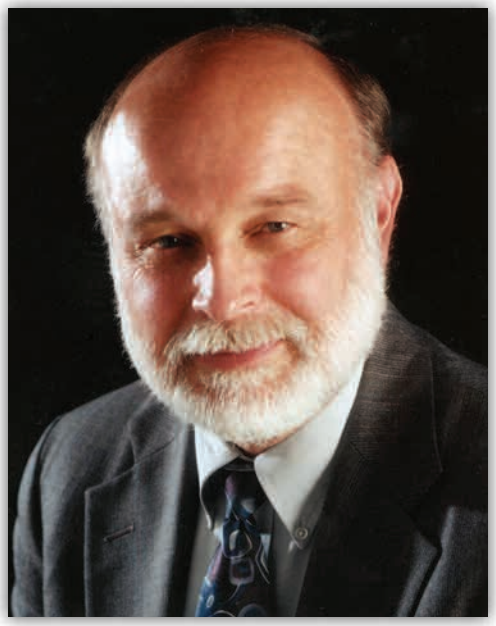
# Adventist Health

# INTERNATIONAL

## 2006 Annual Report

# President's Report



One of the great satisfactions of parenthood is watching your children mature and take responsibility for their own futures. This is certainly the case with AHI and its many hospitals. As systems mature and experience is gained, a new sense of self-confidence is born that bodes well for the future of each institution. There will continue to be setbacks, of course, often caused when key personnel leave or some other crisis occurs. But even those crises seem less ominous as reserves are built up, systems are in place, and planning becomes routine.

In this 2006 *Annual Report*, we share with you some of the strategies that have blessed AHI since its beginning. Turn-around plans and the strength that comes from national systems have been cornerstones to stability and progress.

Finally, I want to mention the incredible support that each of our donors has provided this year. AHI received more than $1 million from a number of individuals, churches, and organizations this past year. It is this financial support that leverages everything else that we do. Whether replacing broken equipment, repairing buildings, training staff, restocking pharmacies, or meeting old debts, your financial support is critical to the success of AHI. Thank you for the confidence you have placed in us. It is humbling to see your contributions and listen to your encouragement.

There are as many as 10 new countries that are waiting to join AHI, so careful analysis is under way on what we can handle. A limiting factor is how much support is needed and what we can safely provide. Our more stable institutions are now largely self-sufficient, enabling us to concentrate on the newer ones.

Thank you for helping us bring hope and healing to our many staff around the world.

Richard H. Hart

Richard H. Hart, MD, DrPH, president
Adventist Health International

*Front cover: children in Honduras. Photo by Patricia K. Thio*

*Strengthening Adventist systems in the developing world for today's health ministries*

- Management support
- Governance
- Facility improvement
- Country system integration
- HIV/AIDS care
- Children's charity fund

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Adventist Health International (AHI) is a multinational, nonprofit corporation with headquarters in Loma Linda, California. AHI has been established to provide coordination, consultation, management, and technical assistance to hospitals and health care services operated by the Seventh-day Adventist Church, primarily in developing countries. AHI is not a funding agency and depends on various organizations, foundations, governments, and individuals to provide financial assistance when needed.

AHI believes that every health care institution must be firmly rooted in its community with concern for all aspects of development, and will pursue policies and programs that accomplish this aim. AHI is committed to the education of local health care professionals and will encourage the establishment and/or retention of professional training programs whenever appropriate.

# Why national systems?

One of the key strategies of AHI in each country is to form a national Adventist health care system. This is relatively simple when there is only one hospital and perhaps a few associated clinics. But in many countries there may be several hospitals and many small clinics.

Most hospitals are owned by the respective Church union, with the clinics often owned by a smaller field or conference. When there are multiple institutions, there has often been a pattern of competition among them, vying for scarce resources. This has led to barriers that prohibit effective collaboration and sharing.

*Organizing a national system in India*

To overcome these limitations, AHI begins by establishing a national board that governs all health institutions operated by the Church in that country. This one AHI country board receives reports from each institution, monitors finances and progress, and can appropriately allocate resources as needed. In many cases, there are equipment items or personnel that can be more evenly distributed for the collective good. A national strategy for development can be prepared with each institution understanding its unique contribution to the whole.

Another major advantage of a national system is for collective contracting and grant proposals. When a hospital submits a proposal to initiate HIV/AIDS programming, for instance, and can only offer one site for patients, it does not gather much attention. But when a national system can offer multiple hospitals and a network of clinics scattered across the country, it becomes much more competitive. Standard protocols can be developed and implemented, supervision by qualified professionals is available, and grants can be managed more effectively.

Purchasing medical supplies is also enhanced when there is a system needing common items. Better pricing, on-time delivery, and negotiated contracts are all possible with the purchasing power of a larger order. Common accounting systems are also easier to implement when there is one board with shared software and goals.

Finally, having a national system enables AHI to determine more effectively the various personnel needs and develop educational systems to meet those needs. Clinical rotations for students can be located at multiple sites and employment opportunities are available to graduates. Working together makes good sense, saves resources, and creates a platform for development.

# Reawakening Spirituality

From the very beginning, the purpose of AHI has been to strengthen the health ministry of the Adventist Church.

In the mid-1990s, there was concern in the Church regarding a growing number of failing health institutions, located primarily in developing countries. Loma Linda University felt a keen responsibility to be part of a solution. So in 1997, Adventist Health International was formed. Since then, through partnerships with other Adventist health systems, much has been accomplished and the Church has been strengthened in a variety of practical ways.

