Rwanda has known, in recent years, a stability that neither Haiti nor Guatemala can claim.


* * *

Concerns about political entanglement and the ramifications of “relief work” in settings of violence are not unwarranted.¹ As we commence our work in Rwanda, we see ourselves not as “relief workers” but as a group working in solidarity with the victims of what we’ve called “structural violence.” Our plan is to initiate, with Rwandan co-workers, a comprehensive AIDS prevention-and-care program aimed at the neediest populations. This term is broad and includes, certainly, refugees and people displaced by war.

If over the past two decades PIH and its many partners have garnered any special insight, it’s that it is possible to deliver high-quality medical services to the poor even in times of violence and political instability. Our projects in Haiti have weathered a dozen *coups d’état*; our work in Peru began at the tail end of a civil war; our efforts in Chiapas and Guatemala have been shaped determinately by violence. Rwanda has also felt the devastating blows of structural violence, especially evident in the staggering number of

documented victims of gendered violence.² One of the first tasks at hand is to bring proper medical care to these women and to their children. The *British Medical Journal* reported in April 2004 that an estimated 70 percent of the 25,000 current members of the Rwandan Widows’ Association are HIV-positive, mainly because they were gang-raped during the genocide ten years ago. Most of those women are now dying, untreated, of AIDS. The current cost of AIDS treatment, pegged at \$138 per month by the author of said article, is beyond the means of most of these women. International efforts to provide ART to some of the estimated 500,000 Rwandans living with HIV are set to commence this year, but only one small program prioritizes rape survivors. Although many of these victims have been brave enough to recount their stories and even to identify, when possible, the perpetrators, most are still far from receiving life-sustaining therapy. As they sicken and die, another chance to do justice is lost. “If you have not protected somebody in

1994, at least stop her dying now, 10 years later,” said Esther Mujawayo, a survivor and founder of the Widows’ Association. “Or what are we saying? Women are still dying and again the world is watching.”³

As PIH takes on its first major new project in years, we’ll be asking staff, partners, and our funders to help us to do justice through pragmatic solidarity with the poor of Rwanda. We will not be able to do a good job there unless we’re willing to respond to the needs of those we serve, and these needs will move us, as ever, far beyond any one disease or affliction. 

Paul Farmer is a co-founder of Partners In Health.

In addition to our partnership with the Clinton Foundation, PIH’s work in Rwanda would not be possible without the generous support and unwavering encouragement of PIH board member Diane E. Kaneb and her husband, Albert J. Kaneb.

¹ The experience of Médecins Sans Frontières in neighboring Zaïre following the Rwandan genocide suggests that there are situations in which humanitarian interventions are problematic. I can still recall horrific news reports and images of the cholera outbreak in the refugee camp at Goma; I was in medical school at the time. Only later did we learn that the refugee camps were often only nominally under the control of the United Nations or other relief organizations such as MSF; the camps had in fact been hijacked by the architects of the genocide, who had fled Rwanda with enormous reserves of cash and armaments and set up a parallel government in exile, a government that openly declared its plans to continue the war and complete its genocidal project. More to the point, the *génocidaires* had profited directly from the humanitarian aid that poured into Zaïre after the genocide. Fiona Terry, then working with MSF in the Goma camp, writes searingly about mistakes made in allowing humanitarian aid to be diverted to the regrouped *génocidaires* and the former Rwandan military:

The history of the Rwandan refugee camps graphically illustrates the paradox of humanitarian action: it can contradict its fundamental purpose by prolonging the suffering it intends to alleviate. Relief agencies rushed to avert immediate disaster among the refugees pouring into Tanzania and Zaïre, but inadvertently set the scene for the eventual disaster. . . . Former leaders manipulated the aid system to entrench their control over the refugees and diverted resources to finance their own activities. In short, humanitarian aid, intended for the victims, strengthened the power of the very people who had caused the tragedy. The consequences were devastating. (*Condemned to Repeat? The Paradox of Humanitarian Action*. Ithaca, NY: Cornell University Press, 2002, 1-2).

² Writing in the *Lancet*, Paula Donovan, a longtime U.N. advisor on gender and HIV/AIDS in Africa, observes:

No-one knows how many of the genocide’s massacred were already HIV-positive, or what proportion of the. . . adult Rwandans now living with HIV/AIDS became infected during the genocide. We will never know whether the rapes committed during the genocide account for today’s high HIV/AIDS prevalence in Rwanda, or whether, if uninterrupted by that horrific period of wholesale destruction, the natural course of the pandemic would have brought the country, like so many of its neighbors, to a comparable rate of infection today. (Rape and HIV/AIDS in Rwanda. *Lancet* 2002;360(S):S17-8.)

³ “By contrast, the official channel for American aid, USAID, mentions prisoners convicted or suspected of participating in the genocide as a target group for AIDS counseling and testing. . . . The leaders of the genocide, facing justice at the International Criminal Tribunal for Rwanda in Tanzania, routinely receive antiretroviral treatment. The British government has pledged £200,000 over two years to treat genocide witnesses with AIDS but has not offered treatment to the wider population of rape victims” (Hilsum L. Rwandan genocide survivors denied AIDS treatment. *British Medical Journal* 2004;328(7445):913.).

Preventing the *Jènm Maladi*: The PMTCT Program in Boucan Carré

Mother-to-child transmission of HIV at birth or through breastfeeding, now nearly unheard-of in the United States, remains a ranking problem in Haiti and other resource-poor settings. The Pan American Health Organization estimates that 30 percent of children born to HIV-positive mothers in Haiti will have the virus at birth. The risk of transmission through subsequent breastfeeding is also high, 10 to 17 percent. Recently, Zanmi Lasante scaled-up its prevention of mother-to-child transmission of HIV (PMTCT) program in Boucan Carré, designed to reduce and ultimately eliminate HIV transmission from seropositive mothers to their infants.

