

ANNUAL IMPACT REPORT



JANUARY 2019 - SEPTEMBER 2020

CARE FOR THE PERSON
SYSTEMS FOR THE POPULATION
INNOVATION FOR THE PLANET

CONTENTS

- 2** **SEVEN YEARS IN**
Letter from the Executive Director
- 4** **21 MONTHS IN REVIEW**
Major Milestones & Outcomes
- 6** **EMBRACING COMPLEXITY**
Our Integrated Approach
- 8** **TURNING INSIGHTS INTO IMPACT**
Introducing PIVOT Science
- 14** **ENHANCED COMMUNITY HEALTH**
Piloting Paid CHWs & Proactive Care
- 20** **MODELING PRIMARY CARE FOR ALL**
Our Path to Universal Health Coverage
- 26** **A MODEL DISTRICT HOSPITAL**
Building Hospital Capacity
- 32** **COVID-19**
Not Just Response – Resilience
- 36** **SAVING LIVES THROUGH SCIENCE**
Rights-Driven Research & Publications
- 40** **LIVING OUR SHARED VALUES**
A Team-Wide Recommitment
- 44** **WITH GRATITUDE**
Partners & Supporters
- 50** **AUDITED FINANCIALS**
FY2019 and FY2020

In partnership with Madagascar's Ministry of Public Health, we are building a replicable, evidence-driven, district-level model health system that promotes universal access to quality medical care.

SEVEN YEARS IN

TARA LOYD, EXECUTIVE DIRECTOR

Dear PIVOT family,

This moment in time is about survival. From the ongoing pandemic to racial justice to climate change, as a global community we are faced with that reality every day.

I used to describe my job as having a foot in both worlds. One in Ifanadiana District, Madagascar, where – when PIVOT began – 1 in 7 children didn't live to celebrate a 5th birthday and 1 in 14 women didn't survive childbirth. And one at home – navigating my roles in motherhood and leadership, bouncing between pre-school pickups and board meetings. These last months have changed that. I don't hear people taking daily life – health, safety, or even weather patterns – for granted as much anymore. The fragility of humanity has been laid bare by all that we are experiencing together in this very moment.

As civil rights leader John Powell says, “If we don't turn toward each other, we don't survive.”

If you are reading this letter, it is because you have already turned towards our brothers and sisters in rural Madagascar, honoring their well-being as though it were that of your next-door neighbor or your own. We simply couldn't do what we do at PIVOT without your support. **Empathy is the word that rings clearest for me. Without it we have nothing.** This year has been about building and rebuilding it, as we are reminded daily of our interconnectedness.

The launch of **PIVOT Science** this past September is our way of connecting the head and heart of our organization's work. It is a manifestation of **our moral obligation to act to save the lives in front of us, to build model health systems that reach everyone, and the reminder that we (the global “we”) need science now more than ever.** Mathematical models of COVID-19's potential spread are used to make decisions about whether to open schools, shut down borders, or ensure PPE gets in the hands of all frontline health workers. PIVOT is in the position to back those efforts with data, research, and actionable lessons to narrow the persisting “know-do” gap we face as global health implementers.

Our **pilot to professionalize community health workers (CHWs)** was a hallmark of the past year for PIVOT, with enhanced training, case-finding, and full-time pay for full-time work. The data from the first year of this effort show that the **utilization of the health system went up 200%** in Ranomafana (our flagship model commune) when CHWs were formally integrated and professionalized as part of the public health system. As we work to scale that pilot, the government will use the data to advocate for paying CHWs on a national scale.

The **500,000th patient supported by PIVOT** was another milestone we proudly crossed last summer, just as the need for quality and accessible healthcare became clearer and more urgent than ever. As partners to the Ministry of Public Health, we are taking all that we've learned in these half a million moments to inform the architecture of universal health coverage in Madagascar. In the two years ahead, we'll combine our lived experience with robust information systems to reach the people we have yet to reach – those living in the most remote and rural communities and beyond.

At the beginning of 2020, pre-pandemic, I made a conscious effort to scale back our US-based team to shift a greater portion of our resources – along with responsibility and authority – to our colleagues in Madagascar. As the Malagasy leadership team took the reins from our Ranomafana headquarters, I have seen a shift in who is showing up and speaking up at the decision-making table. As a lesson from everything this year has offered, I think all organizations like ours must undergo a similar evolution, so as to not only believe but to experience firsthand: **the people closest to the problems are closest to the solutions, and we must listen to what they have to say.**

We thank you for doing just that.

Onward together,



>636,900
patient visits supported

21 MONTHS IN REVIEW

JANUARY 2019 - SEPTEMBER 2020*

BY THE NUMBERS

2019

JANUARY

Faced with the country's worst measles outbreak in 50 years, joined forces with MOPH to vaccinate 70,000 children

FEBRUARY

Unveiled new data visualization platform for real-time access to information about our programs and impact

MARCH

Featured in *Science Magazine's* article "A Prescription for Madagascar's Broken Health System: Data and a Focus on Details"

APRIL

Initiated costing study to better understand the investment required for Madagascar to achieve universal health coverage

MAY

Launched internal, organization-wide effort to recommit to our values
(More on our values: Page 40)

JUNE

Began support in 7th, most remote facility yet (8 hours by moto from paved road), where utilization tripled after 6 months of service

JULY

Following 5 years building our M&E department from the ground up, Laura Cordier assumed the role of National Director

AUGUST

Built infectious disease ward and first-ever blood bank at the district hospital
(More on the hospital: Page 26)

SEPTEMBER

Expanded agenda to remove financial barriers, now covering all (rather than most) services, medicines, and transport fees

OCTOBER

Implemented pilot for enhanced community health, including pay for CHWs
(More on pilot outcomes: Page 14)

NOVEMBER

Conducted assessments at every district health facility to identify areas of greatest need and inform expansion plans

DECEMBER

Welcomed delegation led by Minister of Health Pr. Julio Rakotonirina to inaugurate major facility renovations

2020

JANUARY

Reached majority Malagasy and female representation in leadership
(More on our team: Page 43)

FEBRUARY

Reduced size of US team in a conscious effort to shift greater share of authority and resources to Madagascar-based team

MARCH

Following first reported case of COVID-19 (March 20), dispatched an ambulance team to support central government's response

APRIL

Alongside the MOPH, staffed a roadside checkpoint to help mitigate the spread of COVID-19 across regions

MAY

Achieved a 100% success rate among children discharged from malnutrition treatment program

JUNE

Procured and donated essential COVID-19 response supplies and equipment
(More on COVID response: Page 32)

JULY

Officially implemented free meal service for all patients and accompagnateurs at the District Hospital

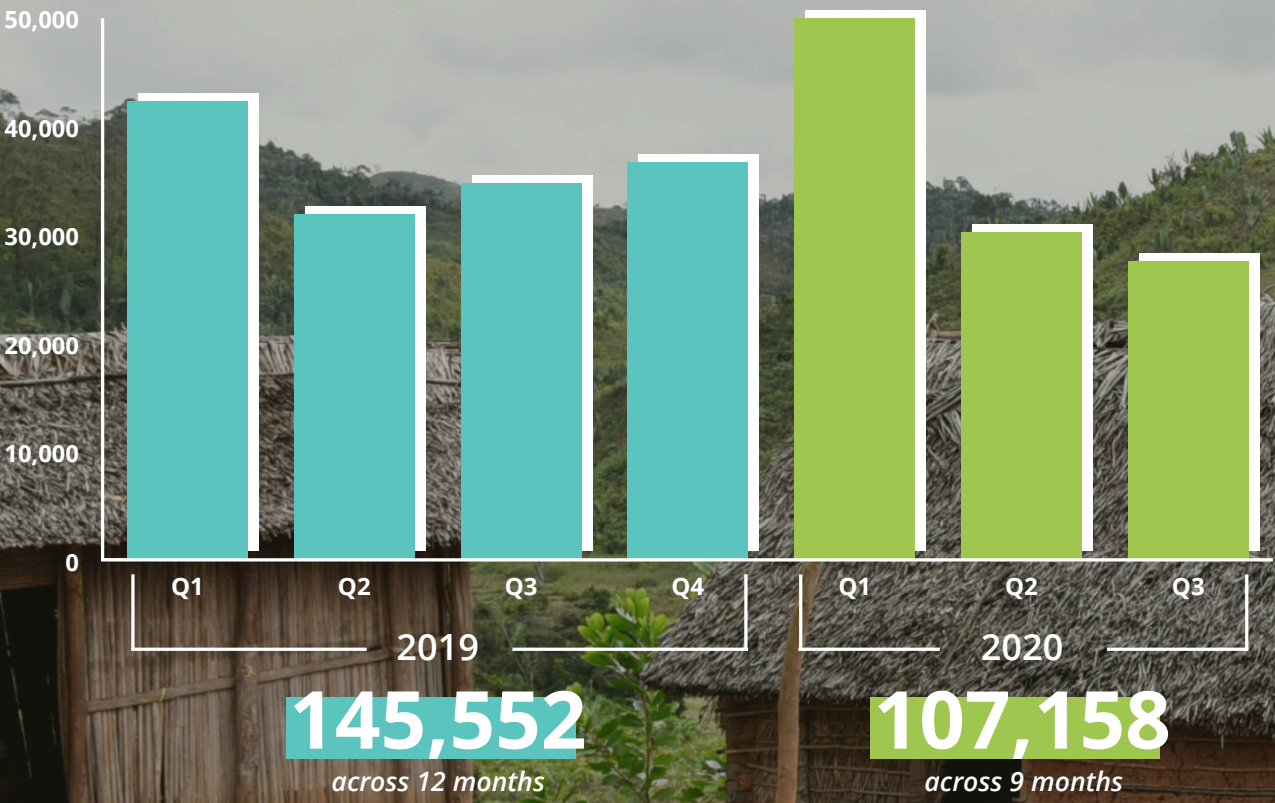
AUGUST

With partner Centre ValBio, initiated establishment of an RT-PCR lab in Ranomafana

SEPTEMBER

Launched PIVOT Science to enable greater innovation in rights-based research
(More on Science: Page 8)

PATIENT VISITS SUPPORTED AT ALL LEVELS OF CARE



INCLUDING:



* From 2014 through 2019, our fiscal year aligned with the calendar year. In 2020, we consciously shifted this so that we could better align our planning and budgeting season with that of our governmental partners. As such, this report covers activities from FY19 (January 1, 2019 - December 31, 2019) and FY20 (January 1, 2020 - September 30, 2020). From FY21 forward, our fiscal calendar will run October 1 - September 30.