Davis Memorial Hospital (DMH) in Guyana and Gimbie Adventist Hospital in Ethiopia provide some good examples. Each of these hospitals has become financially stable, reducing their burden to the Church.

Both have seen the quality of care and relationships with the local government improve, and the reputation of the Church and health work recover dramatically. Both are now able to pay off their debts, develop new training programs for local young people, and restore a steady flow of tithe to the Church. At the same time, with the renewed hope and enthusiasm of the local church, the membership has practically doubled. Both hospitals have expanded their physical plants in order to house their revitalized congregations. In the case of DMH, a large new sanctuary was needed!

In Zambia, a program was started to introduce and attract Adventist students attending local universities to explore professional opportunities within the Church. The results of that program are indeed promising. Having Adventist health professionals desire to work in our institutions and freely testify of their faith while working with God to provide whole-person healing to their patients is truly inspiring.

AHI is also working to strengthen the educational programs for health professionals connected with our institutions. It is important to provide young people with careers in heaven-ordained service so that they can provide much-needed support for the Church and their communities. In today's world, there are many forces seeking to draw young people away from Adventist institutions and even out of their countries. AHI is committed to building local capacity for our Church and our communities to provide the best service and help to those in greatest need.

*Spiritual outreach in Nigeria*

# Honduras

The small Central American country of Honduras joined AHI in early 2006. A turn-around plan (TAP) was developed by a small group from AHI–Global in January, and the search for staff and funds began. Though Honduras has been quiet politically, it suffered a huge national tragedy from Hurricane Mitch some years ago. Much of the country was destroyed and many national initiatives are still focused around the damage that occurred.

There are two small health care institutions operated by the Honduras Union in the country. Hospital Adventista de Valle de Angeles (HAVA) was developed through the leadership of Drs. Frank and Janet McNeil back in the 1980s. Located in a pine forest at 5,000 feet elevation, northwest of the capital of Tegucigalpa, it flourished as a quality health care institution for many years. An outpatient facility in Tegucigalpa has also been operational for some years, located in a rented three-story house, with narrow stairways and only street parking.

HAVA was built in a five-winged star configuration, with each wing providing a necessary function—two wings with a total of 24 patient rooms that are sufficiently large for double occupancy, an outpatient wing, a support services wing, and a surgery and delivery wing. The building is in good shape, though routine maintenance has been limited as finances have become increasingly difficult. A series of hospital managers has tried various strategies to reestablish the place, with limited success. It had been averaging from one to three patients, usually


*The entrance to Hospital Adventista de Valle de Angeles*

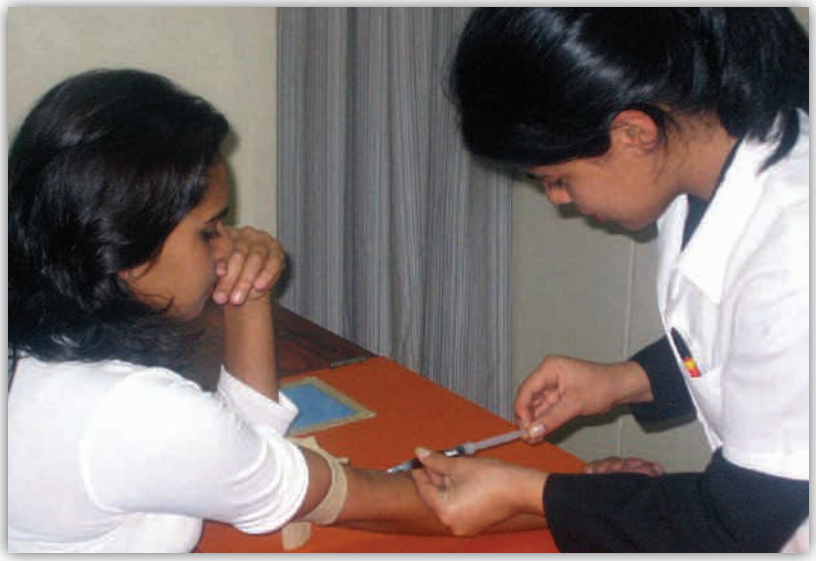
long-term and of low clinical intensity.

Several significant events have occurred during 2006 that have started to bring the institution back. Dr. Raul Schneider, an orthopaedic surgeon from Argentina, has finished his obligatory two years of civil service at a government hospital in order to obtain his Honduras license. He is now able to see patients regularly and will anchor the orthopaedic and rehabilitation service that is planned.

*Refurbishing one of the buildings at HAVA*

Veronica Alvarado has been appointed administrator, coming from a background in bank management, and is assisted by Fernando Pineda as business manager. These hospital leaders are being assisted by Chandra and Charlie Baier, most recently from Gimbie Adventist Hospital in Ethiopia, to implement the TAP and start down the long road of recovery. Patient count is already averaging more than 10, and the hospital closed 2006 with a positive bottom line. Several new services are being developed, including a commercial pharmacy, which will expand the financial base.

Challenges for 2007 will include complete renovation of the physical plant at HAVA, and some decision about the long-term location of the Tegucigalpa clinic. Orthopaedic instruments and equipment are desperately needed. Because of its proximity to the United States, a steady stream of volunteers is starting to assist in the TAP. Hope is bright that this "star" on the hill will shine once again.



*A student-in-training draws "pain free" blood from a patient*

# TAP

## What is it?

The word has many meanings. To some, it is a faucet, or a way to drain water. For others, it is a type of dance. Or it could be secretly gathering information from a phone line. Or even a touch on the shoulder indicating selection for some purpose. Or a military bugle indicating time. For those in the medical profession, it often refers to draining fluid from the lung or abdomen.