PMTCT mothers are tough. They carry an eight-month-old child on one arm and a fifteen-pound box of infant formula on their head. These women ford rivers and trek for hours on rocky mountain paths to visit the new Partners In Health/Zanmi Lasante (PIH/ZL) hospital in Boucan Carré, the Centre de Santé Saint Michel, at least once a month. These are women who give birth in the hospital in the morning and walk home in the afternoon. These women are HIV-positive but are doing everything they can to protect their babies from the virus.

On this Saturday morning in mid-December, 13 HIV-positive mothers have gathered at the hospital for a

PMTCT training session. They are all either pregnant or have a child younger than 18 months. While some of the moms do not know their own age, and many have never left their village, they do know that breastfeeding can pass on the *jènm maladi*, HIV, to their babies.

“Did everyone get a pot?” Marielle, the nurse midwife, asks the group. “Wi,” the mothers reply in chorus. “Does everyone have a bottle and infant cup?” Again, “yes.” Zanmi Lasante provides every mother in the PMTCT program with all the supplies necessary to prepare infant formula: a pot to use exclusively for boiling water, a bottle, an easily-sanitized infant cup, and a nine-month supply of formula. Every month, each

mother brings her baby for a check-up so that Zanmi Lasante medical staff can track both the child’s and the mother’s health. When they come for their appointments, the mothers collect the next month’s supply of infant

formula. All the HIV-positive mothers and their newborns also receive appropriate antiretroviral therapy (ART) or prophylaxis.

Unsafe drinking water poses a significant danger in the use of infant formula in a place like Haiti, where potable water is virtually nonexistent. Yvrose, one of the PMTCT mothers, knows the consequences all too well. On November 10, 2004, she gave birth to a baby girl, Danaika. Though several weeks premature, Danaika was healthy. Yvrose, however, was not. After delivery she began vomiting incessantly, and so she returned to the hospital for five days. Yvrose left Danaika, along with her infant formula, in the care of her mother, Danaika’s grandmother. Perhaps Yvrose was so sick that she neglected to tell grandmother to boil the water, or perhaps grandmother forgot. Whatever the reason, grandmother did not use clean water to mix Danaika’s infant formula. After three days of diarrhea, Danaika died.

In the United States, it is standard protocol for HIV-positive women to abstain from breastfeeding. Not so in developing countries, where formula feeding is often discouraged by public health experts. Skeptics would point to Danaika’s death as a perfect example of why formula feeding is simply too dangerous in a place like Haiti, where fewer than half



Yvrose and Danaika, shortly after birth. Sadly, Danaika died just days later of diarrheal disease, a common occurrence in areas with unsafe drinking water.

of the rural population has access to safe drinking water. Yes, the experts say, formula feeding will reduce the incidence of HIV transmission, but it will *increase* the overall child mortality rate because of unclean water and improper preparation of formula. Furthermore, they argue, infant formula is quite expensive.

In spite of the cost, Partners In Health believes that the benefits of formula feeding—i.e., preventing HIV transmission from mother to infant—far outweigh the risk posed by breastfeeding. The risk of transmission per liter of breast milk is 1:1,000, which is similar to the risk of transmission per episode of unprotected heterosexual intercourse. However, if an infant is born seronegative and the mother does not breastfeed, there is zero chance of transmission. Zanmi Lasante thus does whatever it takes to make formula feeding a safe reality for the women in the communities we serve.

The PMTCT program at Boucan Carré faces many challenges, but the overall impact has been positive. The risks—severely limited access to potable water, improper preparation of formula, and an irregular supply of formula—are difficult, though not impossible, to overcome. The more HIV-positive mothers participate in the program, the more success sto-



Formula feeding is critical in preventing HIV transmission from mothers to their newborns.

ries we will have to share with new moms entering the program. The more experience ZL staff and mothers have, the more communal wisdom there will be in Boucan Carré. The program will grow larger and more robust. Education alone, however, will not be enough if these mothers do not have access to quality health care, food, and clean drinking water as well. For Zanmi Lasante, the unavailability of potable water should not be a factor in the debate over breastfeeding versus formula feeding. Rather than accepting it as an excuse to forgo formula feeding, we see lack of access to clean water as a mandate

to fix the water system. Two water projects have already been completed in Boucan Carré, and another is underway.

* * *

At the PMTCT training session, Marielle demonstrates how to properly mix the infant formula. The new mothers are attentive. The experienced ones, who know the process all too well, watch disinterestedly; they can recite the process in their sleep. Marielle shows the mothers how to thoroughly clean a gallon container to hold the boiled water. Less bacteria will enter a tightly capped container, she explains, than a covered pot. She

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The goal of PIH/ZL's water projects, a key component of our Program on Social and Economic Rights, is to improve access to safe drinking water by installing or renovating existing water systems and by teaching local communities to use their water resources effectively.

Water projects differ depending on local needs, resources, and existing infrastructure. Most PIH/ZL water projects include the construction of a spring cap, the drilling of a well, or the installation of a full-scale hydraulic pump. Other components include restricting animal access to water sites (by means of barriers and/or digging separate watering holes); building cisterns to store collected water; installing sedimentation boxes to improve water quality; constructing

accessible terminal fountains; preserving upstream banks to protect the hydraulic equipment and water source from damage and clogging caused by erosion; and training local communities on proper water use and storage and health implications.