In Ifanadiana District,
when PIVOT began:

1 in 7
children died
before their
5th birthday

1 in 14
women died
during her
reproductive
years

\$14
per capita was
being invested in
health care

IDENTIFYING THE CHALLENGE

Why, when solutions are known, affordable at scale and supported by policies, do they not reach the people who need them?

The answer, commonly known as the “know-do gap,” is that **even simple solutions require delivery via health systems**. Complex systems are intrinsically challenging to fix because the whole is different than the sum of the parts; a breakdown in one area of the system often has cascading effects on others.

The lack of critical evidence on how to strengthen health delivery at a system-wide level remains one of the great barriers to improving services and influencing policy that serves those most in need.

By integrating quality health care and scientific innovation throughout Ifanadiana’s district health system, we are creating a new model for global health delivery.

ESTABLISHING A MODEL HEALTH DISTRICT

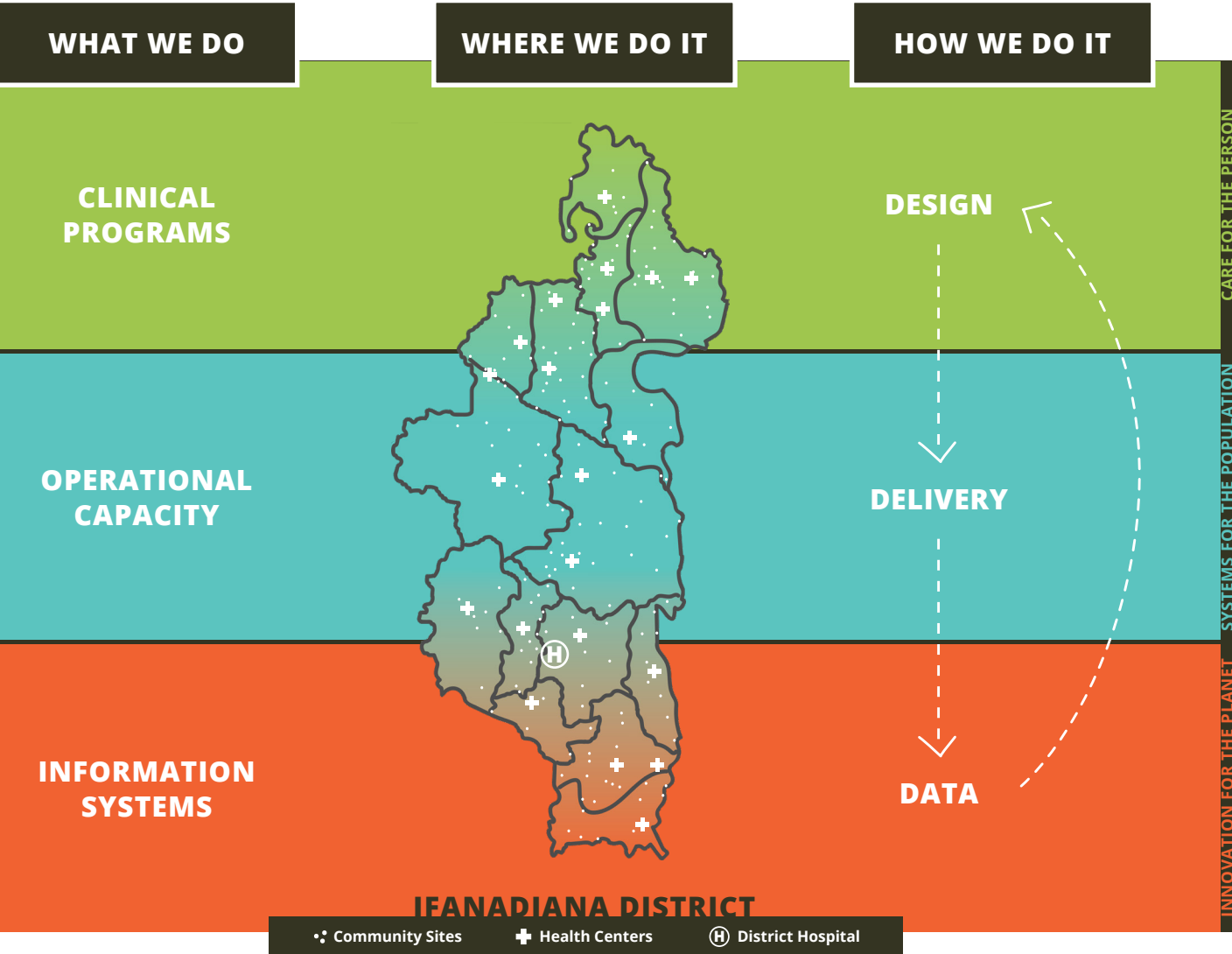
In Madagascar, a government district presents the most important, replicable unit of the public health system. Each includes a **hospital** to serve the district population, **health centers** in each municipal commune for delivery of primary care, and a network of **community health workers** providing care in their home villages. Since 2014, we’ve been working alongside the Ministry of Public Health to transform Ifanadiana District into a scalable model for Madagascar, producing lessons that can be applied in similar settings worldwide.

USING IT TO ACHIEVE HEALTH FOR ALL

From communities, to health centers, to the district hospital, we combine the delivery of high-quality **clinical programs**, with an emphasis on strengthening system-wide **operational capacity**, as well as the integration of robust **information systems** to monitor outcomes, conduct scientific research, and constantly improve our approach. **These components are the basis of the government’s universal health coverage plan rolling out in Ifanadiana as pilot for the country.**

“There is a gap between today's scientific advances and their implementation, between what we know and what is actually being done.”

– Lee Jong Wook
Former Director of the
World Health Organization



TURNING INSIGHTS INTO IMPACT

INTRODUCING:



Can model systems revolutionize global health as they have revolutionized the life sciences?

The development of an individual fertilized egg into the collection of cells, tissues, and organs that comprise a self-reproducing organism was once thought to be so wickedly complex as to be insoluble. What was needed was a platform that unified insights from many different disciplines; not on a particular biological mechanism, but around the interconnected set of processes that constitute the organism. Thus arose model organisms, the use of which have led to countless scientific breakthroughs, including vaccines for COVID-19.

This year, in keeping with this line of thought, we launched PIVOT Science, which aims to provide an enabling environment for scientific innovation that informs and advances our model of universal health coverage (UHC). With an unwavering commitment to advancing health as a human right, PIVOT Science shares the culture of the rest of the organization, with a management structure that supports scientific curiosity and allows space for creative freedom.

The PIVOT Science team is composed of PIVOT staff as well as a broader network of researchers – including ecologists, mathematicians, epidemiologists, physicists, biologists, engineers, and social scientists – from Madagascar and around the world.

"Through model systems, most major questions in developmental biology that were thought to be insoluble 40 years ago are now solved."

– Mark Krasnow

**Professor of Biochemistry at Stanford School of Medicine,
Member of the PIVOT Board & PIVOT Science Task Force**

PIVOT SCIENCE'S GUIDING PRINCIPLES



**Leverage and integrate
with existing systems**



Improve health services



**Produce evidence for
policy and scale-up**



**Strengthen long-
term partnerships**



Build local capacity



**Promote curiosity,
discovery, and innovation**

MAJOR RESEARCH DOMAINS

- Population-Level Impact Evaluation
- Geography & Community Health
- Operational Research for UHC
- Eco-Epidemiology & Surveillance
- COVID-19 and Molecular Diagnostics
- Capacity-Building

KEY COLLABORATORS

- Center ValBio at Stony Brook University
- Institut de Recherche pour le Développement
- Institut National de la Statistique de Madagascar
- Institut Pasteur de Madagascar
- Research Core at Harvard Medical School
- University of Antananarivo
- University of Fianarantsoa
- Stanford University

(See Pages 36-37 for more on our rights-driven research.)

THE STORY BEHIND THE SCIENCE

DR. BENJAMIN ANDRIAMIHAJA, SENIOR ADVISOR & BOARD MEMBER



My name is Dr. Benjamin Andriamihaja, and I have been a member of the PIVOT board since 2014.

I am a scientist, founder and director of the Madagascar Institute for the Conservation of Tropical Ecosystems, and a part of the leadership team for conservation research station Centre ValBio, one of PIVOT's primary local partners. I worked alongside PIVOT Board Member Dr. Patricia Wright in the 1990s to establish Ranomafana National Park, which today serves to protect thousands of endemic animals.

Over my years of involvement with the park and the science that it generates, I came to realize something: **There is no such thing as a healthy national park without healthy local people, and there can be no healthy local people without a healthy national park. The two are inseparable.**

The moment I realized this was the moment I realized that, if I wanted to help the country and the forest that I love, I must strive to find a healthcare solution that worked for local people. This epiphany may have come to nothing had I not met Jim and Robin Herrnstein, two of PIVOT's co-founders, when they came to visit Centre ValBio to learn more about the decades of scientific research we had spearheaded there.

Being scientists themselves, they immediately knew that the forest they saw had to be protected. But they also saw that its beauty exists side-by-side with some of the worst poverty in the world. Communities adjacent to the park were in a precarious situation, trapped in a vicious cycle of economic instability, underfunded education, and lack of access to even basic healthcare.

The problems were clear, but the solutions were not.

We agreed that we needed a scientific approach; a creative, evidence-driven intervention that would bring modern solutions to a generations-old problem. So together we enlisted Dr. Matt Bonds and Dr. Michael Rich, hoping that we could leverage their successes working with Partners In Health in Rwanda to launch an evidence-driven health systems strengthening effort as government partners in Madagascar. But, like hiking through the dense forest, making progress on this shared vision was difficult.



One story in particular from those early days illustrates the sort of challenge that we and the local communities were up against:

During our first group outing to visit a local health facility, we visited Ranomafana Health Center. There, we came across a young girl who was suffering from a severe case of cerebral malaria. Her parents, like so many before them, had made the **multi-day journey on foot from their rural community** which, given the state of the health system, was thought of as a last resort.

