

Home Visit (Mumbai, INDIA)

ANNUAL REPORT 2025

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A grandmother raising her grandsons, with support from SAHI, following a fire at their 'home' (southern Madagascar)

ATIA 2025

GENERAL OVERVIEW

2025 IN BRIEF

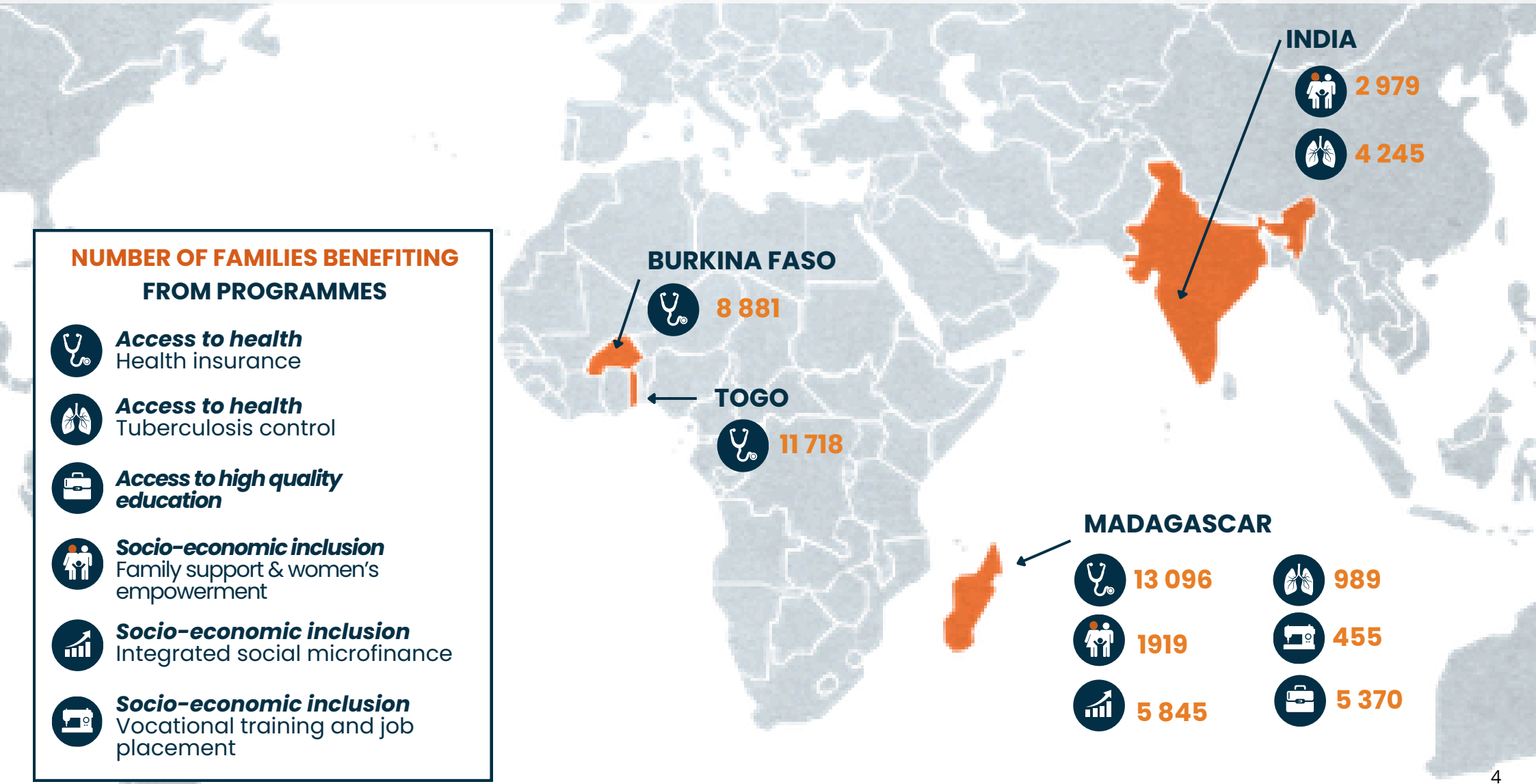
- **4** countries
- **14** programmes

- **55 497** beneficiary families
  i.e. around **222 000** people

- Total expenses: **€3.4 million**
- Average cost / family / year: **€63**

NUMBER OF FAMILIES BENEFITING FROM PROGRAMMES

- ***Access to health***
  Health insurance
- ***Access to health***
  Tuberculosis control
- ***Access to high quality education***
- ***Socio-economic inclusion***
  Family support & women's empowerment
- ***Socio-economic inclusion***
  Integrated social microfinance
- ***Socio-economic inclusion***
  Vocational training and job placement