Preventing the *Jènm Maladi* continued

walks around the circle, holding a cup and pointing to the measuring lines on its side. She passes around the prepared milk so that the mothers can note the proper consistency. Marielle sees that Julienne, mother of five-and-a-half-month old Nelson and one of the more experienced formula-feeding moms, is bored. When she completes her demonstration, Marielle asks Julienne to repeat the process for the group. Julienne expertly mixes the formula, then giggles as she runs around the circle, imitating Marielle, thrusting the cup of milk inches away from each mother's eyes. Everyone laughs,

including Marielle.

Dr. Jérôme Gregory, head of the HIV and TB program at the Centre de Santé Saint Michel and a firm supporter of the PMTCT efforts, is also present at the meeting. Holding a box of oral rehydration salts, he looks the mothers in the eyes. "Any baby with diarrhea must begin the oral rehydration serum immediately, and then be brought to the hospital," he says emphatically. "Death is possible." The mothers are silent.

Marielle turns to Sonia, five months pregnant: "Sonia, please describe to everyone how to mix the oral rehydration serum." Face

firm, chin up, eyes straight ahead, Sonia explains the process to the other twelve mothers in the room: "Mix three plastic soda bottles of water that is *byen, byen bouyi*—well, well boiled—with the packet of oral rehydration salts." Just eight months before, Sonia had lost her newborn baby; she will not let history repeat itself. Neither will any of the other mothers in the room, nor Marielle, nor Dr. Gregory, nor the rest of the Zanmi Lasante staff. 

Elizabeth Whelan has been working in Boucan Carré since September 2004.

Expanding the Proje Sante Fanm

The rain had fallen hard the night before. The narrow footpaths crisscrossing central Haiti were slippery with mud, making it even more difficult for 25-year-old Naromie Axilian (not her real name), now 39 weeks pregnant, to climb up and down the many mountains that lie between her hut and the health center. After eight hours of walking, Naromie arrived late in the evening at the new Boucan Carré hospital, where she laid down her blanket on the cold, hard earth alongside other waiting patients and slept restlessly until the clinic opened the next morning.

This was Naromie's first visit to the Boucan Carré hospital. The midwife performed a physical exam and some routine tests, including for syphilis and HIV. Naromie was told to return the following day for her test results. Unable to make the long trip home only to return again the next day, she spent another night sleeping outside the clinic. With the dawn of the next morning, Naromie learned she was

HIV-positive.

Naromie was born and raised in a small village in Haiti's Central Plateau. She lived with her parents, sister, and two brothers in a one-room hut with a dirt floor and a thatched roof. Like most people in rural Haiti, Naromie's family practiced subsistence farming. She attended school for only three years before being forced—due to lack of money for books, uniforms, and fees—to stop and find work. She began selling rice, oil, and other food staples at the local market. Her family continued to struggle economically, particularly after a devastating bean crop, and Naromie was sent to Port-au-Prince to find work. Lonely and in unfamiliar surroundings, Naromie met a young man with whom she had her first and only sexual encounter. Upon learning that Naromie had become pregnant, he abandoned her and took all of the money she had been saving. Panicked and alone, Naromie returned to her home village.

Unfortunately, Naromie's story is all too common in rural Haiti, where women face myriad obstacles and dangers that heighten their vulnerability to disease and poverty. Due to economic hardship, many of the women we serve at our Partners In Health/Zanmi Lasante clinics in the Central Plateau were obliged, as young girls, to leave school and find work, often far from home, where they were coerced—directly through physical force or less directly as a consequence of the desperation engendered by their dismal straits—to enter into exploitative sexual relationships. This repeated pattern results in a high incidence of unwanted pregnancies and sexually transmitted infections (STIs), including HIV.

While sweeping political, social, and economic reforms are needed to alleviate the senseless suffering and injustice on a grand scale, PIH/ZL

* * *

is taking small but important steps towards breaking this crushing cycle by providing comprehensive, free health care—obstetrical and gynecological care, family planning services, and testing and treatment for STIs and other illnesses—for these vulnerable women through the Proje Sante Fanm (women’s health project).

Obstetrical Care

Perhaps the gravest risk to Haitian women’s health and well-being is, simply, becoming pregnant. Due to lack of access to doctors, midwives, and nurses, among other factors, Haitian women are forty times more likely to die from pregnancy-related complications than are women in the United States. At PIH/ZL, we ensure that women can give birth safely by making available high-quality prenatal, intrapartum, and postpartum care by trained obstetrical providers. Each Zanmi Lasante site in the Central Plateau has a fully-functioning women’s health clinic staffed by a



New mothers and their babies return to the clinic for monthly check-ups.

well-trained, college-educated Haitian midwife. Additionally, there are four full-time obstetrician/gynecologists who cover all six sites.

In addition to our trained clinicians, PIH/ZL also relies on *matrons*, traditional birth attendants, to help women deliver babies at home. *Matrons* are men and women with no prior formal training who have nonetheless been identified by their community as capable of helping in the delivery of babies. PIH/ZL has long recognized the invaluable services provided by these experienced and accessible *matrons*, and offers trainings and monthly review sessions to train the *matrons* to identify complicated or high-risk pregnancies that need to be referred to a clinic or hospital. PIH/ZL also supplies *matrons* with birthing kits containing gloves, gauze, vitamin A, soap, a scrubbing brush, a razor blade, a plastic drape, and string to clamp the umbilical cord to help protect the *matrons*, mothers, and newborns from infection. The partnership between PIH/ZL clinicians and *matrons* ensures that pregnant women receive the safest and most efficient obstetrical care possible in rural Haiti, inside and outside the clinic.