They made the difficult choice to **leave their work and other children behind for an unknown period of time**, chancing that the nearest health center would be staffed and equipped with what was needed to save her.

But what they encountered was a facility ill-equipped to meet the child's needs. When we arrived, it was obvious that Claudine was close to death, but she was not being treated.

Let me be clear: the problem was not in understanding what her condition was; we and the local doctors knew. The problem was also not in knowing what treatment she needed to recover; we have known that quinine treats malaria since the 17th century.

No, the problem was that **the quinine and IV bags were simply not available to the local healthcare system**. And, even if they were, **the family could not afford the few dollars it would take to buy them** at a nearby pharmacy.

We knew we had to act immediately. We took the family from the health center to a local pharmacy, bought the necessary supplies, then brought them to the district's one hospital. There, the little girl recovered in just two days, using less than five US dollars in supplies, and medical knowledge that is over 400 years old.

The worst part of this was knowing that this girl's life was saved by pure happenstance, and that so many others were dying in similar circumstances every day. So, with all the urgency that this incident instilled in us, we asked ourselves: How do we solve this problem?

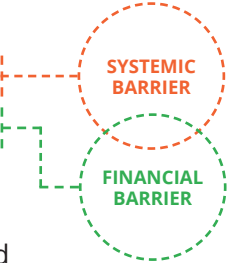
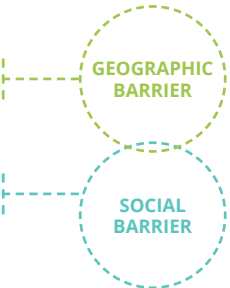
We decided that an NGO should be started, but it must be unique from any other healthcare intervention that already existed in Madagascar. It couldn't be a short-term solution that treated just the symptoms of a broken health system; we needed a strategy with a scientific approach, that would allow us to understand and address the underlying problems that were preventing people from getting the care they needed.

When we shared this idea with the Ministry of Public Health, I was elated to find that they were keen to try innovative solutions to the issues they and their communities had been facing for generations. They shared our passion for change, and needed access to the resources that could make it a reality.

This is where PIVOT found its opportunity to move the needle on health outcomes in Madagascar, and where a seed that would eventually grow into PIVOT Science was planted.

By surrounding our healthcare delivery efforts with robust data feedback systems from the start, we have been able to constantly improve access to and quality of care in Ifanadiana District over the past 7 years. We are constantly honing our understanding of the barriers to care that the population faces – be they **geographical, social, systemic, or financial** – and using rigorous research to overcome them.

Now, with PIVOT Science positioned to propel PIVOT's health systems strengthening strategy forward, **we are effectively narrowing the "know-do gap" in Madagascar** so that those in need of care no longer have to think of accessing public healthcare as a last resort, but rather as a reliable first stop on their journey to health.



● ----- “Ny marary andrianina” ----- ●

“The patient is king”

– Malagasy Proverb

Christian, age 4, at Ranomafana Health Center with his mother, awaiting news of his successful discharge from the malnutrition treatment program.



COMMUNITY HEALTH

OVERVIEW:

With thousands of miles of footpaths separating rural communities from the formal healthcare system, a network of professionalized, proactive frontline community health workers is the key to connecting people to the care they need and to achieving health for all in Madagascar.

Between January 2019 and the end of September 2020, PIVOT's community health program supported:

173

community health workers (CHWs)

bringing access to care closer to home for over 80,000 people

77

community-based health posts

where CHWs receive patients seeking basic health services

44,945

pediatric patient visits to CHWs

reducing the need for families to travel long distances on foot to access care

2,591

home visits to sick children

by CHWs piloting proactive care

(12-month pilot period only)

SPOTLIGHT: ENHANCING COMMUNITY-BASED CARE



This past year marked a crucially important and long-awaited milestone on our journey to universal health coverage: **sign-off from Madagascar’s government to pay community health workers (CHWs)** as part of a pilot study in our model commune, Ranomafana.

BACKGROUND | Compensated, professionalized community health workers are essential to bringing care to all corners of Ifanadiana District. Though the MOPH did not approve PIVOT’s first proposal in 2014 to provide a salary to CHWs, they did agree to implementing a new cadre of community health supervisors to provide mentorship and technical support for CHWs. Since then, our community team has focused on organizing regular trainings for CHWs, making field visits to observe and support them while in action, supporting community health posts with building materials, and providing modest compensation linked to participation in such activities.

But the health system cannot expect reliable full-time work from CHWs appointed as volunteers, and whose expected service to the community inherently compromises their ability to maintain a personal income, and vice versa. That’s why **the opportunity to pay CHWs at a rate equivalent to Madagascar’s minimum wage represents a huge step toward improving access to care for all.**

EQUITABLE PAY, EQUITABLE ACCESS | With backing from the MOPH to provide these essential frontline workers a dependable full-time wage for full-time work, we launched a pilot in October 2019 to enhance the existing national community health strategy that we have been supporting since 2014. Alongside key partners and funders, the aim is to improve the health of the population by increasing access to high-quality community-based care. Ongoing research will determine the impact of the program as its footprint expands, the per capita cost for care delivery under the new model, as well as health worker and community satisfaction.



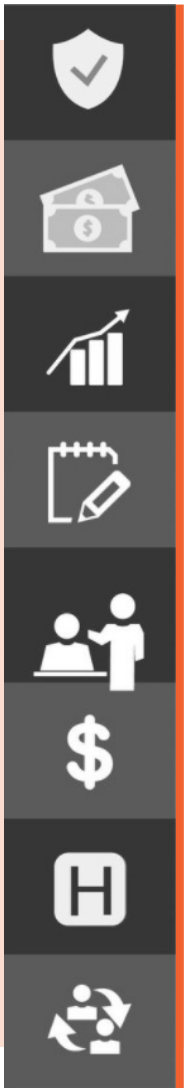
TWELVE-MONTH PILOT OUTCOMES

Based on these results, we look forward to expanding this proactive care model as part of our strategy to achieve universal health coverage throughout Ifanadiana District by 2022.

NOT GOING IT ALONE

Our enhanced community health pilot approach is supported by the eight design principles for effective community-led health systems, developed by the **Community Health Impact Coalition (CHIC)** and endorsed by USAID and UNICEF. Our fellow coalition members have been working to apply these same principles to their community health programs across the world. In order to optimize community-led health systems, we work to ensure that CHWs are:

- ACCREDITED
- ACCESSIBLE
- PROACTIVE
- CONTINUOUSLY TRAINED
- SUPPORTED BY A DEDICATED SUPERVISOR
- PAID
- PART OF A STRONG HEALTH SYSTEM
- PART OF DATA FEEDBACK LOOPS

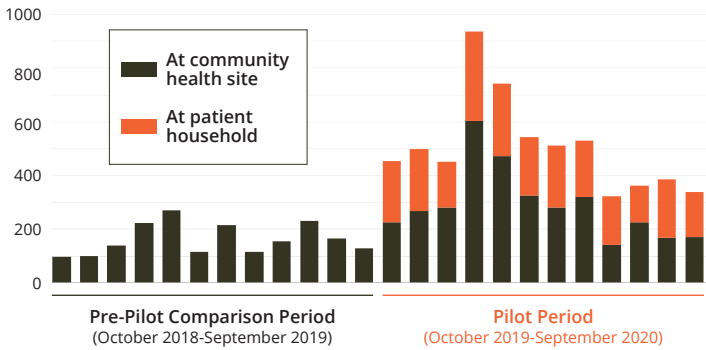


THE NEW APPROACH | In addition to professionalizing CHWs, **the new approach also introduces proactive care.** Each CHW is assigned a specific set of homes to visit on a regular basis, which ensures improved case-finding and follow-up care, while also fostering greater community trust in the system. To that end, importantly, the pilot program keeps the existing health posts staffed, now on a regular schedule, to avoid disrupting the system that the population is familiar with.

To achieve this two-pronged approach, we recruited additional CHWs per capita, and have increased the frequency of field-based supervision to twice monthly rather than quarterly, ensuring each CHW has the opportunity to develop skills and maintain a high quality of care for all patients.

PROMISING OUTCOMES | **Preliminary results for the pilot study (right) showed increased utilization and improved quality of care.** With continued government support, we plan to extend this approach to 4 more communes in 2021, and across the remainder of the district in 2022. Our aim is for the government to be able to use evidence from Ifanadiana District to advocate for paid, supervised, accredited CHWs as a crucial part of achieving universal health coverage in Madagascar and similar settings around the world.

Monthly Under-5 Consultations by CHWs in Ranomafana Commune, Before and During Pilot



The number of community-based **consultations for children under 5 increased by more than 200%** compared to the same period a year prior in the pilot commune.

In the pilot commune, **43% of patient care was delivered via proactive home visits**, telling us that household-level care is key to ensuring that rural populations have access to the care they need.

Adherence to Child Health Management Protocol by CHWs*

84%
in pilot commune

67%
in non-pilot communes

In Ranomafana, **quality of care improved markedly, reaffirming the importance of frequent CHW supervision**, as provided in the pilot.

Twice-Monthly CHW Supervision Rate*

94%
in pilot commune

64%
in non-pilot communes

*Excludes April-June 2020, at which time in-person supervision was paused due to COVID.



FOR KENITA AND MILLIONS MORE

In early 2020, 18-month-old Kenita was at home with her family when her mother discovered that she was running a fever. When it persisted for more than a day and Kenita continued not to act like her usual energetic self, her parents decided it was time to seek care.

Kenita's parents are farmers from Ambodiaviavy, a village of 1,060 residents in Ranomafana Commune, where PIVOT's enhanced community health model has been in place since October 2019. The family's home is situated such that any of their options for getting Kenita to care would require leaving their farm behind for an unknown period of time and risk falling behind on the work they rely on for income.

For thousands of families like Kenita's in Ifanadiana District, arriving to care typically means traversing mountainous terrain (and often bodies of water) on foot, very likely in rainy weather (given the season), carrying their sick child to the nearest facility. In many cases – especially prior to the progress the Ministry of Public Health and PIVOT made to strengthen the district health system there – this would also mean risking arriving at a health center that might not be staffed, equipped, or supplied with what a child like Kenita would require for effective treatment.