ATIA'S APPROACH

CREATED IN 2008, ATIA IS A NON-PROFIT ORGANISATION, SPECIALISED IN THE DESIGN AND IMPLEMENTATION OF CONCRETE DEVELOPMENT AID PROGRAMMES.

Its purpose is to help the most disadvantaged families improve their living conditions by themselves.

Extreme poverty is characterised by severe deprivation in multiple areas that affect families simultaneously.

Progress made by a family in one area can therefore be undermined by setbacks in another. For example, micro-entrepreneurs may be forced to liquidate their business assets to pay for medical care in the event of illness or an accident.

- **At the social and economic level,** our programmes aim to reduce family poverty by raising awareness of rights and accessible services, and by strengthening motivation. Particular emphasis is placed on empowering women, tackling domestic violence, and improving access to economic opportunities.

We also help families to increase their income by providing training, assisting with job placement, and promoting self-employment through social microfinance. The vast majority of our beneficiaries are mothers.

- **In terms of health,** we develop community-based health insurances for the most vulnerable families to improve their access to local healthcare. We also contribute to the fight against tuberculosis, which disproportionately affects disadvantaged families, and to strengthening the healthcare system by training health professionals.

- **In the field of education,** we work to improve access to quality preschool and primary education for children in deprived areas, reduce school dropout rates and enhance the educational resources available to teachers and parents.



ACTIONS LED BY AND WITH LOCAL PARTNERS

ATIA: ACTING AS AN INCUBATOR FOR LOCAL ORGANISATIONS

ATIA works with vulnerable populations through local partner associations, either pre-existing or created with its support, which jointly implement the activities.

These partners receive technical, organisational and financial support from ATIA until they become autonomous.

ATIA is involved in designing and implementing activities through expatriate staff — programme managers or technical advisors — who are based directly in the field. With the support of their head of sector at the headquarters, they assist local partners in carrying out activities, train teams, help establish local associations, ensure that activities are of a high quality, and oversee the proper use of funds.

Heads of sector, as well as Administrative and financial managers, provide continuous support to partners from both the headquarters and through regular field missions