Gynecological Care

Gynecological problems in Haiti range from straightforward urinary tract infections and perimenopausal symptoms to life-threatening breast masses and sexually transmitted infections. Aggressive screening and treatment of STIs is one of our top priorities. A recent study performed by our Boston and Haiti-based staff found that the rate of STIs in the Central Plateau is alarmingly high, with nearly 20 percent of new patients presenting to Zanmi Lasante’s women health



A health worker in Lascahobas explains the female condom to a curious crowd.

clinics with at least one STI (Smith Fawzi et al., 2004). When certain STIs go untreated, not only is the rate of transmission of HIV elevated up to tenfold, but women are also at greater risk for impaired fertility and other potentially fatal consequences. Additionally, pregnant women with untreated STIs are at risk for preterm delivery, miscarriage, and neonatal complications such as blindness and pneumonia. At Zanmi Lasante clinics, every pregnant, symptomatic, or at-risk woman is counseled, tested, and, if necessary, treated using algorithms that reflect the local epidemiology. Every woman is encouraged to have her partner tested and treated as well, so as to avoid re-infection. In the future, we hope to perform another study to evaluate the effectiveness of this aggressive and comprehensive effort to reduce STIs.

In this upcoming year, PIH/ZL is committed to expanding the women’s health program by improving our ability to detect and treat cervical and breast cancer. For many years, palliative care was all we had to offer

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Expanding the Proje Sante Fanm continued



Julie Mann examines a pregnant woman at the Boucan Carré clinic.

women who presented with advanced breast cancer. We are now working with a team of radiographers and specialists to bring a mammography machine to Haiti and are also training local staff to perform better clinical breast exams, read mammograms, do biopsies, and provide treatment when needed. Cervical cancer is the most common cancer for women in developing countries, and in recent years many women have presented to our clinics with very advanced, invasive disease. Zanmi Lasante does not currently have the capacity to perform routine Pap smears, but one of our goals for 2005 is to bring Pap smear screening to all of our sites. Countless lives will be saved when we are able to offer comprehensive cervical and breast cancer screening and treatment.

Family Planning

Family planning, one of the most effective ways of reducing maternal mortality, is another essential component of our women's health program.

When women are counseled, educated, and provided with contraceptive options, they are more likely to delay childbearing, have fewer children, and reduce their risk for obstetrical complications. For over 14 years, PIH/ZL has been offering free condoms and other contraceptive methods, and at each of our sites there is a full-time nurse with specialized training in the provision of sex education and reproductive health counseling. Additionally, for women who decide they do not want to get pregnant again, we offer permanent sterilization through tubal ligation.

Despite a high patient volume at our family planning clinics, there are many women who, unable to make the long journey, are not benefiting from the education, counseling, and care we offer. To address their needs, two years ago Zanmi Lasante piloted a program in Cange to train and mobilize a new category of community health workers who specifically promote family planning and women's health issues. These *ajans fanm* travel throughout the countryside, teaching women and men about STIs (including HIV) and contraceptive methods, distributing condoms and oral contraceptives, and referring pregnant women and others to the clinics. The *ajans fanm* are proving to be an indispensable component of our women's health efforts, and we hope to expand the program to all of our sites this year.

Preventing Mother-to-Child Transmission of HIV

One of the most pressing problems we face in our women's health program is the transmission of HIV from pregnant women to their newborns. In rural Haiti, approximately

5 percent of all women attending prenatal clinics are infected with HIV. If these women receive no antiretroviral therapy during pregnancy, their chance of transmitting the virus to their infant at birth is 30 percent.

Zanmi Lasante recognized very early on that averting vertical transmission of HIV must be a top priority in our efforts to curb the epidemic. In 1995, we began providing HIV-positive pregnant women with zidovudine, which resulted in a 10 percent drop in the rate of vertical transmission. Zanmi Lasante currently offers every pregnant woman seen—about 10,000 a year—HIV counseling and testing. (The number of women who choose not to be tested is almost nil.) Women found to be HIV-positive are counseled and provided with a small monthly stipend to cover basic nutritional needs and monthly travel costs to the clinic. They are also paired with an *accompagnateur*, a community health worker who will deliver and observe antiretroviral therapy twice daily. Combination therapy—exactly what HIV-positive pregnant women in the United States receive—is extremely effective in preventing vertical transmission of the virus from mother to infant. (In the United States, vertical transmission is now almost nonexistent.)

When women present to clinic too late in their pregnancy for ART alone to be effective, we are able to perform cesarean sections and other surgical interventions in our three fully-equipped operating rooms. Again, this is equivalent to the care HIV-positive pregnant women receive in the United States. After birth, because of the high risk of HIV transmission through breastfeeding, we also urge all HIV-positive moth-

ers to formula feed, and, through the PMTCT program (see “Preventing the *Jènm Maladi*” on page 4), give them the means to do so safely.

Zanmi Lasante’s capacity to provide comprehensive, high-quality health care has been instrumental in reducing the rate of mother-to-child transmission of HIV to less than two percent in the areas we serve, and we are continuing to improve on these successes through education, screening, and treatment. In November 2004 we piloted an inexpensive PCR test—now used throughout the developed world—that has enabled us to more rapidly diagnose HIV in infants. Until recently, high costs, sophisticated laboratory requirements, and the need to refrigerate test samples made viral testing prohibitively expensive in resource-poor settings; we were constrained to using antibody testing to determine a baby’s serostatus, a method that is not definitive until an infant is at least 18 months old (the maternal HIV antibody, which passes from mother to child via the placenta, can last in the child’s system for



up to 18 months). The new test yields reliable, stable, and noninfectious samples that are easily shipped to Europe for lab processing. Confirming an infant’s serostatus within one to four months of birth allows us to provide more timely treatment and follow-up for the few infants who do contract the virus from their mother. Additionally, it is a profound relief for parents to know the serostatus of their child so much sooner.