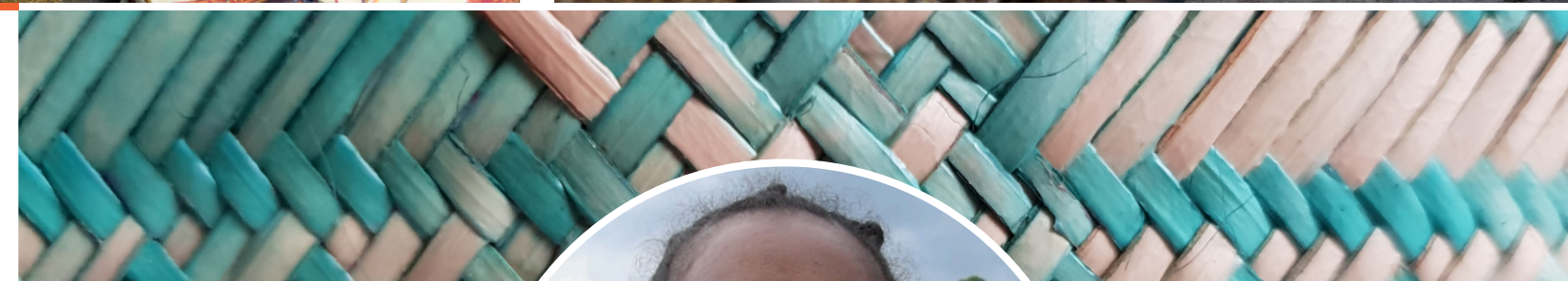
Just as Kenita's mother prepared to depart in search of treatment for her daughter's fever, Chantal arrived at their door (*Photo 1*). Chantal is one of the community health workers who is participating in our ongoing proactive care pilot and, on this particular day, she was walking her designated circuit for household-level care, which includes Kenita's home.

Regardless of whether Kenita had been ill that day, Chantal's visit would have involved the full child health screening she provided. She weighed and measured Kenita, examined her for signs of malnutrition and other common childhood health threats, and – upon confirming her high temperature – administered a rapid test for malaria.

Fortunately, Kenita's malaria test came back negative. Chantal proceeded to give her parents paracetamol to reduce her fever, knowing that even a benign febrile illness can cause health complications like seizures if not adequately controlled. Chantal also provided guidance for dosage, and assured the family that she would return in three days to check on Kenita's condition.

When she returned, she was met by an energetic, playful, and fever-free Kenita (*Photos 2 and 3*). A brief examination inside the family's home was all that Chantal needed to confirm that Kenita was symptom-free, with no further treatment required.

Had care not arrived when it did, Kenita's story could have had a very different ending, which remains the too-common reality for many in Madagascar. We are proud to be supporting the professionalization of Madagascar's community health workers using evidence from this pilot that demonstrates the lifesaving importance of their work on the frontlines around the world.



"As a community health worker, I humbly accept all people who seek care, no matter where they're from or how much money they have."

– Chantal Ravaonirina
PIVOT-supported Community Health Worker

Due to this pattern, too many families are unable to get to care in time, and what initially might have been a basic case of a curable illness turns into something more complicated or difficult to treat.

Per her training, Chantal also took this opportunity to advise the family on basic disease prevention measures, encouraging them to use their mosquito nets at night, especially given the time of year.

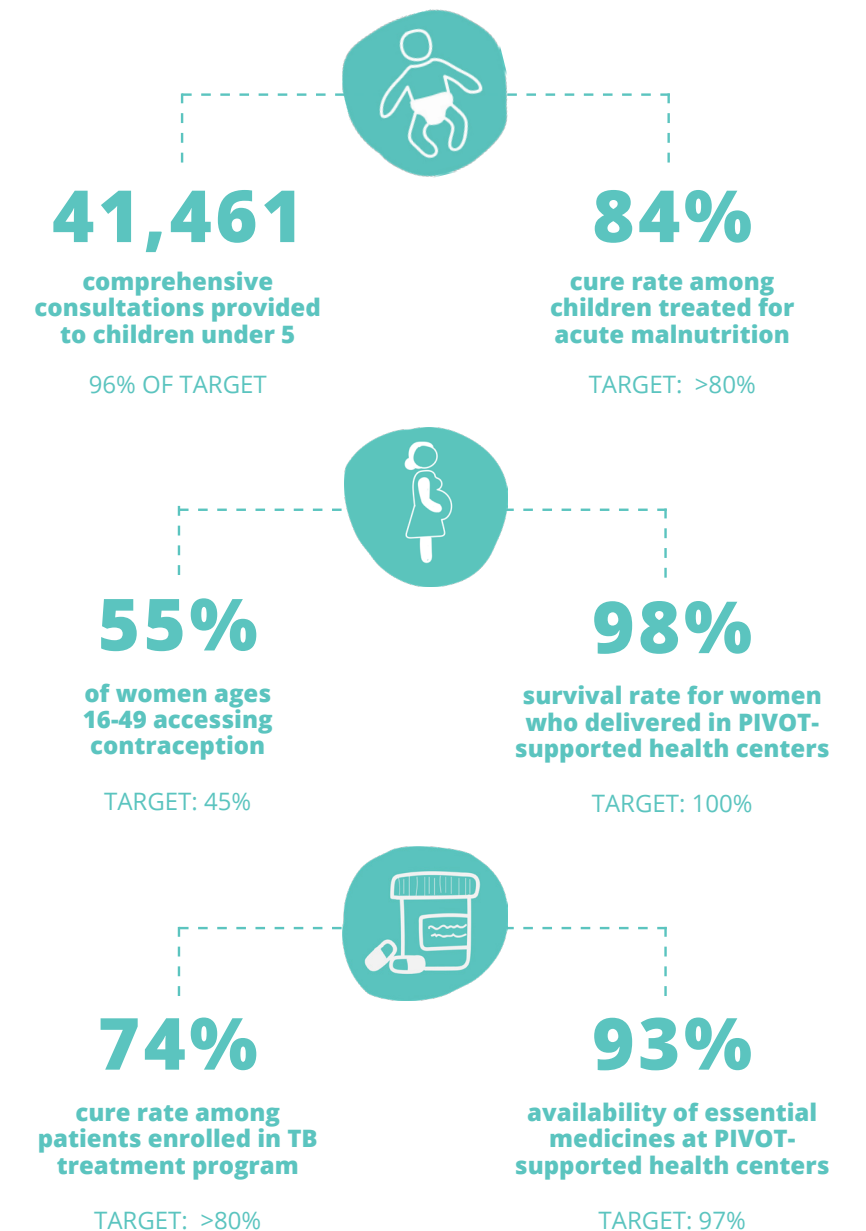


PRIMARY CARE

OVERVIEW:

In Madagascar, the public health system's *centres de santé de base* (basic health centers) are the cornerstone of comprehensive primary care. In addition to ensuring adequate staffing, supply chain, and infrastructure, the PIVOT team focuses its health center-level clinical programs to address a range of the population's most urgent health needs, prioritizing childhood health, infectious disease, and maternal and reproductive health.

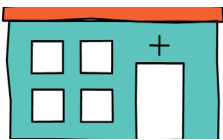
From January 2019 through September 2020, some of the major 21-month outcomes of those activities included:



As an essential link for patients referred by community health workers to higher levels of care, PIVOT-supported health centers will also play a crucial role on the path to achieving universal health coverage in Ifanadiana District by 2022.

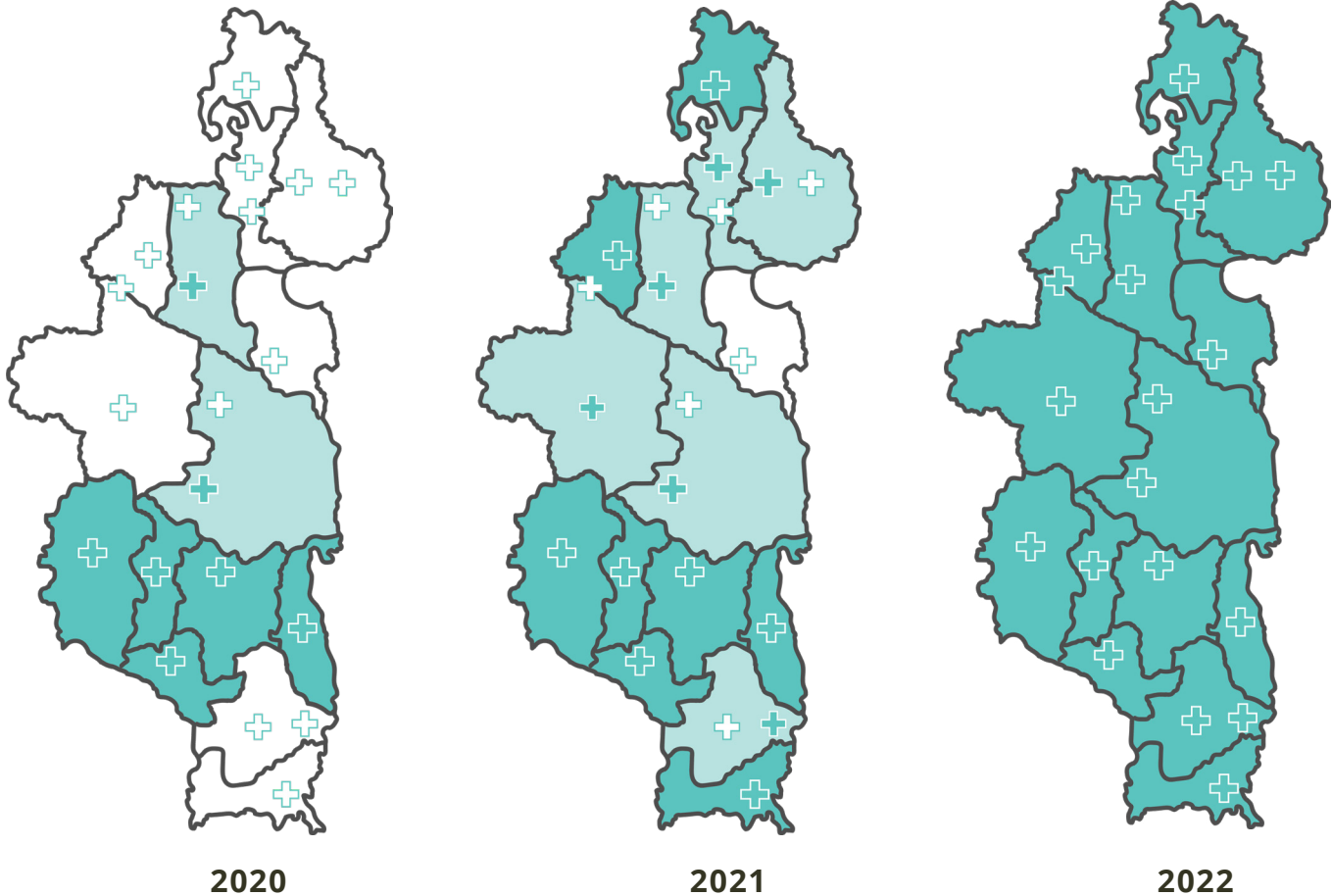
[Read on to learn more about our UHC expansion plans \(Pages 22-23\).](#)

SPOTLIGHT: MODELING UNIVERSAL HEALTH COVERAGE FOR MADAGASCAR



In late 2019, the Ministry of Public Health **officially designated Ifanadiana as the pilot partner district** to perfect and scale a national model of universal health coverage (UHC).