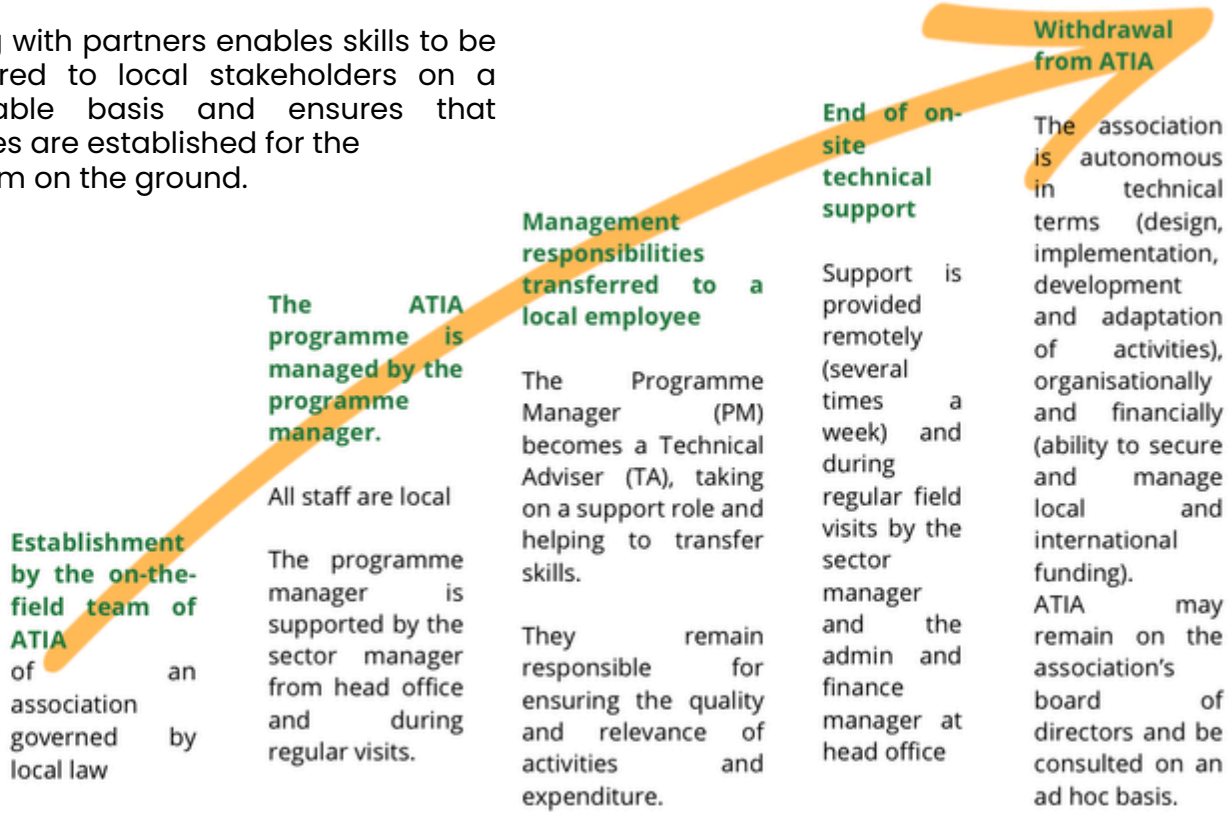
Collaboration with local associations is based on formal partnership agreements, which are reviewed and updated annually.

Once a partner has achieved a solid technical level, as well as organisational and financial viability, ATIA gradually withdraws from the system. The local association then becomes autonomous in both implementing and financing its activities.

As development is a long-term process, this path to autonomy generally takes at least ten years — and often longer.

Working with partners enables skills to be transferred to local stakeholders on a sustainable basis and ensures that initiatives are established for the long term on the ground.