Naromie’s Future

The services offered through Zanmi Lasante’s women’s health program are saving countless lives in the Central Plateau. Were it not for PIH/ZL’s expansion to the commune of Boucan Carré, where we revitalized what had been a dilapidated, poorly staffed, and underutilized health clinic (see “Boucan Carré Dedication: Celebrating ZL’s Expansion in Rural Haiti” in the Summer/Fall 2004 issue of the *PIH Bulletin*), Naromie would have had no place to seek prenatal care, learn her HIV status, and deliver her baby safely. More likely than not, she would have died from AIDS or from obstetrical complications. Thanks to the generous support of PIH’s donors, Naromie’s story continues to unfold.

After learning of her diagnosis, the Zanmi Lasante team—midwife, physician, nurse, and social worker—offered Naromie counseling, provided her with social support, and arranged for further testing. While PIH/ZL provides antiretroviral therapy to all preg-



A newborn receives a PCR test to determine her HIV status.

nant HIV-positive women as a matter of course, there was concern that, in Naromie’s case, ART alone would not be enough. The extent of her immunosuppression indicated that her HIV infection had progressed to full-blown AIDS, and she was very close to her due date. After much discussion, Naromie was taken to Zanmi Lasante’s main hospital in Cange, where a cesarean section was performed.

Today, Naromie is the mother of a healthy, HIV-negative, 18-month-old boy. Through the PMTCT program, she was given infant formula and taught how to boil water and clean bottles in order to feed him safely. Naromie and her baby return to the Boucan Carré hospital each month for health check-ups and family planning counseling. In addition to receiving daily directly observed ART from an *accompagnateur*, she participates in a social support group for women infected with HIV. Through Zanmi Lasante’s social assistance program, Naromie, in good health, is now employed as a cleaning woman at the Boucan Carré hospital where her life was saved. 🌟

Julie Mann is a nurse-midwife at Partners In Health.

Celebrating a New Community Health Center in Amatán, Chiapas

In August 2004, a group from Partners In Health visited our sponsored project in Chiapas, Mexico, the *Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC)*, or the Support Team for Community Health and Education. PIH's visit coincided with the inauguration of a new community health center in Amatán.

High in the lush green hills of northern Chiapas, the sound of laughter and the smell of simmering chocolate and chili *mole* mix together, wafting through the rain-fresh air to Julia's house on the hillside below the commotion. Julia, 44 years old and mother of six, has been unable to walk for several years due to severe rheumatoid arthritis, but she smiles when she hears the festive clamor. She thanks the *promotor* (health promoter) for his visit, for the acupuncture treatment she just received, and for his dedication to the people of their community. For several days there

have been processions and street fairs with sweetbreads and fireworks, and daybreak church services to honor the Bishop's visit. In this part of Amatán, however, something else is happening. Community members from this neighborhood and from the surrounding villages have brought a dozen chickens and bushels of fresh mangos and pineapples in preparation for a feast to celebrate the signing of community service agreements and the lease for the new health center.

This celebration launches a new era of locally-directed primary care services in Amatán and also celebrates the *promotores'* many years of dedication to the effort. Their training began several years ago under the auspices of EAPSEC, which, here as elsewhere in Chiapas, has trained *promotores* in public health, primary health care, and community development. Like *accompagnateurs* in Haiti, *promotores* in Chiapas are local community members of all ages, selected

for their commitment and willingness to serve. EAPSEC training sessions prepare *promotores* both for community leadership and for appropriate diagnosis and management of medical issues ranging from respiratory infections to nutritional deficiencies, musculoskeletal

complaints to traumatic injuries. For each condition, *promotores* are trained to assess and diagnose the immediate medical issue and, drawing on their own and the patients' local knowledge, suggest treatments both allopathic and alternative. However, *promotores* are also uniquely trained to assess underlying social, economic, and political factors which may contribute to the malady—issues often related to the pervasive poverty of the patients or to the difficulties of accessing preventive and care services.

The feast is a fitting tribute to the work of the *promotores* and a coalition of local leaders who brought the community health center to fruition. Prior to 2004, *promotores* had practiced from their homes using portable *botiquines*, medical kits. Built of solid cement blocks with a shiny metal roof, the new 1,200 square-foot center includes a well-stocked pharmacy, a community meeting space, a small cafeteria, and four exam and consultation rooms, enabling the *promotores* to centralize their services for the town's nearly 20,000 inhabitants. This impressive space was constructed in the first six months of 2004 with support from PIH and US-based church groups as well as extensive in-kind labor, gifts from community members and the local church, the mayor's discretionary funds, and other donations.