But for those of us involved with AHI, it is a very central part of our planning for each new institution. For us,TAP stands for the all important turn-around plan that is so vital to our work. These complex plans evolve over several visits and many discussions. They usually have multiple components, including finances, personnel, equipment, paying old vendors, rewriting contracts, identifying long-term debts, etc. What is always fascinating is how similar the problems are within struggling hospitals, regardless of the country or situation. This has become so common that we have evolved a series of four grades or levels that categorize these similar characteristics. Most of the institutions, when they join AHI, are at the bottom (Level 1) and gradually move up. It often takes two to three years to migrate from one level to the next.

Why do we develop TAP's? Because once you are able to clarify the challenges and put them in a plan, they appear less formidable. They can be talked about, timelines developed, and progress monitored. Even some huge goals, such as paying off old debts or constructing new buildings, can become manageable when broken down into smaller pieces and placed in an overall strategy.

A common comment among those who work within AHI–Global is the depressing nature of the ride in from the airport to each hospital. It is usually the time when one first hears of all the challenges and the despair that is usually associated with the telling. But by the time the visit is over, after options are considered and plans are voted, the return to the airport is usually one of enthusiasm and optimism. What a difference a few days and a sharing of burdens can make.

And it is in this process of implementing TAPs that every donor and participant in AHI can play a role. For it is


*Through its TAP, Gimbie Adventist Hospital now thrives*

in these negotiations that commitments need to be made, promises expressed, and confidence in the ongoing relationship becomes imperative. Our continued funding base, increasing numbers of national and international personnel available, and the value of a systems approach to issues is at the foundation of every TAP. Within AHI, this little three letter word, TAP, means mountains are being moved.

## Adventist Health International
## *Institutional Benchmarks*

### Level one
- Has difficulty meeting local payroll costs consistently.
- Requires external financial support for survival.
- Employee benefits are absent or unknown.
- Usually has excessive staff for necessary workload.
- Considerable deferred maintenance on physical structures.
- Lacks basic functioning equipment in some or all areas.
- Experiencing difficult relations with local or national government.
- Usually has outstanding debt to sponsoring organization.
- Difficulty recruiting expatriate and national professionals.
- Associated educational programs, if any, do not meet national standards.
- Debts to providers and others paid late and irregularly, with no credit standing.
- Employee tithe withheld but not remitted to Church.

### Level two
- Able to meet local payroll costs regularly from patient revenue.
- Has appropriate staff for amount of work.
- Employee benefits, including health care and retirement, are being serviced.
- Physical structures are being regularly maintained or plan in place.
- Has basic clinical laboratory, radiology, and other equipment.
- Stable relations with governing bodies.
- Debt management plan in place, if necessary, and being met.
- Core staff in appropriate disciplines in place.
- Educational programs meet basic standards.
- Has developed revenue streams with potential for growth.
- Debts paid on time with solid external relations.
- Has basic continuing education program in place.

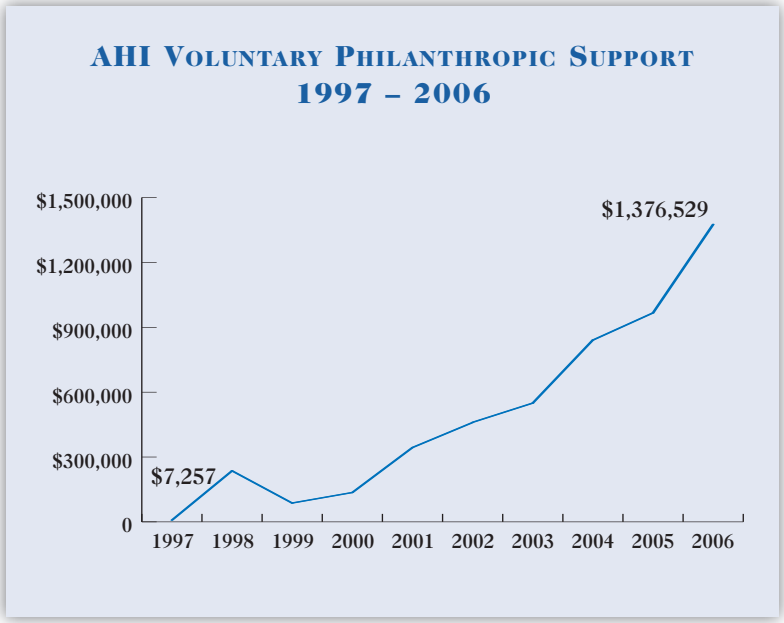
### Level three
- Using external support for capital development or program initiation only.
- Future staff are being sponsored or recruited with advanced skills.
- Employees have positive morale with good work habits.
- Strategic plan in place for future growth.
- Clinical lab and radiology set standards for local area.
- Educational programs set standard for the country.
- Engaged in variety of community health programs with external support.
- Grant proposals generated regularly for new initiatives.
- Three-month reserve fund in place.
- Succession planning for key staff positions is functioning.

### Level four
- Financially self-sufficient, including expatriate staff.
- Has developed specialty areas with community reputation.
- Has reference clinical laboratory for area or country.
- Contributes actively to national programs and committees.
- Six-month reserve fund in place.
- Educational programs are viewed as best in country.
- Provides consultation to other private and government institutions.
- Provides leadership for disease control and other community programs.
- Has strong continuing education program for multiple disciplines.