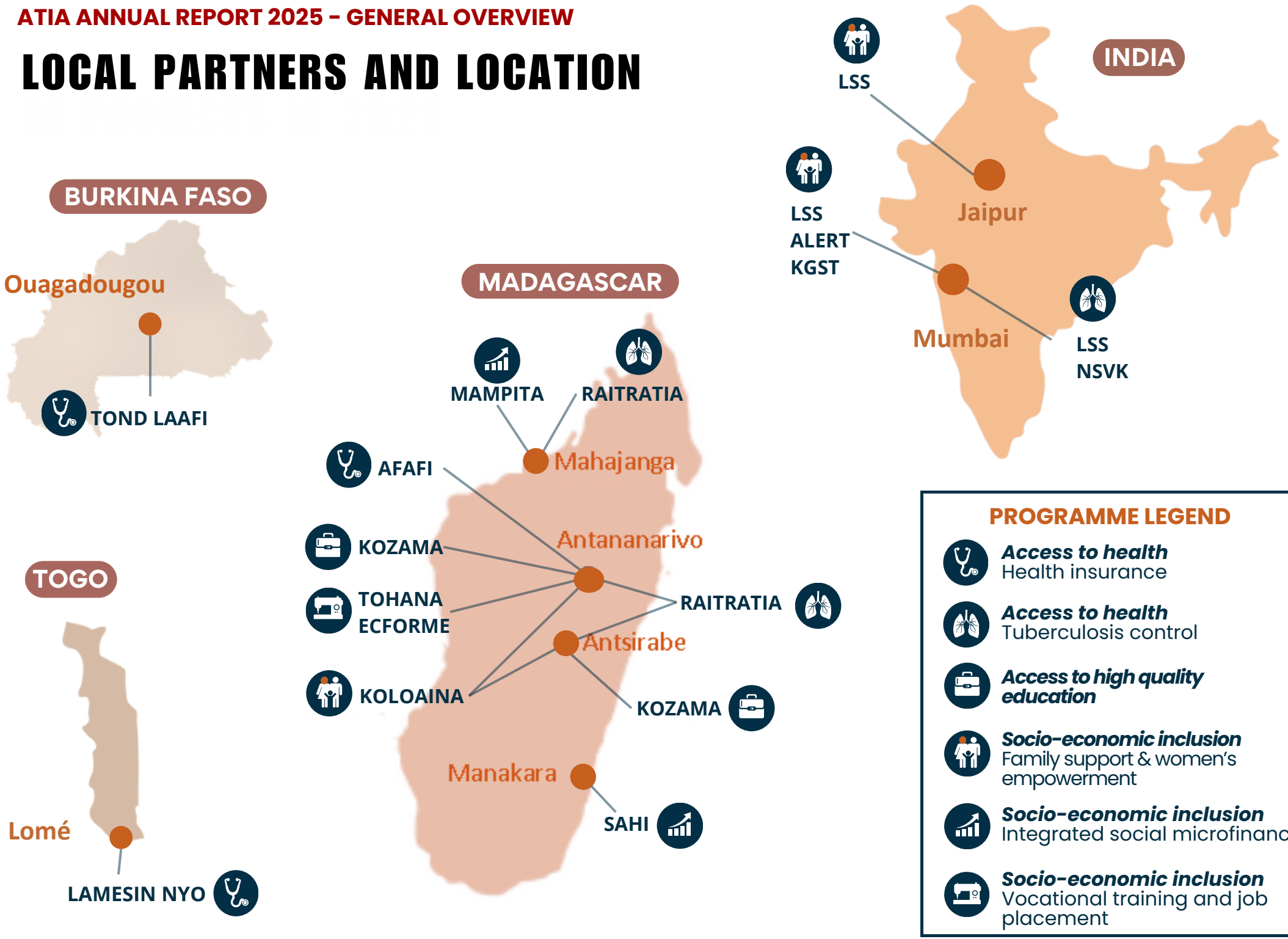
Programmes whose activities generate revenue (health organisations, microfinance schemes, training organisations with production facilities) can become self-sustaining more quickly, as part of their activities is already self-financed. Social, health and education programmes, on the other hand, must be 100% subsidised, and ATIA's support may be required in the longer term.



SITUATION AND DISTRIBUTION OF PARTNERS IN 2025:

1	1	9	3

LOCAL PARTNERS AND LOCATION OF PROJECTS - A 2025



PROGRAMME LEGEND

- ***Access to health***
  Health insurance
- ***Access to health***
  Tuberculosis control
- ***Access to high quality education***
- ***Socio-economic inclusion***
  Family support & women's empowerment
- ***Socio-economic inclusion***
  Integrated social microfinance
- ***Socio-economic inclusion***
  Vocational training and job placement

PROGRAMMES HISTORY

Programmes created by INTER AIDE before 2008 and taken over by **ATIA** et still supported by ATIA en **2025**

1980's - Family Development Programme
INDIA
Social

1980's - TB
INDIA
Tuberculosis control

1995- KOLOAINA
MADAGASCAR
Social

2003 - VAHATRA
MADAGASCAR
Social microfinance

2007 - AFAFI
MADAGASCAR
Health insurance

2008 - MAMPITA
MADAGASCAR
Social microfinance

2008

2008 - 2018

CREATIONS

2009 : KOZAMA
MADAGASCAR
(Antananarivo)
Education

2015 : SAHI
MADAGASCAR
(Manakara)
Social microfinance

2016 : ADESEF
MOZAMBIQUE (Maputo)
training and entrepreneurship

2018 : TOND LAAFI
BURKINA FASO (Ouagadougou)
Health insurance

AUTONOMISATIONS

(programmes created before 2008)

2012 - 2018 :

- INDIA (Mumbai et Pune)
Microfinance and Health insurance
- MADAGASCAR (Antananarivo)
CEFOR Microfinance
- PHILIPPINES (Manille)
ENFaNCE Microfinance and social

+ Creation-extension of the Family Development Programme in Jaipur (INDIA) *Social*

2018

2019 - 2024

CREATIONS :

2019 : HFC
BANGLADESH (Dacca)
Health insurance

2019 : TOHANA
MADAGASCAR
(Antananarivo)
Professional training

2020 : RAITRA
MADAGASCAR
(Antananarivo, Antsirabe, Mahajanga)
Tuberculosis control