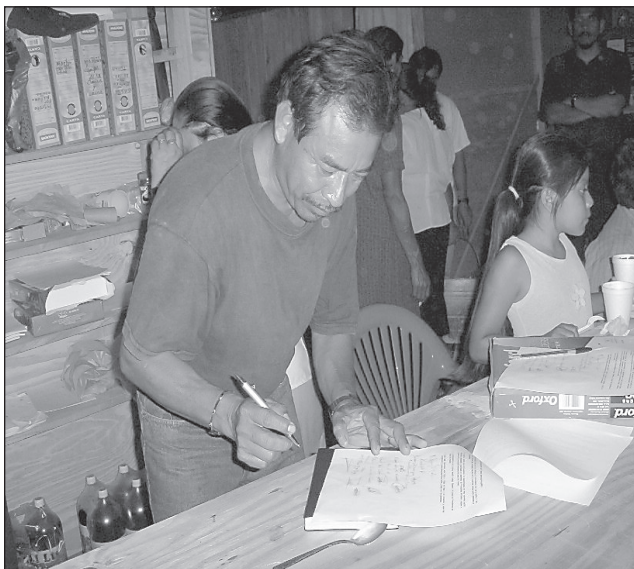
Amatán is rich in natural resources, but its residents, mainly indigenous Maya, have long struggled with poverty, political violence, and health



Many hands prepare fruit for the feast in Amatán.

problems that rank among the worst in the country. Throughout much of the southern Mexican state of Chiapas, violence by state-supported militias and federal army units have crippled access to basic health care. PIH has worked in Chiapas with the EAPSEC team since 1989, recruiting and training dozens of community health workers, developing local health services for those most in need (out of which arose the Amatan clinic project), and providing a model for ongoing education and community development as a mechanism for strengthening the pursuit of social justice and equity for all in Chiapas.

Over their 20-year history, EAPSEC has trained more than 500 commu-



A promotor signs an agreement formalizing his commitment to the clinic and to the community's health.

nity health promoters; currently the team supervises 96, all of whom operate in four regions of Chiapas state—Highlands, Soconusco, Northern, and Guatemalan Border—to address local health care needs. EAPSEC has written more than 20 training manuals which have been used in health education programs and distributed

to local communities. EAPSEC has also facilitated numerous community development and leadership training projects on topics such as maternal and child health, diagnosis and prevention of water-borne diseases, dental health, and tuberculosis case detection. EAPSEC draws upon communities' own strengths in problem solving and connects motivated learners to materials crucial for personal and social development.

Now that the Amatan clinic is operational and its patient load is increasing daily, EAPSEC is poised to expand the management and clinical training it offers *promotores* so that they will be able to maintain better local control and oversight and respond to local needs.

Just as a home visit is appropriate for Julia, given her condition, *promotores* will now be able to develop new outreach and clinical programs in response to trends they discover in the course of attending to local concerns. Several community-initiated projects are currently underway: participating in professional medical education by serving as a rural internship site for a medical college

in Mexico City, developing advanced tuberculosis detection facilities, and continuing courses on nutrition education and medicinal plants.

In the other three regions of Chiapas where EAPSEC-trained health promoters operate, results are equally impressive, even without the benefit of a physical clinic. In the Soconusco



PIH visitors and the EAPSEC team in front of the new community center.

region, 26 EAPSEC *promotores* serving a population of nearly 9,000 inhabitants in 20 communities provided 200 medical consultations in 2003. And in the Highlands region, a more advanced group of 35 health promoters provided over 6,000 medical consultations.

By evening on this August day, more than 150 community members have come to the clinic to hear blessings from church leaders, the mayor, and his staff and to celebrate and welcome the new facility. After feasting on fruit and chicken drenched in the rich *mole* sauce, the *promotores* step forward one by one to sign the agreements formalizing their commitment to the clinic and to the needs of their communities. One of Julia's children runs down the hill with a plate of food. The music resumes, and the new clinic in Amatan is officially inaugurated. 🎉

Tina Holt is a family physician at Boston Medical Center. She has been volunteering with PIH since 2002, developing funding and educational support streams for our partners in Chiapas and Guatemala.

Advancing Tuberculosis Care in Russia

In November 2004, twenty Russian physicians assembled for a two-week course on the latest and most effective techniques for diagnosing and treating multidrug-resistant tuberculosis (MDR TB). The course is one component of a three-part MDR TB training and research initiative generously funded by the Eli Lilly Foundation. Ironically, the conference center which housed the training used to be an isolated Siberian tuberculosis sanatorium, only recently renovated to accommodate conferences and functions. Physicians attending the November session were the third group to participate in a comprehensive training program conducted by Partners In Health and Brigham and Women's Hospital (BWH) staff.

The physicians represented a broad range of civilian and prison health care systems but shared a common focus on combating the growing MDR TB epidemic in Russia,

where the burden of disease is among the highest in the world. Although the trainees are experienced tuberculosis physicians, most are limited in their ability to effectively treat MDR TB, due primarily to an endemic dearth of specialized training as well as a lack of the administrative support required for the effective management of MDR TB programs. Until recently, these circumstances left many doctors without a full supply of the second-line medications needed to treat their patients. The challenge for TB physicians is daunting, especially in light of coexisting conditions that undermine treatment of this pernicious disease, such as patients' poor nutritional status, high rates of alcoholism, and inadequate housing and transportation. The unpleasant side effects of treatment are another barrier which patients must overcome in order to consistently adhere to their prescribed regimens. Fortunately, through direct funding

from the Russian Ministries of Health and Justice, loans from the World Bank, and grants from the Global Fund to Fight AIDS, Tuberculosis, and Malaria, resources to support MDR TB treatment are now more obtainable in Russia. The availability of second-line drugs, combined with a growing knowledge base of the most effective treatment models, have made our training sessions a timely and valuable resource for Russian physicians eager to improve their ability to care for patients.

Each day, the training participants settled into the small classroom for a full schedule of group discussions and lectures by experienced TB physicians from both the prison and civilian health systems in Tomsk, Moscow, and Novosibirsk, as well as PIH/BWH faculty based in Russia and in Boston. Sequestered in the back corner of the room was a highly skilled interpreter who simultaneously translated the proceedings into Russian or English for the attendees, who wore headsets similar to those used at the United Nations. The course drew on the experiences of PIH-supported treatment programs in Russia, Haiti, and Peru and included presentations on clinical guidelines, patient-centered care delivery models, and research methods. An introduction to the use of computers for patient care and data collection also was offered.