# Ten years of philanthropic Support

Those of us who are asked to mentor and teach students in higher education are often compelled to ask them, "What inspires you?" Students respond in varied ways—their view of a broken world and the contributions they might make, their professional ambitions and aspirations, their personal goals.

The year 2006 marked a special milestone for AHI—10 years of philanthropic support! We are inspired and thankful for the philanthropic support that many individuals and organizations have given to move AHI health care, re-energizing activities forward. AHI has been blessed by the contribution each individual and institutional donor has made.




We briefly note some philanthropic statistics:

- During a 10-year period, donors have contributed more than $5 million.
- The growth in philanthropic support to AHI has been inspiring to watch—from a total of $7,275 in 1997 to more than $1.3 million in 2006.
- The number of gifts made to AHI has increased dramatically over the decade—12 in 1997 to 440 in 2006.
- The average financial commitments that individual and institutional donors have made have also grown: $606 in 1997 to $3,125 in 2006.
- Total support in 2006 was at $1,376,529—the highest annual total in 10 years.

It is the contributors to AHI that have enabled this organization to expand its global involvement. In 1997, AHI volunteers worked with one hospital in one country. In 2007, AHI's involvement includes 32 hospitals and 52 clinics in 13 countries. Our contributors' dollars have been translated into re-energized, more effective health care institutions for the present and future—institutions on whom thousands, if not millions, depend. And then, of course, there is the ministry that these entities' health care and support staffs provide in restoring souls as well as bodies. We are thankful for, and honored by, what each of you, the contributors to AHI, do. Please continue your support.

# AHI Leadership

Those interested in keeping up to date on AHI activities throughout the year are encouraged to visit our webpage at **<www.adventisthealthinternational.org>**.

## Board members

Lowell C. Cooper, *chair*
B. Lyn Behrens
Mardian Blair
Maitland DiPinto
Larry Dodds
George Egwakhe
Ruthita Fike
Allan R. Handysides
Kevin J. Lang
Harold L. Lee
Pardon Mwansa
Claude Sabot
Charles C. Sandefur Jr.

## Regional representatives

Alexis Llaguno, MD
*Southern Africa–Indian Ocean Division*

Elie Honore, MD, MPH, MHA
*Inter-American Division*

Fesaha Tsegaye, MD, MPH
*East–Central Africa Division*

## AHI headquarters

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## Management team

*President*
Richard H. Hart, MD, DrPH

*Chief financial officer*
Llewellyn L. Mowery Jr., CPA

*Secretary*
Donn P. Gaede, DrPH

*Dental services*
Quint P. Nicola, DDS

*Environmental services*
David T. Dyjack, DrPH

*Equipment procurement and maintenance*
Jerry E. Daly, MA, MSLS

*Facility/construction and maintenance*
Kenneth J. Breyer, ME

*Financial management*
Daniel E. Fontoura, MBA

*Legal services*
Kent A. Hansen, JD

*Nursing services*
Jan Zumwalt, RN, MS, MBA
Dolores J. Wright, DNSc, RN

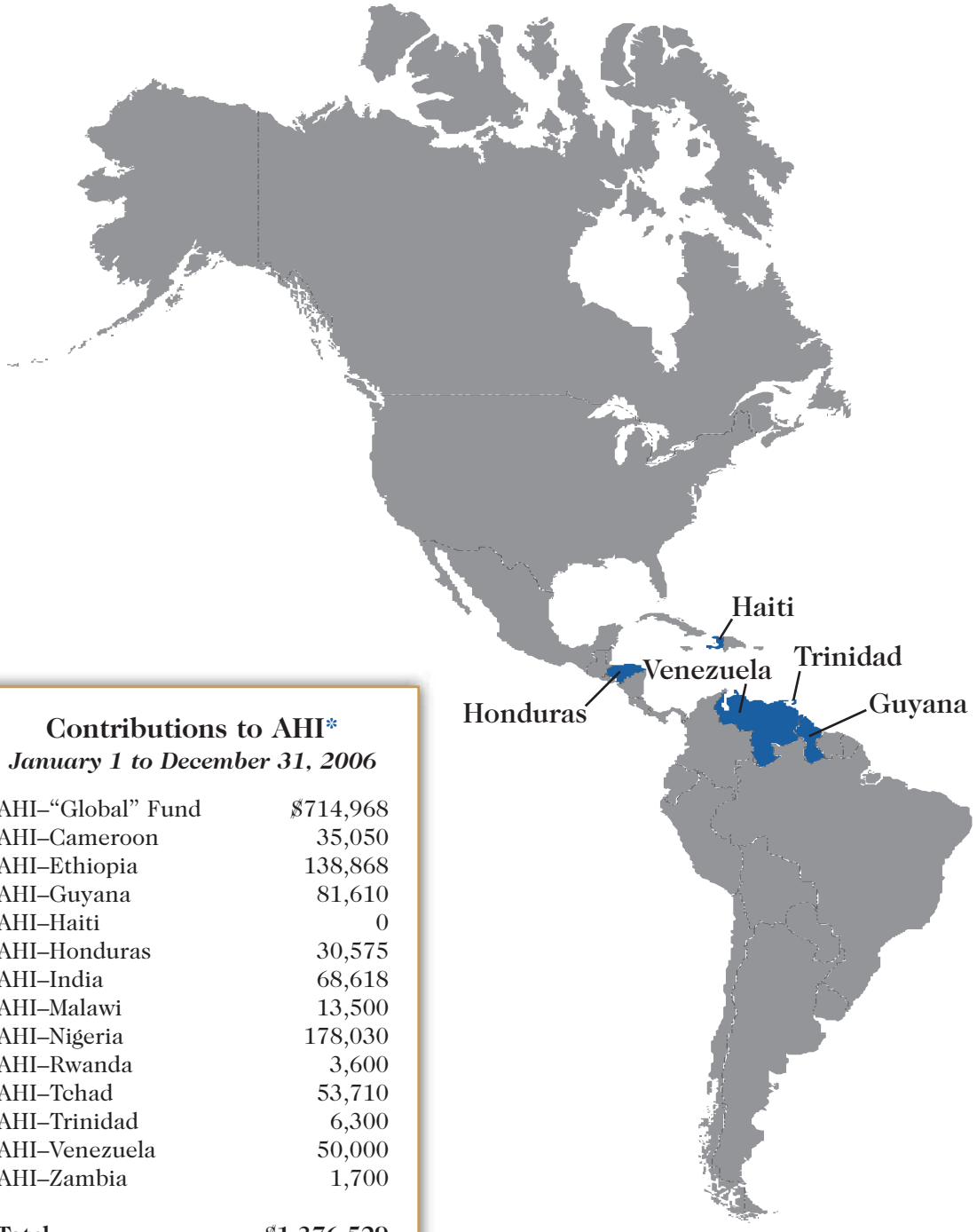
*Philanthropic services*
Albin H. Grohar, PhD