EXPANDING OUR FOOTPRINT TO ENSURE HEALTH FOR ALL



Ifanadiana District



In 2014, when PIVOT first removed fees for patients seeking care, we saw health center utilization quadruple. The years since have been about perfecting the elements – such as improvements to infrastructure, supply chain, and staffing – that made that possible, ensuring their sustainability, and working with the government to help incorporate them into UHC plans that can be scaled nationally.

Since the Ministry of Public Health's decision in 2019 to entrust PIVOT as a collaborator for the roll-out of UHC, rigorous planning has been underway to ensure that all components of the health system are accounted for in the process.

We know one crucial component is **high-quality primary care – without it, there is no functional health system**. If treatment cannot be provided at a patient's doorstep, community health workers must be able to reliably refer people to well-functioning health centers. And, if we catch diseases earlier and primary care functions well, hospital care is needed only for more extreme cases.

That's why PIVOT's process of ensuring quality primary care is currently focused around expanding primary care and community health services to communities we have not yet reached.

As we close out 2020, we are active in 7 health centers and the communes that host them. **By this time next year, we intend for that number to have doubled and to be offering full support to 14 public primary care facilities in the district.** Broadly, this entails:

- renovating health facilities for safe and dignified delivery of care;
- staffing and equipping health centers up to or beyond Ministry norms;
- ensuring robust supply chains and biomedical services;
- and building capacity among personnel – from cleaners to doctors – who commit their lives to service of their neighbors' wellbeing.

CHECK OUT OUR PLANS FOR EXPANDING THESE SERVICES

All the while, our integrated data systems enable our Monitoring & Evaluation and Science teams to analyze thousands of performance indicators, which will allow the government to iterate and adjust their plans based on the outcomes of the UHC pilot we are poised to launch at the start of 2021.

After years of using insights from our data to design and prioritize more effective interventions for remote populations with unparalleled granularity, our findings will arm the global community with new evidence for reducing geographic barriers to care. We will demonstrate how high-quality integrated UHC can be implemented in communities at the very last mile.

CLINICAL PRIORITIES AT THE PRIMARY CARE LEVEL:



CHILD & ADOLESCENT HEALTH



MATERNAL & REPRODUCTIVE HEALTH



MALNUTRITION



INFECTIOUS DISEASE

A CLINICAL TEAM DRIVEN BY VALUES



For my team, **HEALTH AS A HUMAN RIGHT** is about guaranteeing the availability of essential medicines at all levels of care.

Léa Rahajatiana
Deputy Director of Biomedical Services

HUMILITY means crossing waist-deep rivers on foot, enduring countless mosquito and flea bites, in order to deliver care to the most remote communities in the district.

Eldine Andriamaro
Community Health Supervisor

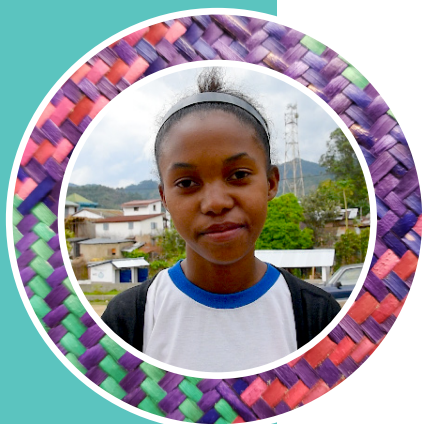


SOLIDARITY is a collaboration – between health center staff, ambulance teams, and a patient’s family members – to ensure patients’ wellbeing while they’re in our care.

Anjara Fenosoa Ratsimbarimanana
Ambulance Nurse

I embrace the **PURSUIT OF LEARNING** by attending trainings and reading the latest medical journals to keep my knowledge fresh and improve quality of patient care.

Solange Miadanarivo
Hospital Nurse



Having a **BIAS TOWARD ACTION** means not just waiting for patients to come to us, but also making home visits to find people in need of care.

Véronique Rasoamanarivo
PIVOT-Supported Community Health Worker

I practice **ACCOUNTABILITY** to our patients by providing psychological support throughout their hospitalization so that they can successfully complete their treatment.

Haritiana Rasolonirina
Social Worker



I’m committed to advancing the **SUSTAINABILITY** of our work by training and building technical capacity among Ifanadiana District’s primary care workforce.

Dr. Baolova Ratsimbazafy
Deputy Director of Primary Care

OUR VALUES GROUND US IN WHO WE ARE AND WHO WE ASPIRE TO BE.

We use our shared values as a guiding framework for decision-making – from the broad and strategic to the small and quotidian – and to promote mutual understanding with our Ministry partners.

As of 2019, every new PIVOT team member’s onboarding includes a values orientation. From doctors to drivers, nurses to cleaners, our 7 values provide an anchor that unifies our 200-person staff across hierarchy and geography, no matter what challenges we face.

(See Page 40 for more on PIVOT’s values.)



DISTRICT HOSPITAL

OVERVIEW:

Ifanadiana District has one central hospital, which offers the highest level of care available locally to the district's population of 190,000. Since 2014, PIVOT has been supporting the Ministry of Public Health to augment the facility's overall capacity, with a recent focus on improvements to existing infrastructure.

Over the last 21 months, we've fulfilled our commitment to transform it into a beacon of reliable health services – from basic services to more specialized care. We've built new pediatric, malnutrition, and infectious disease wards, established the first ever blood bank, and strengthened the pharmacy, laboratory, and emergency care units.

In the process of doing so, we've supported the following services at the hospital between January 2019 and September 2020:

>24,000

diagnostic tests performed at the on-site laboratory

592

surgical interventions carried out

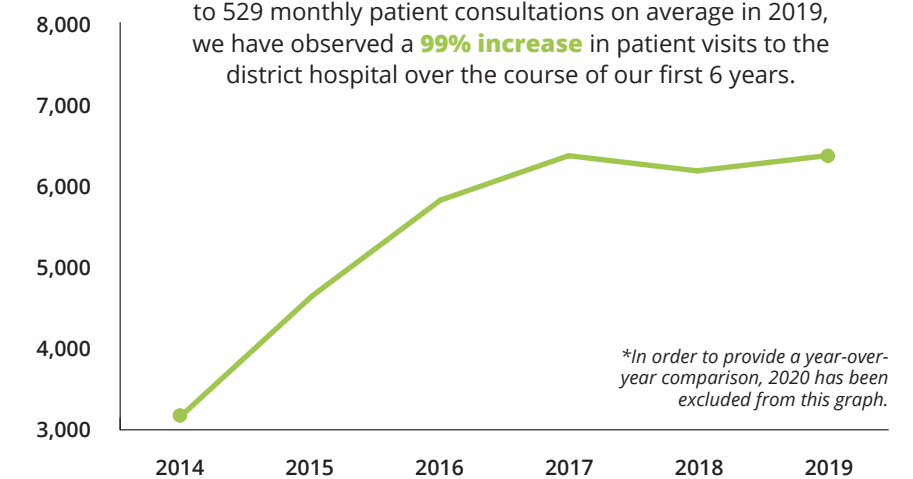
>89,000

meals served to patients and accompagnateurs

Robust diagnostic, surgical, and nutritional services are indicative of a high-capacity hospital that is reducing the need for patients to seek care outside of Ifanadiana District.

External Patient Consultations by Year*

From an average of 266 monthly patient consultations in 2014 to 529 monthly patient consultations on average in 2019, we have observed a **99% increase** in patient visits to the district hospital over the course of our first 6 years.



>36,000

external consultations for patients of all ages since 2014

SPOTLIGHT: BUILDING CAPACITY AT THE DISTRICT HOSPITAL



The story of Ifanadiana District Hospital over the past 21 months can be summarized as one of steady progress toward our goal of establishing a model district hospital and, in turn, strengthening trust between our teams, partners, and patients.

In 2014, PIVOT's founding team put forth a vision of a transformed hospital campus to better serve the patient population, their families, and our government partner. Over the course of 2019 and 2020, together with our Ministry of Public Health colleagues, we have made that vision a reality.

At PIVOT, we believe that **dignified facilities** are a prerequisite to providing respectful patient care, that **food** is as important as medicine, that a district **laboratory** should be able to meet the majority of patients' needs locally, and that an on-site **blood bank** can mean the difference between life and death.

Each of these points represents a milestone in the process of establishing a model district hospital that meets the needs of the population. Throughout that process, we are mindful to ensure that everything we do in Ifanadiana District can eventually be scaled and replicated by the government of Madagascar across the country's other 113 districts and their hospitals.

Entering the hospital grounds today, in contrast to 7 years ago, it is a place where one can envision giving birth safely, where the operating theaters are clean and well-functioning, where children who need to be hospitalized for severe malnutrition can have round-the-clock care, and where those who need care for deadly infectious diseases can be isolated safely and with dignity.

Moving forward, the challenge is to maintain those improvements – a uniquely difficult task in a place where the rainforest begins to reclaim buildings as quickly as the last coat of paint can be applied – and continue the trend of expanding and improving clinical services. Together with our government partner, we're committed to ongoing support to the staff, stuff, space, systems, and social support necessary to be a beacon of hope for the community.