Under the three-part training program, a few months after the intensive didactic course, participants return for a first-hand look at treatment and diagnostic facilities and protocols in Tomsk area hospitals, ambulatory facilities, and labs. Several months later, PIH/BWH faculty and Tomsk



Russian physicians examine X-rays at a PIH/BWH-led training session.



A physician examines a former prisoner with MDR TB in the Tomsk Hospital.

TB physicians visit the home facilities of the trainees. These site visits are designed to support the physicians and their colleagues in applying the tools discussed during the training under local conditions. On-site technical support with electronic databases and communications, using computers provided to the participants by the Eli Lilly Foundation, is also offered.

The formal and informal feedback

received from participating physicians and faculty has been uniformly positive, both regarding the quality of the lectures and the value of the content. In true Russian style, a number of trainees offered eloquent accolades at the closing ceremony and celebratory dinner, stating that it was the best course they'd ever attended. Official endorsement of the training program came in the form of Continuing Medical Education credits awarded by the Ministry of Health and the Novosibirsk TB Research Institute to those who completed the program.

To date, 57 physicians have participated in this MDR TB training program. We expect that number to more than double under the two and a half years of additional funding assured us by the Lilly Foundation. We hope to involve participants from other regions of Russia, as well as other countries of the former Soviet Union, in future training courses. However, even with this extended program, only a fraction of the physicians who would benefit from specialized training can be included. A long-term goal is to encourage integration of the content, principles, and methods of this initiative into the official Russian medical education curriculum, ensuring that this vital

information is broadly and consistently disseminated. 

Amy Judd is Director of Program Development at the Division of Social Medicine and Health Inequalities at Brigham and Women's Hospital.

Russia's epidemic of drug-resistant tuberculosis is one of the worst in the world. Economic decline, the breakdown of social safety nets, alcoholism, and a high incarceration rate have been key factors in the dramatic increase of tuberculosis and the subsequent rise of multidrug-resistant strains. In the population of Tomsk Oblast, Siberia—where Partners In Health has been working since 2000 to expand its successful MDR TB treatment model—11.2 percent of new TB infections are drug-resistant. In the rest of Russia, MDR TB rates range from 5 to 45 percent of new cases. This high rate makes the epidemic quite complex, especially in the prison system, where drug resistance is even more prevalent. In 2002, more than 79,000 prisoners in Russia had active TB, with multidrug-resistant strains in 16 percent of newly diagnosed prisoners and in 50 percent of chronic patients.

PACT Office Relocates

The Prevention and Access to Care and Treatment (PACT) Project in inner-city Boston focuses on HIV prevention and improving outcomes among those already infected. In order to be more accessible to the communities it serves, PACT moved to a new office in Dorchester in November 2004. Now located at the intersection of Washington and Talbot Streets in Codman Square, the new space is front and center in the bustling community. Please join us at PACT's Open House on March 9, 2005, featuring PACT Director Dr. Heidi

Behforouz; John Auerbach, Executive Director of the Boston Public Health Commission; Dr. Gary Gottlieb, president of Brigham and Women's Hospital; Dr. Bill Walczak, Executive Director of the Codman Square Health Center; and several PACT participants. Please see back cover for more information and to RSVP.



1000x1000 Update: A Heartfelt Thanks to Our Supporters

In August 2004, Partners In Health launched a campaign to increase its base of support at the \$1,000-plus level. At PIH we don't aim low, and so, considering that in 2003 we had 370 members in the Partners Circle, we set the ambitious goal of increasing membership to 1,000. We called our campaign "1000x1000."


We are happy to report that by December 31, membership in the Partners Circle had increased 124 percent, bringing us to 827 in 2004. While some may see this as falling 173 short of our initial goal, we are in fact thrilled. The growth in donors led to an increase in funding of nearly \$2 million, far surpassing our internal goal in launching 1000x1000. It is you—our faithful as well as first-time donors—we have to thank for this success.

Several events and activities, local and national, helped us achieve our year-end Partners Circle and fundraising goals. 2004 saw a significant increase in the number of events held on our behalf by PIH supporters across the country. These events ranged from university lectures to church fundraisers; from private fundraising parties to town events organized through local libraries; from book clubs—including "The Empty Nesters," "The Bookies," and "The Bookish Babes"—who passed the proverbial hat for us after reading *Mountains Beyond Mountains*, to schools where students and teach-

ers organized classes and clubs to explore issues of global justice and health equity and sponsored events such as dance-a-thons, bake sales, and toy drives. In total, all of these events raised over half a million dollars for PIH in 2004.

It's dramatic to see the jump in number of Partners Circle members in the states in which these events took place. For example, in Illinois, our Partners Circle membership increased from 6 to 45 after an August event. In Pennsylvania, membership went from 17 to 37 after an orchestra concert held in Philadelphia on our behalf. More and more people contact us asking "what can we do?" or "here's what we propose" or, best of all, "here's the money we raised for you!" It is exciting to hear from our donors, who range in age from 8 to 88, give or take a few. Our supporters include a 9-year-old who periodically sends us a rolled-up wad of dollar bills that she carefully sets aside from her allowance; a high school junior who led the organizing efforts for the first annual Walk for Haiti, which raised over \$16,000 for PIH in 2004 (see "The First Annual Urban Walk for Haiti" in the Summer/Fall 2004 issue of the *PIH Bulletin*; see back cover for information about this year's upcoming walk); and a high school teacher who, after teaching about global justice and equity issues, encouraged his students to fundraise for PIH and submit a reflection journal as their final project (not to worry, the students weren't graded on how much

money they raised). Many churches have praised PIH's work on behalf of the poor in their sermons and then sent us their offerings. During the holiday season, several families, in lieu of exchanging gifts, pooled their money to build a house for a family in Haiti. Another local friend generously donated 1,000 copies of *Mountains Beyond Mountains* and also covered the cost of printing the *Saving Lives in Rural Haiti* DVD so that we would have a special way of thanking our Partners Circle members. And, this spring, we even have a few groups organizing cross-country bike rides to raise awareness and funds for PIH. As you can see, our donors are resourceful, energetic, and, most of all, big-hearted.