*Public relations*
Dustin R. Jones, MA

*Tropical medicine electives*
Larry Thomas, MD, DTM&H

# AHI

## Institutions




### Contributions to AHI*

***January 1 to December 31, 2006***

| | |
|---|---|
| AHI–"Global" Fund | $714,968 |
| AHI–Cameroon | 35,050 |
| AHI–Ethiopia | 138,868 |
| AHI–Guyana | 81,610 |
| AHI–Haiti | 0 |
| AHI–Honduras | 30,575 |
| AHI–India | 68,618 |
| AHI–Malawi | 13,500 |
| AHI–Nigeria | 178,030 |
| AHI–Rwanda | 3,600 |
| AHI–Tchad | 53,710 |
| AHI–Trinidad | 6,300 |
| AHI–Venezuela | 50,000 |
| AHI–Zambia | 1,700 |
| **Total** | **$1,376,529** |

**Only includes funds transferred through AHI–Global*

# Across the Globe


## AHI projects

| | |
|---|---|
| AHI–Global projects | $714,968 |
| AHI–African continent projects | 424,458 |
| AHI–Caribbean and West Indies area projects | 168,485 |
| AHI–India projects | 68,618 |
| **Total contributions to AHI projects** | **$1,376,529** |

# Country Reports

As AHI has continued to grow, we are forced to present less and less about more and more in our *Annual Report*. Country reports have been reduced to a few paragraphs of highlights, except for new countries that have joined in the last year, like Honduras in this report. We have tried to compensate for this by placing more stories and reports on our website, and we encourage all our readers to access this at <www.adventisthealthinternational.org>. There you will read some of the incredible stories that happen every day in the communities and facilities that make up our network. In this report we summarize the highlights that marked 2006.

## Inter–American Division

***Guyana***—As one of the two original countries that joined AHI in 1997, Davis Memorial Hospital (DMH) in Guyana has continued to develop into a quality institution. Plans for a new Health and Diagnostic Centre are still being refined while adequate funds are being raised. The addition of Dr. Caleb Solis, a surgeon from Bolivia, has expanded our capacity during the year. Bertie Henry continues to provide leadership as administrator and Dr. John Wilson as medical director. Dr. Karla Guerra has established a top flight dental clinic that is busy and ready to expand.

The addition of Jerry and Lanelle Northrup, volunteers from Nevada, has also been a recent help. Jerry works in facility management and is one of those fix-it type people who are so incredibly valuable in a mission hospital. Lanelle is a nurse who has provided leadership in both nursing services and the Foundation Healthcare Worker training program. The Northrups have also contributed to the outreach activities of DMH and the surrounding churches. We hope to find a budget that can continue their services in Guyana, as well as other hospitals of the Inter–American Division.

***Haiti***—Our hospital in Port-au-Prince, Haiti, continues to provide valuable clinical care in a country that struggles daily with political stability and security issues. The two large generators installed last year have been essential, as electrical power in this capital city has deteriorated again to an unpredictable three or four hours a day. The plan for renovation of various parts of the hospital to provide more efficient services has been delayed again due to insufficient materials and funding. AHI upgraded a young Haitian dentist at Loma Linda this past year in anticipation of starting a dental clinic. She and two colleagues were recently kidnapped in Port-au-Prince. They barely escaped and she felt compelled to leave the country immediately for her own safety.

The challenges in Haiti raise a question that is frequently discussed in AHI circles. When should security concerns for our national and expatriate staff mandate shutting down a facility or limiting services? It is a tough question when one recognizes that the many patients living in these areas do not have the privilege of seeking care elsewhere and are usually dependent on our medical institutions for any health needs they may have. So we use our best judgment and pray for God's protection in some pretty tough situations. Haiti deserves special prayer and attention over the next year as the country strives to achieve political stability and our little hospital struggles to provide basic services.

*Trinidad*—Community Hospital in the island paradise of Trinidad continues to inspire and amaze all of us. When this small hospital in the capital of Port-of-Spain joined AHI about four years ago, it was nearly $2 million in debt and on the auction block to be sold. Now it has paid off its entire debt and has embarked on a $2 million renovation program that will completely revitalize the entire physical plant. This will be done in seven phases to allow for continuation of services as repairs and upgrades are completed in various sections of the building. The board and administration felt strongly that it was important to upgrade the existing facility before major additional buildings are added. This will provide a financial base to support the construction costs of new specialized facilities that are planned, such as neurological and rehabilitative care, oncology, dialysis, and heart disease treatment.