New construction at the district hospital included:

- Infectious disease ward for isolation and treatment (*Photo 1*)
- Housing for families and *accompagnateurs* of hospitalized patients
- Expanded pediatric center for greater patient capacity
- Fence around the perimeter of the grounds for increased patient security
- Laundry facilities for both custodial personnel and *accompagnateurs*
- Housing for the on-site chief hospital physician
- Kitchen for preparation and delivery of meals for patients, their families, and staff (*Photo 5*)
- New mortuary space, relocated further from central buildings
- Water tower installed for reliable access to clean water

Other facility strengthening initiatives included:

- Establishment of an acute care unit within the emergency department
- Launch of on-site blood bank, with hosting of regular blood drives (*Photo 2*)
- Enhancement of laboratory testing capacity (*Photo 4*)
- Creation of a call center for doctors in remote communes to call for specialized guidance and/or referral coordination
- Development of a COVID surveillance and management system and isolation tent (*Photo 3*)

Professor Dr. Julio Rakotonirina, then-Minister of Public Health, leads a visit of high-level delegates from the central government, cutting the ribbon to inaugurate major renovations completed at Ifanadiana District Hospital in late 2019. (*Photo 6*)

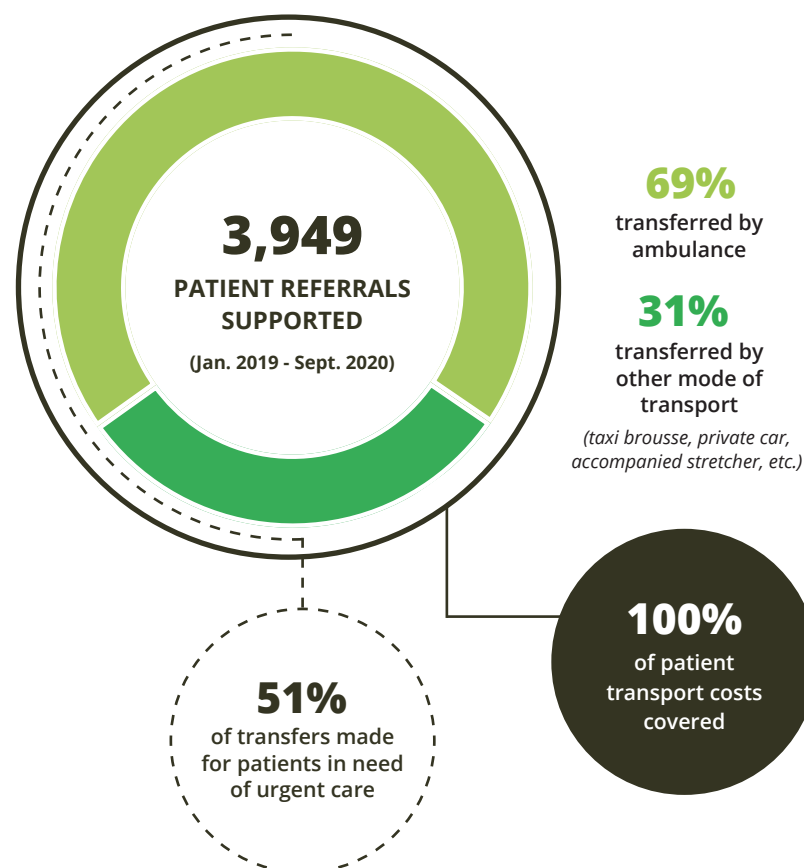




AMBULANCE REFERRAL NETWORK

In a country where the majority of the rural population lives far from the formal road system, traditional means of transport to care commonly involves a cadre of family members and community volunteers physically carrying loved ones to the nearest health facility. When a patient's needs require greater levels of care than community-based health workers can provide, PIVOT is proud to meet patients and their accompagnateurs where footpaths meet roads, and take it from there.

Operating the first 24/7 ambulance referral system in the country has enabled PIVOT to foster **greater trust in the overall public health system by connecting people to the services they need and covering all related transportation costs**, demonstrating how PIVOT is willing to do whatever it takes to provide lifesaving care.



SOCIAL SUPPORT

In Madagascar, leaving your family, work, and other responsibilities behind to get yourself or a loved one to care can be a leap of faith. Will the health center be equipped to serve you, how long will you be away (from children in your care, from your source of income), where will you sleep, and how will you provide food for your potentially hospitalized loved one? These are questions answered by our team of social workers, who accompany people through the continuum of care, including back home after discharge.

For the many members of the population who have never engaged with the formal health system, **our social workers are there to act as patient advocates to those navigating information presented by clinicians, and to provide psychosocial support to those hospitalized for extended care.**

The social team also complements facility-based services by extending supplemental care beyond acute health crises. For example, if one child in a household was malnourished enough to need in-patient care, we know there is a high likelihood that the entire household faces food insecurity. Through home visits, **our social workers make the links necessary to provide the most vulnerable families we serve** with support tailored to their specific needs.

(Jan. 2019 - Sept. 2020)

Provided essential supplies to an average of

162
VULNERABLE FAMILIES PER MONTH

INCLUDING:

>1,300
newborn kits
to mothers who had just given birth

>2,300
supplemental nutrition kits
to families of malnourished patients

>3,100
food & hygiene kits
to households with tuberculosis patients



COVID-19 RESPONSE

OVERVIEW:

PIVOT is no stranger to responding to crises, be they public health emergencies or devastating weather events. Madagascar sees annual bouts of plague, measles, and other illnesses eradicated from many other regions of the world, as well as frequent cyclones and droughts that result in mass displacements and food insecurity.

As we have learned through experience, building a strong, resilient health system is crucial to sustaining the health of a population. It's essential not only to mobilize resources that help mitigate and prepare for pandemics such as the one caused by COVID-19, but also to ensure our regular services don't falter. After seven years of partnering with the Ministry of Public Health, we've established the sort of strong foundation that was necessary to nimbly respond to the threat of COVID-19 together.

Since Madagascar's first diagnosed case of COVID-19 on March 20, 2020, our teams have mobilized to accomplish the following:

- Procured and distributed **PPE and essential equipment** (oxygen concentrators, pulse oximeters, vital sign monitors, and other materials critical for the diagnosis and management of patients) across Ifanadiana District and regions beyond
- Conducted **community education campaigns** through radio announcements, door-to-door canvassing, and at community events
- Published detailed **clinical guidelines** in French and English on the prevention, diagnosis, and management of COVID-19 in a setting like Madagascar, and shared with government health officials and peer organizations
- Loaned **ambulance and a team of paramedics** to the national government to support the COVID-19 response in Madagascar's capital Antananarivo
- Supported the government's **roadside checkpoint, screening over 70,000 travelers** for symptoms of COVID-19
- Established designated **isolation areas** for people infected with COVID-19 needing hospitalization and those unable to safely quarantine at home
- Established **psychological support services** for staff impacted by the global pandemic, including the opportunity for group or private counseling in Malagasy, French, and English
- Distributed **over 40,000 masks** throughout the district and, in the process, educated the population about the importance of masks, hand hygiene, and social distancing
- Initiated the set-up of a local molecular biology laboratory with **RT-PCR testing** capacity in collaboration with founding partner Centre ValBio, and distributed antigen rapid tests to extend COVID-19 testing beyond the nation's capital city

NOT JUST RESPONSE—RESILIENCE

DR. ALISHYA MAYFIELD, CHIEF MEDICAL OFFICER

We're writing this impact report during a moment unlike any other in modern history. A moment in which 214 countries and territories are linked by an infectious disease that none of us even knew existed when the year began. This is the first time in over 100 years that we have had to deal with a global pandemic of this magnitude, and we're seeing firsthand just how interconnected we truly are.

One of the most important lessons of the last few decades has been the need for resilient healthcare systems. This has been demonstrated time and again, whether it was with HIV, Zika, SARS, or Ebola. A resilient healthcare system is one that can sustain shocks and continue to function. It can meet the needs of people suffering from pathologies like stroke, heart attack, or pneumonia, and provide care for women going into labor and people requiring surgery, while at the same time dealing with the outbreak of a new infectious disease.

During the Ebola epidemic in West Africa, it's estimated that over 11,000 people died of Ebola. At the same time, almost as many people (over 10,600) died of healthcare problems that were unrelated to Ebola – things like malaria, diarrheal diseases, and complications of pregnancy – that went unaddressed because of the strain that Ebola put on the healthcare system. We also saw large outbreaks of measles soon after the Ebola epidemic, because so many children hadn't been able to get vaccinated during that period.

One of the key questions that we face currently in Ifanadiana District, and around the world, is: **How do you respond to an infectious disease outbreak while keeping the healthcare system functional?**

The answer is fundamentally the same whether you're in the United States or in a rural part of Madagascar: **We need to build strong healthcare systems and mobilize additional resources to rapidly meet new demands, while at the same time ensuring ongoing healthcare services remain intact.** We need to make sure there are services for the babies being born into the world, their mothers with asthma, their dads with diabetes, and everything in between.

In Ifanadiana District, we've spent years building up the healthcare system in partnership with the Government of Madagascar. We already have a network of trained community health workers. We support public primary care facilities that have the staff, equipment, and medications they need. We have been working alongside our Ministry of Public Health colleagues to strengthen the district hospital since 2014. We manage an effective referral system, complete with ambulances and trained paramedics who safely transfer patients from one level of care to another every day.

In addition, we've built that **critical component that is often lacking in emergency response: real trust with the communities we serve.**

Thus, when COVID-19 entered our global consciousness, we were prepared to mobilize a rapid, effective response to it. We believe we've truly lived up to the name "PIVOT" by reconfiguring our services and rapidly responding to this unfolding situation throughout 2020.

We managed to source, ship, and distribute personal protective equipment (PPE) to healthcare facilities across Ifanadiana District in roughly the same amount of time it took to do this in the United States, and leveraged our network of international partners to procure COVID-19 tests, which we distributed via our Government partners (Photo 3).

Under the leadership of Dr. Herinjaka Andriambolamanana, our Manager of Infectious Disease in Madagascar (Photo 1), we've trained healthcare personnel on how to safely identify cases of COVID (Photo 2) and on the appropriate use of PPE. At the community level, we've distributed tens of thousands of masks (Photo 4) and coordinated disease-prevention campaigns (Photo 5). At the district hospital, we've tripled the oxygen capacity, and worked across teams to develop guidelines for how to reconfigure healthcare settings in order to safely manage patients whether they have COVID or another disease.