Post-holiday winter is a time for slowing down, regrouping, and reflecting on things past, things dormant under the frozen earth, and things waiting to come to fruition. While our 1000x1000 campaign continues full swing, we want to take this opportunity to send out a collective bow of deep gratitude to you, our generous and creative supporters. It is you who make our work on behalf of the destitute sick possible, and it is your increased support that funds our growth and expansion, not only into new areas in the countries where we have been working for years, but now even into a new continent. 

Heidi Fischbach is Development Associate for Donor Relations at Partners In Health.

Recent Events

Fall-Winter 2004

Libraries in Dover, Concord, Winchester (all in Massachusetts), and Camden, Maine held Partners In Health benefit events centered around Tracy Kidder's *Mountains Beyond Mountains*.

October 2, 2004

11th annual Thomas J. White Symposium

Meeting the Global Challenge: Scaling Up HIV Treatment

To a standing-room-only crowd (even in the overflow room), United Nations Special Envoy for HIV/AIDS in Africa Stephen Lewis delivered the keynote address at PIH's annual Symposium. The Thomas J. White prize was awarded to our Haitian colleagues Loune Viaud, Dr. Fernet Léandre, and Dr. Maxi Raymonville for their outstanding work in keeping Zanmi Lasante operations running at full speed despite political upheaval, devastating floods, and violent uprisings.



November 6, 2004

Paul Farmer received the Ronald McDonald House Charities Award of Excellence for outstanding contributions to improving childrens' lives.



December 1, 2004

World AIDS Day

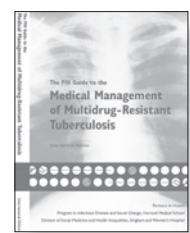
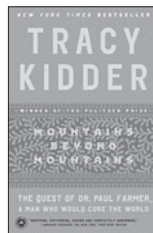
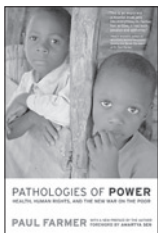
In what has become an annual tradition, our partners and patients in each of our sites in central Haiti commemorated World AIDS Day with large community gatherings featuring speeches, educational efforts, entertainment, and a spirit of solidarity with all people living with HIV/AIDS.



January 18, 2005

The American Repertory Theatre in Cambridge, MA held a fundraiser performance of Pieter-Dirk Uys' acclaimed show *Foreign AIDS*, the proceeds of which benefited Partners In Health and Physicians for Human Rights.

Now Available



Link to Amazon.com from the Partners In Health website (www.pih.org), and a portion of your purchase will be donated to PIH.

Photos: Paul Farmer (1), Elizabeth Whelan (4, 5a, 7a, 8, 9), Quoy Ton (5b), David Walton (7b, 15c), Tina Holt (10, 11), Valery Kasatkin (12, 13), Tom Ribaldo (15a, 15b)



Join the 2005 Partners Circle by making a donation of \$1,000 or more. If \$1,000 is too much for you to give at this time, consider making donations in monthly installments by setting up an automatic online donation plan at www.pih.org/donate/index.html.

Just 170 donors short, we have extended our 1000x1000 campaign. Help us meet our goal:

- Give friends and family a copy of Tracy Kidder's *Mountains Beyond Mountains* (now available in paperback), which tells the story of PIH and its co-founder, Dr. Paul Farmer.
- Provide friends and family with a packet of PIH materials. We'd be happy to send this to you or directly to your friend on your behalf.
- Refer friends and potential donors to www.pih.org.
- Host a house party or other fundraiser for your friends and acquaintances. Please contact Edward Cardoza, Director of Development, at (617) 432-0049 for more information.

Current and Upcoming Events

February 1-27, 2005 Exhibit of watercolors by Robert Hsiung at the Depot Square Gallery in Lexington, MA, with proceeds benefiting PIH. For gallery information and a sample of Mr. Hsiung's work, visit www.depotsquaregallery.com or call (781) 863-1597.

March-May 2005 One Book One Lincoln: townwide reading of *Mountains Beyond Mountains*, sponsored by the Lincoln, MA library. Please visit www.lincolnpl.org/one_book_one_lincoln.htm for a listing of events.

March 9, 2005 PACT Project Open House: Come celebrate PACT's new home at 622 Washington Street, 3rd floor, Dorchester, MA. Enjoy tours of the new space, distinguished speakers, and light refreshments. For more information or to RSVP, please call Lexie Pierson at (617) 474-8502.

March 30, 2005 Paul Farmer will deliver the Tanner Lectures on Human Values at the University of Utah, Salt Lake City, UT.

April 5, 2005 Paul Farmer will deliver the inaugural Angelopoulos Lecture at the Kennedy School of Government, Cambridge, MA.

April 10, 2005 Second Annual Urban Walk for Haiti, Cambridge, MA: all proceeds will benefit Partners In Health/Zanmi Lasante programs. For more information or to contact the walk organizers, visit www.wfh2005.org.