Dr. Richard Spann continues to be at the heart of this turn-around plan, putting in long hours of both clinical time and establishing strong community connections. With the addition of a much-needed business manager, Community Hospital is now the primary provider of neurosurgical services on the entire island. A second neurosurgeon is being recruited to share Dr. Spann's workload. Toward the end of 2006, Dr. Bob Soderblom of Loma Linda started again to travel regularly to Trinidad to support the dialysis unit, due to lack of adequate nephrologists on the island. Additional niche markets are being explored to fully utilize Community Hospital's valuable reputation and solidify its leadership position.

*Venezuela*—This oil-rich country joined AHI in late 2005 with the specific need to complete the shell of a hospital building in the city of Barquisimeto. This project had been started nearly 15 years earlier but had run out of funds due to high inflation, and the four-story concrete framework had been sitting exposed to the weather. A careful TAP was designed that required initial donations to complete space for outpatient services on the ground floor, allowing the clinic to become more profitable and able to support additional construction work itself. Great progress has been made with this strategy, despite necessary changes in the floor plans and expensive construction materials. It is hoped that this first phase can be opened later this year. Thanks go to many individuals, as well as Versacare Foundation and Hope for Humanity for their major gifts.

This will still leave three more floors to work on—the basement for support services, and the second and third floors for inpatient services, surgery, and obstetrics. When completed, this new facility will once again be able to compete in this rapidly developing city of one million. The physicians will be able to move

*Members of the AHI–Venezuela board pose for a picture*

their outpatient services out of the dental clinic, allowing the dentists to expand and capitalize on their great reputation in the city.

The large multispecialty clinic in Caracas also continues to provide quality services despite its crowded conditions. As Barquisimeto stabilizes, plans are to assist other facilities in the country.

*Dr. James Appel poses with friends in Tchad*

### S. Asia–Pacific Division

***India***—India joined AHI with a total of 10 hospitals in this country of 1.2 billion people. AHI's plans were to initially concentrate on the two or three hospitals that were the most threatened to protect their future. This emphasis was placed on Giffard Memorial Hospital in Nuzvid, and Ranchi Adventist Hospital in Ranchi. Both facilities had active nursing schools and fairly large physical plants. Gradual upgrades were made in each place, with a new residence hall being completed in Nuzvid, a remodeled OR and ICU in Ranchi, improved equipment in both, and strengthened staff. In addition to the many local staff, Don and Gail Schatzschneider provided leadership at Nuzvid, while Elwin and Jaya Vedamony continued to lead Ranchi. With thanks to many AHI donors over the last several years, especially Hope for Humanity, more than $200,000 of upgrades were provided to these two institutions. This stabilized their financial picture and renewed hope for the future in each place. Smaller projects were also completed at some of the other facilities, including a new doctor's home at Mattison Memorial Hospital.

The biggest highlight of 2006 was the AHI summit conference held in Shimla in May. With funding from multiple sources, travel and lodging expenses were provided for several key leaders from each of these 10 hospitals to come together. For many, this was the first opportunity to share the larger vision of the Church and sense the scope of AHI and its network. The conference was facilitated by Dr. Gulu Bazliel from Simla Sanitarium and Hospital and culminated in a Sabbath spent at this facility. Without question, this conference reaffirmed the value of a national system and the advantages of sharing best practices and social support.

The end of 2006 saw some major changes occurring in AHI–India. The Southern Asia–Pacific Division has a development strategy of training young Adventists with careers that can let them emigrate to gain employment in the United States and England. One of the most effective areas for this is nursing, so the division would like to upgrade both Nuzvid and Ranchi to colleges of nursing to provide full BSN degrees. By regulation, this requires a 250-bed hospital facility at each place. The METAS trust from Surat has been asked to take on these two hospitals and implement this aggressive development goal. There are many issues yet to resolve, but this

transition is under way. AHI will retain responsibility for the other eight hospitals in the division and concentrate its energy on developing each of these.

### West–Central Africa Division

*Nigeria*—While the hospital at Ile-Ife remains the flagship institution in Nigeria, both Jengre in the north and Aba in the east received special attention in 2006. Several churches, individuals, and organizations have launched a "Buy-a-Brick" campaign to raise $100,000 for upgrading the equipment and facilities at Aba. New ultrasound and ECG machines have already been purchased and delivered. This partnership with AHI is an encouraging development, showing the continued passion of many Nigerians who retain loyalty and support for their home country even as they pursue careers abroad. Dr. Emmanuel Enyinna has had a long and distinguished career and agreed to move back to Aba to provide medical and administrative leadership to this renewal plan.

The large Jengre campus is now populated by dilapidated buildings and houses, only a pale reflection of what was once a vibrant institution. Dr. Chikwe Amaike has provided medical leadership under these difficult circumstances, while pleading Jengre's case for assistance. That call was heard by Dr. Ken and Marilyn Kelln, who had worked in Jengre more than 40 years ago. Ken had just retired from the gastroenterology section of Loma Linda University and they decided to donate one year to teaching endoscopy skills in Nigeria. They collected several gastroscopes and colonoscopes, and are spending six months at Jengre, their previous beloved post, followed by time at Ile-Ife and Aba. In addition, a $20,000 grant from Hope for Humanity and a generous $50,000 gift from a friend of the Kellns provided the means to launch a major renovation plan for Jengre.