2023 : LAMESIN NYO
TOGO (Lomé)
Health insurance

AUTONOMISATION

2024 : VAHATRA
MADAGASCAR (Antsirabe)
Social Microfinance

CLOSURES

2021 - ADESEF
(MOZAMBIQUE)
Lack of efficiency (cost per beneficiary too high)

2023 - HFC (BANGLADESH)
Lack of social adhesion and of financial viability

+ ECFORME
(MADAGASCAR)
taken over

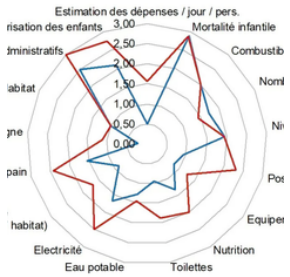
Extension of **KOZAMA**
(Education, Madagascar)
in Antsirabe

Evolution of **RAITRA** in **RAITRATIA**
Community health

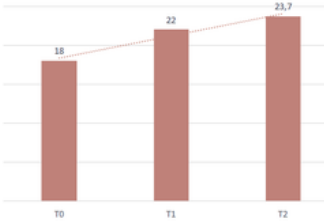
Extension of **KOLOAINA** (Social, Madagascar) in Antsirabe

2025

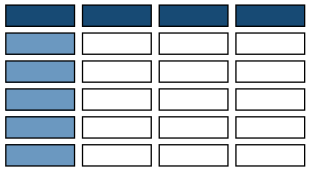
MONITORING TOOLS



The 'PAT (Poverty Assessment Tool) score' :
Tool measuring multidimensional pocerty, developed by ATIA, integrating international references (MPI Univ. Oxford).
Evaluates 5 fields : economics, health, education, social et living conditions. Each criterion (17 in total) is rated from 0 to 3 (max. 51 pts).



The Empowerment scale *(6 dimensions)* :
Tool developed by ATIA from international scientific références to measure women autonomy and its evolution.
Evaluates: mobility, decision-making processes, savings, nutrition, physical domestic violence, household tasks.
The score is between 0 and 30.



The Objectives list *(27 possible objectives)* :
Each family works with the social worker to set its priorities.
The objectives set are then monitored at each visit, which makes it possible to measure the resolution rate (according to pre-defined criteria) by area: health, finances, psychosocial issues, education and administrative documents.
E.g.: "enrol my child in school"; "obtain an identity card"; "visit the doctor", etc.

***ATIA* IS COMMITTED TO CONTINUOUSLY ANALYSING THE TARGET POPULATION OF ITS PROGRAMMES, BOTH TO ENSURE THAT IT CONSISTENTLY REACHES THE MOST VULNERABLE PEOPLE, AND TO EVALUATE THE IMPACT OF THE PROGRAMMES ON THEIR LIVING CONDITIONS.**



Data collection and analysis :
Data collection and analysis:
Each family has a structured individual file, which is updated at each visit. All data is entered into a database shared across the entire programme and is analysed on a regular basis

Example:

As part of the social support programme in India, assessments at T0 (before a family begins receiving social support), at T1 (at the end of the support period, i.e. after 6 months) and at T2 (6 months after the end of the support period) enable the impact of the interventions and the sustainability of that impact to be measured. In 2025 in Mumbai and Jaipur (India), more than 33,860 home visits were recorded, and all 2,979 case files are documented and traceable. Analysis of these records shows that, on average, families:

- scored 7 points higher (on a scale of 51) on the 'PAT score' assessment
- achieved 75 per cent of the goals they had set themselves within 6 months.

Furthermore, the women have:

- reduced their tolerance of domestic violence from 67 per cent to 17 per cent,
- increased their income by 30 per cent (for those already in employment).

At baseline (T0), 88 per cent of the women had no income. By the end of the follow-up period, 70 per cent were in paid employment.



A support group between mothers-in-law (Mumbai, Inde)

ATIA 2025

THE PROGRAMMES

ACCESS TO EDUCATION

- **Strengthening of the public education system:** MADAGASCAR

STRENGTHENING OF THE PUBLIC EDUCATION SYSTEM





Morning ritual in a school

Madagascar continues to face a structural crisis in the education sector, which is particularly acute in rural areas and deprived urban neighbourhoods.