As of December 1, 2020, Madagascar has reported just over 17,000 cases of COVID-19 and only 251 related deaths.

While this is still far too many, it pales in comparison to what's happened in the United States. Some of this can be attributed to the earlier onset and detection of cases in the US, but also to the more rapid and effective shutdown that took place across Madagascar. However, while much of the recent press on COVID-19 in sub-Saharan Africa has focused on the slower-than-expected rise in cases and deaths, this information is based on significant limitations in both testing and data collection, which means none of us really know how this epidemic will play out in Africa in the coming months.

Despite all of this uncertainty, we remain optimistic.

PIVOT is stronger than ever before. Our clinical and operations teams have spent most of 2020 both preparing for COVID-19 and laying the groundwork for the Government's plans to achieve UHC in Ifanadiana District. The PIVOT Science team's epidemiological modeling and research will help all of us better understand the threat of SARS-CoV-2 in rural Africa. Together with our local partner Centre ValBio (CVB), we are working to build high-tech polymerase chain reaction (PCR) testing capacity in Ranomafana, while simultaneously rolling out rapid testing across the District that allows people to get a diagnosis in just 15 minutes. And you, PIVOT's community, are helping us ensure that frontline workers know we have their backs during this dangerous time.

COVID will not be over anywhere until it's over everywhere, which is why we're especially grateful to have you on this journey with us. We will keep you informed of our progress as we - the Government of Madagascar, PIVOT, and our supporters - continue onward together in the face of this pandemic.



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2

3



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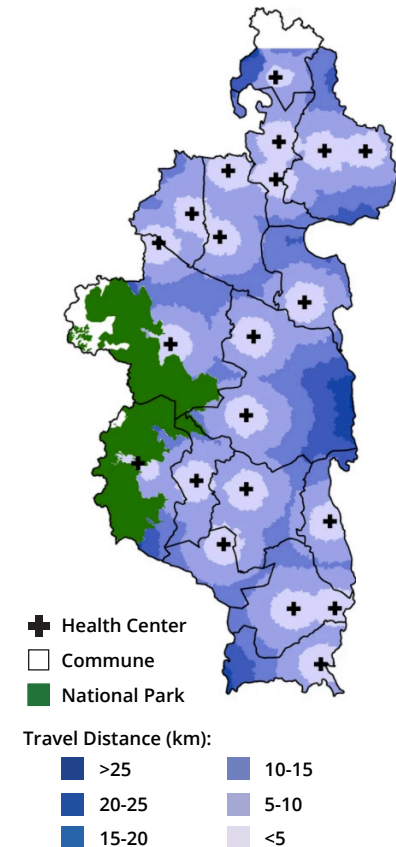


5



SPOTLIGHT: SAVING LIVES THROUGH SCIENCE

INNOVATING AROUND GEOGRAPHIC BARRIERS TO CARE



Geography is one of the greatest barriers to accessing care in rural areas of the developing world. This past year, **Dr. Felana Ihantamalala** (postdoctoral researcher for PIVOT and Harvard Medical School) led a study to develop precise, context-specific estimates of geographic accessibility to care to help with the design and implementation of interventions that improve access for remote populations.

Using a participatory approach, she **mapped over 100,000 buildings, 5,000 residential areas, and 23,000 kilometers of footpaths** throughout Ifanadiana District. These were combined with high-resolution data on land cover, elevation, and weather to predict travel time to health care from anywhere in the district.

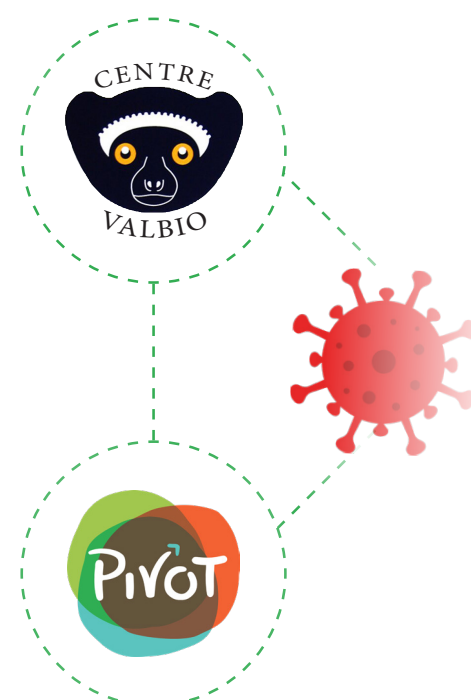
These data are now accessible via an **open-source e-health platform called LALANA (or “path” in Malagasy) that functions similarly to Google Maps** for determining optimal travel paths between any two points in the district.

This innovation could be key to advancing universal health coverage in rural areas around the world.

CONTRIBUTING TO THE FIGHT AGAINST COVID-19

COVID-19 has created a critical urgency to leverage our collective expertise to better understand and fight the pandemic, especially in settings like Madagascar. **We’re investigating questions like: why are reported cases of COVID-19 low in Africa compared to other parts of the world?** We’ve combined mathematical models with data on non-pharmaceutical interventions (NPIs), age-structured contact rates, and testing in Madagascar. The resulting models showed that NPIs work to delay introduction of disease, but low rates of testing in rural areas suggest the outbreak may be worse than reported.

PIVOT Science is partnering with Centre ValBio to establish the only RT-PCR testing lab outside of Madagascar’s capital city. Extending access to testing in CVB’s existing Ranomafana-based molecular biology laboratory will enhance the ability of the public health system to adapt to the spread of cases in rural regions beyond the capital.



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"I'm sick of science not helping people. We don't need science to demonstrate things that already work. We need science to help us understand what doesn't work, and how to fix it."

– Matt Bonds
PIVOT Co-Founder & Scientific Director

Community Health Supervisor Berger accompanies PIVOT-supported community health worker Lemiarina on his walking circuit to provide household-level care.

LIVING PIVOT'S VALUES IN OUR EVERYDAY WORK

Our values ground us to who we are and who we aspire to be. When PIVOT hit the ground running in early 2014, our nascent team narrowed in on implementing strategies to strengthen Ifanadiana District's public health system with speed and enthusiasm fueled by a passion for making lifesaving care accessible to all.

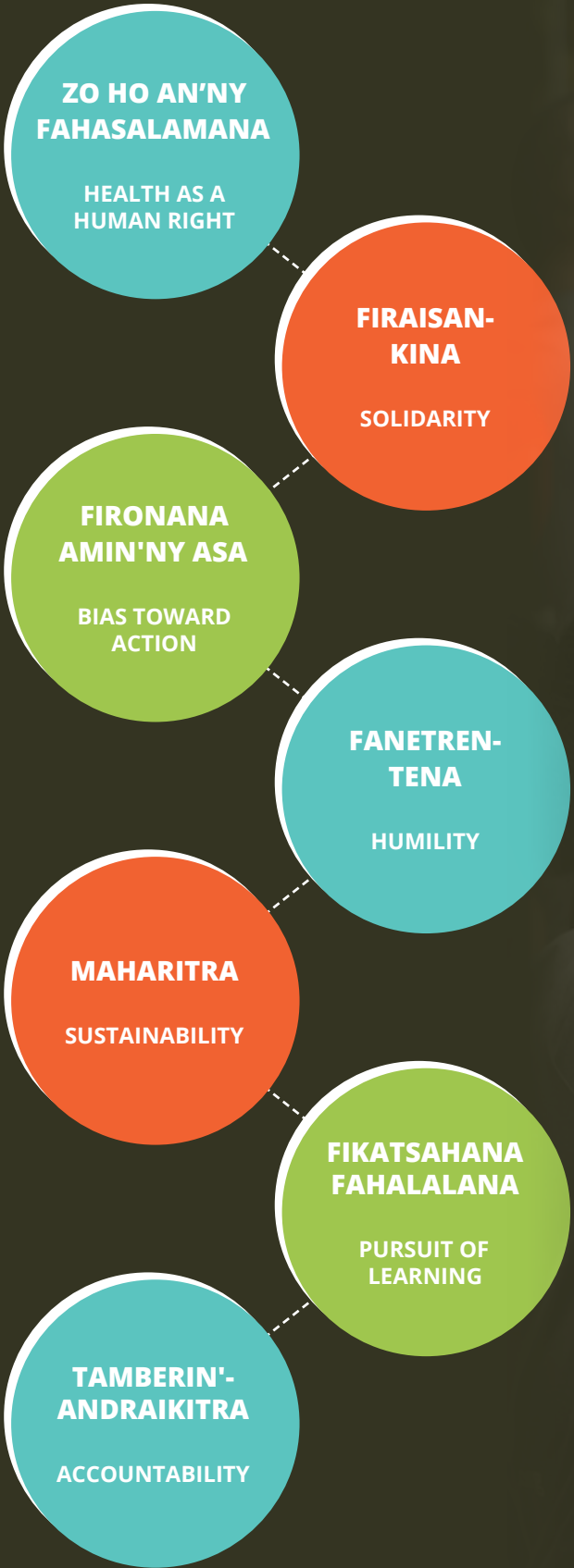
Upon reflection motivated by the 5-year milestone in 2019, we realized that we were taking for granted that each new staff member and government partner would be familiar with the humanitarian values upon which PIVOT was founded, and that our ability to ensure their manifestation in our work may have been outpaced by our growth.

The importance of this amounts to more than cultivating organizational culture – **we believe that our values can and should serve as a framework for making decisions, from the broad and strategic to the small and quotidian.**

So, we dedicated the second half of 2019 to re-engaging with our values (listed on the right) in order to establish a greater understanding of the meaning these values have taken on in our everyday work, explore the Malagasy proverbs associated with them, and determine how we collectively envision using them to inform PIVOT's strategy as well as our actions as individual members of a values-driven team.

Every member of our 200-person staff participated in a series of conversations around our origin story (including our lineage from Partners In Health and founding partnership with Centre ValBio). Takeaways from those conversations contributed directly to the development of a values-based orientation. This is now a mandatory part of onboarding for all new staff and PIVOT-supported community health workers, and has been shared with regional partners and peers, including the MOPH, who has named a deepened understanding of PIVOT's *raison d'être* as a result.