A new hospital is also in the process of joining AHI–Nigeria, called Inisa. This 25-bed facility was originally built by church members on land allocated by the local chief. Now the community has requested it be returned to Church control and a TAP is being put together to refurbish this facility. It is located about an hour's drive from Ile-Ife, making it a logical extension site.

Ile-Ife continues to be the hub for these expanded activities. A major campus reorganization has resulted in greater integration, with Dr. Peter Opreh serving as the CEO of AHI–Ife, Danjuma Daniel as the CFO, and Dr. Henry Ine as hospital administrator. Dr. Herb Giebel continues as director of the Postgraduate Medical Education (PME) program. A new generator compensates for the frequent breaks in national electrical power. A new cafeteria serves both students and staff. The PME Hostel is undergoing phased upgrading of its rooms, at about $5,000 each, to include a private bathroom and small kitchen for each intern and resident. The highlight for PME was the successful passing of the qualifying exams of its first two residents, as well as completion of 10 interns to date. The School of Nursing has regained full accreditation and has occupied a new student hostel for the men. Despite its potential, Ile-Ife continues to suffer from a crisis of the spirit, with many political stresses across the campus. Pray for its stability and spiritual growth.

*Tchad*—What a difference three years has made! Our little hospital at Bere has now distinguished itself as the hospital of choice in southern Tchad. Dr. James and Sarah Appel continue to provide strong leadership and have steadily expanded the facilities and services. A new duplex was completed in November with assistance from friends in

Florida, and a new church building is now being used for worship. The old church has been converted to a chronic disease ward, specializing in HIV/AIDS and tuberculosis. This hospital is one of the most popular destinations for young health professionals from LLU and elsewhere who want to experience the excitement of rural mission life.

The goals for the future are becoming increasingly clear. A second doctor needs to be added at Bere, despite having no additional interdivision budgets. The 10 rural clinics in the district need closer supervision and upgrading. Wards will soon need to be expanded. As services grow and become more sophisticated, additional staff will be needed.

As these moves are planned, however, let us all rejoice in the miracle that has occurred. What was once dead is now alive and thriving, thanks to the commitment of a few. Recent visits with the government officials in Ndjamena indicate their satisfaction with the progress, and they wish AHI–Tchad would take on even more facilities!

***Cameroon***—This has truly been a year of transition in Cameroon. Long-term missionaries Perry and Monita Burtch have returned home after providing leadership in the dental clinic in Yaounde and AHI–Cameroon. They deserve our deep appreciation for many years of effective service. Yenge Isaac has been appointed as the new AHI executive director. His background in nursing, pastoring, and now an MPH from the Loma Linda University Africa program have prepared him well for this responsibility. Koza, Batouri, and Buea hospitals, along with the Yaounde dental clinic and six rural clinics in the country, will be coordinated by Yenge and his team.

Koza Adventist Hospital continues its steady climb to stability. Drs. Greg and Audrey Shank are facing many challenges in this area because of poverty and superstition. Patients come too late for help, or have complications from traditional healers trying dangerous cures. Despite this, the institution is stronger, with a staff delighted to face a future with hope. As equipment gradually arrives and services expand, faith in western medicine is being established. Goals for this future include replacing the rotten wiring on the entire campus to better support electrical services and reduce the risk of equipment damage.

*The bustling dental clinic in Cameroon*

Dr. Andre Nda'a and his team continue to manage Batouri Adventist Hospital in the east, and Dr. Rosemary Mbiru continues leadership at Buea Maternity Hospital. Buea is working on completing its new building and expanding services. A recent grant of $10,000 from the International Foundation will assist in this project.

## Southern Africa—Indian Ocean Division

***Zambia***—The three hospitals in

*AHI–Zambia board members inspect the grounds at Lusaka*

Zambia, Mwami in the northeast, Yuka in the far west, and Lusaka Eye Hospital in the capital, are all bustling with activity. Yuka has three physicians for the first time in its history, led by Dr. Helard Mangold from Argentina. A new well and pipes are bringing pure water to each home and building. The ample garden is being restored, promising many fruits and vegetables. Despite remaining needs, Yuka has more momentum than in recent memory.

Lusaka Eye Hospital went through a major transition this past year and is now stable and growing once again. Patience Matandiko serves as the administrator for both the hospital and the Lusaka Adventist Dental Service. She is assisted by Cesiah Penniecook as business manager. Dr. Eustace Penniecook was the sole ophthalmologist for most of the year, but help is coming. Dr. Michael Stafford continues to develop the dental clinic into a center of quality dental care. Overall leadership for AHI–Zambia is provided by Edward Martin, a young volunteer who has demonstrated remarkable maturity when faced with many challenges.

Mwami Hospital has been approved to start a large maize cultivation project on its land that promises to assist the community with food and provide financial help to the hospital. Dr. Ron Ang as medical director and Enock Chitakwa as administrator continue to provide strong leadership.

A new clinic in the neighboring town of Chipata is being planned that can feed additional patients to the hospital. The nursing school remains active and produces some of the best graduates in the country.

***Malawi***—Now in its second year with AHI, Malawi has implemented some tough TAP's in both Blantyre and Malamulo Hospitals, along with the 18 rural clinics. When carefully analyzed, it was concluded that these institutions had probably 140 extra staff that had joined through the years but were now jeopardizing financial viability. With a major financial loan for severance allowances from the Adventist Health Centre of Lilongwe, all three entities are "right-sizing" their staff and are starting back toward stability. All institutions are waiting for additional equipment. Long-term plans include expanding the clinic in Lilongwe to continue its history of successful service.