Looking ahead, we are eager to share some of the ways in which recommitting to our values drives strategic and structural evolution for PIVOT, all with the goal of building capacity on the ground for longer-term life-saving impact in Madagascar.



LEADERSHIP FOR THE LONG-HAUL

TARA LOYD, EXECUTIVE DIRECTOR

The photo to the right brings me great pride. It represents a maturation of our organization as our Malagasy staff rise to essential positions of leadership. This is our ten-person **Senior Management Team**, composed of the people who are on the ground, running the show. With seven Malagasy members and seven women rounding out this tier of leadership as of February 2020, we are heading in the right direction.

A year ago, a comparable photo would have shown four people – all expatriates, and just one of them a woman. These are exciting times for PIVOT; a chance to have what we are doing in Ifanadiana District contribute to the rest of Madagascar and similar settings worldwide. To achieve its greatest potential, **this effort must be locally led.**

“NGO headquarters, academic journals, and decision makers are too often removed from the problems they purport to solve, allowing the field of global health—knowingly or not—to perpetuate patterns of power and dominance that we must instead dismantle. Those living the reality of the problems have, regularly and structurally, been excluded from authoring the solutions. **This must change.**”

– Tara Loyd

excerpted from her piece in the Stanford Social Innovation Review, “Moving Closer to the Problem and Closer to the Solution.” Access the full article:

bit.ly/pivot-ssir-2020

There has also been a significant shift for our US-based support staff. As you may have read in my piece published this year by the Stanford Social Innovation Review, Moving Closer to the Problem and Closer to the Solution, I laid off the majority of the US team earlier this year. My goal in doing this was to shift PIVOT’s center of gravity from Boston to Ranomafana; to shift authority and access to resources to our field-based Senior Management Team. As difficult as this change was for all touched by it, it marked PIVOT’s first measurable contribution toward the movement to **decolonize global health.**

Also on the US front – as an organization with American founders and supporters – we cannot ignore the renewed fight for racial justice taking place on our own soil throughout this tumultuous year. Following the murder of George Floyd and our country’s long and ongoing history of too many similar stories, PIVOT, like so many others, began to examine how we can be better allies to the **Black Lives Matter** movement here at home. I commit to our continued, deepened work in this space in the coming year.

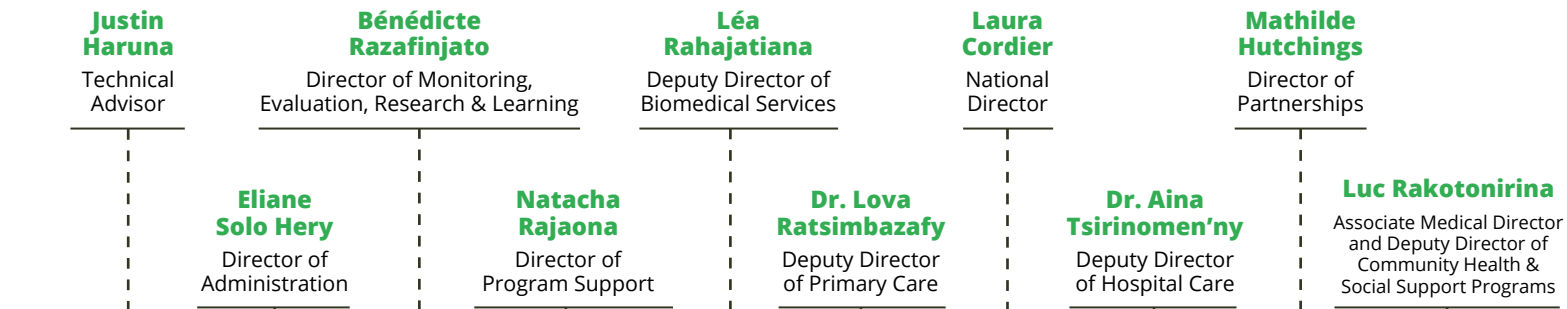
One first step is decoupling these two distinct movements – decolonizing global health and fighting for racial justice in the US – to be sure we are not conflating their goals nor our role within them. The first requires PIVOT to consider who holds leadership in Madagascar and what decision-making authority really looks like in practice (i.e., operationalizing

new relationship dynamics across staff and board in a way that honors the major structural shifts made earlier this year). The second requires taking a hard look at our majority-white US-based staff, advisors, board, donors, vendors, and academic institutions that make up the PIVOT community, and evolving to ensure we are centering Diversity, Equity, and Inclusion in all that we do.

The question I have been asking myself is, once we (those closest to positional power in this world) bear witness to vast inequity and commit to taking action to change it, where are our efforts best placed in the org chart, in relationship to the work of trying to enact change for the better, especially if that work is far (in any sense) from the problems we’ve personally experienced (few they may be). My role and positional power as PIVOT’s executive director is one to examine, as is a commitment to greater diversity and Malagasy representation in our Board of Directors.

These are the kinds of questions 2020 has laid at our feet. Our commitment to learning, humility, and solidarity will guide us in rising to address them, and I welcome the journey. In the coming year, you can expect to hear more about how we continue showing up for these issues as well as other **intersections of equity that we believe are essential to uphold** as a humanitarian organization committed to the health of people, our planet, and our global society.

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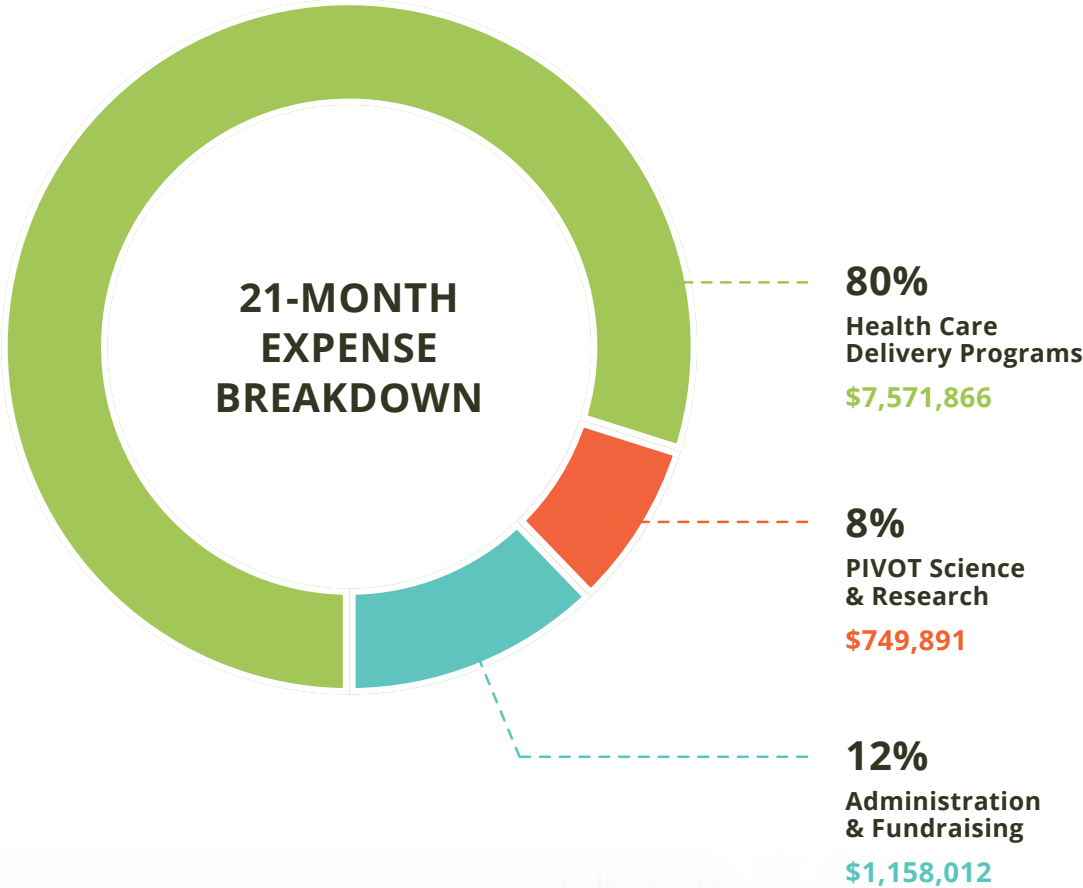
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EXPENSES	FY2020 9-MONTH PERIOD	FY2019 12-MONTH PERIOD
Health Care Delivery Programs	\$2,686,617	\$4,885,249
Research	\$323,473	\$426,418
Administration & Fundraising	\$480,492	\$677,520
TOTAL	\$3,490,582	\$5,989,187

REVENUE		
Grants & Contributions	\$4,028,355	\$5,393,159
Foundations	\$820,717	\$1,147,435
Individuals	\$3,207,638	\$4,245,724
In Kind	\$23,845	\$732,283
Interest & Dividends	\$2,493	\$8,217
TOTAL	\$4,054,693	\$6,133,659
NET REVENUE	\$564,111	\$144,472

ASSETS		
Cash & Cash Equivalent	\$3,373,214	\$2,534,018
Pledges Receivable	\$222,771	\$600,000
Prepays & Other Current Assets	\$426,533	\$195,551
Fixed Assets, Net	\$379,085	\$383,771
Other Assets	\$2,919	\$5,121
TOTAL ASSETS	\$4,404,522	\$3,718,461

LIABILITIES & NET ASSETS		
Accounts Payable	\$184,929	\$194,827
Accrued Expenses	\$187,177	\$118,520
Long Term Debt (PPP Loan)	\$107,572	\$0
TOTAL LIABILITIES	\$479,678	\$313,347
Net Assets, Unrestricted	\$3,496,401	\$2,830,958
Net Assets, Temporarily Restricted	\$428,443	\$574,156
Research Activities	\$91,755	\$283,876
Community Health	\$232,233	\$194,156
Construction	\$74,043	\$74,042
Other	\$30,412	\$22,082
TOTAL NET ASSETS	\$3,924,844	\$3,405,114
TOTAL LIABILITIES & NET ASSETS	\$4,404,522	\$3,718,461





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“Ny fahasalamana
no voalohan-karena”

**“Health is the
first wealth”**

– Malagasy Proverb

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