Both Blantyre and Malamulo Hospitals represent a great potential for the Church in Malawi and need to grow. Malamulo was nearly completely rebuilt with a USAID grant around 20 years ago, and still has one of the best physical plants in all of Africa. Its three schools, nursing, medical assistant, and clinical laboratory, have staffed many

*A health education class sponsored by AHI–Ethiopia*

other institutions with their graduates. Blantyre was also a thriving hospital in this commercial city. It is planned that these two institutions will once again become the center for health professional education for the Church in this division.

### East–Central Africa Division

***Ethiopia***—Gimbie Adventist Hospital in the western highlands of Ethiopia remains the anchor for health care for the Wollega Region of around two million people.

Maternity Worldwide has assisted in expanding both preventive and clinical services for mothers in the area. Dr. Ruth Lawson serves as the administrator for the hospital and seven rural clinics, with assistance from Johannes Mulatu and her team. Additional housing has been built on campus for the many visitors that continue to come. The dream of a School of Nursing at Gimbie is scheduled to be fulfilled this September. Two new dormitories have been completed, and classrooms are being renovated. This will complete a long-standing request from the local government for this training program.

A long-term discussion in Ethiopia has been the future of Zewditu Hospital in Addis Ababa. Originally built by the Church in the 1960s, it was taken by the government in 1975. The current mayor of Addis Ababa would like to give the hospital back to the Church, but there has been considerable political resistance to this idea. A goal for 2007 is to resolve this issue and move on to other plans if this is not achievable.

***Rwanda***—One of the smallest countries in Africa, scarred terribly 13 years ago with its genocide, Rwanda is now thriving both economically and politically. Dr. Mark and Ruth Ranzinger completed their term at Mugonero Hospital in April, and since then it has been staffed by Dr. Mark Habeneza and several other local physicians. Despite a drop in the surgical workload, the hospital has retained financial viability due to many factors, including the able leadership of administrator Kamali Kalisa. External grants for HIV/AIDS services have helped with this stability. A major long-term goal is to reopen the Mugonero School of Nursing. This will require qualified staff to meet the new government requirements. Several are being sponsored for advanced degrees by AHI. It is hoped that this important school will reopen by 2008.

Dr. Venancio Ang continues to provide leadership for AHI–Rwanda. He also carries a major clinical load at the polyclinique in Kigali, which has now reached financial stability. Continued upgrading of buildings, staff, and equipment are needed in the six rural clinics. The dental clinic in Kigali is again short-staffed and is recruiting a full-time dentist.

# Financial Report

## Statements of financial position

| Assets: | (unaudited) 12/31/06 | (restated) 12/31/05 |
|---|---|---|
| Cash and cash equivalents | $ 936,160 | $ 593,097 |
| Other receivables | 1,503 | 4,860 |
| Property and equipment, net | 5,578 | 10,617 |
| Total assets | $ 943,241 | $ 608,574 |
| **Liabilities and net assets:** | | |
| Accounts payable | $ 21,946 | $ 38,820 |
| Due to affiliate | — | 1,237 |
| Total liabilities | 21,946 | 40,057 |
| Net assets: | | |
| Unrestricted | 126,513 | (33,356) |
| Temporarily restricted | 794,782 | 601,873 |
| Total liabilities and net assets | $ 943,241 | $ 608,574 |

## Statements of activities

| Year ended December 31, 2006 (unaudited) | Unrestricted | Designated Projects | Total |
|---|---|---|---|
| **Support and revenue:** | | | |
| Contributions | $235,448 | $1,193,741 | $1,430,189 |
| Interest income | 39,845 | 1,822 | 41,667 |
| Total support and revenue | 276,293 | 1,195,563 | 1,471,856 |
| **Expenses:** | | | |
| International programs | 2,000 | 1,002,654 | 1,004,654 |
| General and administrative | 110,219 | — | 110,219 |
| Fundraising | 4,205 | — | 4,205 |
| Total expenses | 116,424 | 1,002,654 | 1,119,078 |
| **Change in net assets** | 159,869 | 192,909 | 352,778 |
| **Net assets at January 1, 2006** | (33,356) | 601,873 | 568,517 |
| **Net assets at December 31, 2006** | $126,513 | $ 794,782 | $ 921,295 |
| **Year ended December 31, 2005 (restated)** | | | |
| **Support and revenue:** | | | |
| Contributions | $142,991 | $1,077,042 | $1,220,033 |
| Interest income | 24,685 | 1,384 | 26,069 |
| Total support and revenue | 167,676 | 1,078,426 | 1,246,102 |
| **Expenses:** | | | |
| International programs | 138,759 | 743,268 | 882,027 |
| General and administrative | 20,153 | — | 20,153 |
| Fundraising | 10,359 | — | 10,359 |
| Total expenses | 169,271 | 743,268 | 912,539 |
| **Change in net assets** | (1,595) | 335,158 | 333,563 |
| **Net assets at January 1, 2005** | (31,761) | 266,715 | 234,954 |
| **Net assets at December 31, 2005** | $(33,356) | $ 601,873 | $ 568,517 |

*Adventist Health International is a nonprofit corporation as described in Section 501(c)3 of the Internal Revenue Code. Donations are tax-deductible for income tax purposes.*

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**Our work is made possible *only* through the generous support of individuals, organizations, churches, and corporations. We deeply appreciate and thank our partners for their continued support.**

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*Kindergartners collecting quarters for Tchad*

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