Despite political efforts and international support, **access to equitable, high-quality education remains limited.**

The education system suffers from a shortage of qualified teachers, a lack of initial teacher training (nearly 80 per cent of teachers have not received any) and poor teaching conditions: overcrowded classrooms (more than 50 children), inadequate infrastructure and a scarcity of teaching materials. Only 40 per cent of children are enrolled in pre-school (nursery classes), yet pupils who do not attend pre-school are more likely to repeat a year or drop out of primary school.

Furthermore, due to insufficient public funding, families are having to cover an increasing share of schools' running costs, which exacerbates inequalities in access to education and contributes to children dropping out of school, particularly among the poorest families.

Against this backdrop, KOZAMA's initiatives address a critical need: to expand access to pre-school education, strengthen the skills of pre-school and primary school teachers, and improve the learning environment.

KOZAMA works in close partnership with the Ministry of Education and aims to have a lasting impact on the educational attainment of the most vulnerable children.

Against a backdrop of severe constraints, characterised in particular by a persistent education crisis, the programme is demonstrating its ability to bring about lasting improvements in the quality of teaching, prevent school drop-out and strengthen parenting skills, with one objective: to give children the foundations they need to succeed at school.

STRENGTHENING OF THE PUBLIC EDUCATION SYSTEM

Madagascar

Areas: Antananarivo and Antsirabe
Partner: KOZAMA

RESULTS scolar year 2024-25

Interventions in ***72 SCHOOLS***

126 EDUCATORS
82 TRAINED TEACHERS

3508 CHILDREN *pre-schooled*

1979 STUDENTS *in academic support*

621 CHILDREN *in an early learning workshop*

42 SCHOOLS *equipped with books*
3419 BOOKS *distributed*
56 SPEAKERS *trained for management of school libraries*

EARLY LEARNING FOR 0-2-YEAR-OLDS

KOZAMA works with very young children through parent-child workshops that teach parents how to **stimulate their child's development** (play, language, educational environment) and **strengthen the parent-child bond**. The progress has been significant: a 1.5-point increase (out of 8) in children's psychomotor development and an increase of 11 to 25 points (out of 40) in parent-child interactions.

PRE-SCHOOL CLASSES (NURSERY)

In order to accommodate more children in better conditions and to improve their learning, KOZAMA has provided **practical support to 60 state schools and 126 classes:** minor refurbishment of classrooms, provision of furniture and equipment (528 chairs, 500 tables, 30 teaching kits), and the distribution of 'Kahie Boky' workbooks and educational activity kits.

PRIMARY SCHOOL TUTORING

For pupils facing the greatest difficulties, KOZAMA offers weekly academic support in small groups. This year, KOZAMA introduced personalised workbooks to improve progress and monitoring. By the end of the year, these pupils had achieved a **promotion rate equivalent to that of other pupils**, despite their initial difficulties.

In Antsirabe, the innovative remedial programme (light academic support) starting in Year 1, rolled out across 17 schools and relying mainly on volunteers, demonstrates the feasibility and effectiveness of a low-cost model that intervenes as soon as the first academic difficulties arise.

Throughout the year, the teams carried out **home visits** to re-engage pupils who were at risk of dropping out, and a **catch-up programme** during the holidays enabled **392 pupils** to be supported before the start of the new term.

School tutoring



CAPACITY BUILDING FOR EDUCATIONAL AND TEACHING STAFF

Building educational capacity is a key driver of impact. Once again this year, analyses confirm the pedagogical effectiveness of the KOZAMA method, **with 100% of pre-school teachers reaching a satisfactory standard after three years of individualised support.** Among **primary school teachers,** teaching practices have also improved significantly, following a structured support programme combining theoretical training, classroom monitoring and the provision of appropriate teaching resources. At the end of the three-year period, **90% of teachers were assessed as having reached a 'satisfactory' standard**. Headteachers also receive training.





READING CAMPAIGN

In schools ***where access to books had previously been very limited or even non-existent****, reading corners have been set up in nursery classes.* ***Books are now freely accessible****, which has brought about a profound change in teaching practices: pre-school teachers now organise activities centred around these books (reading, group discussions, drawing), use them as regular learning resources and encourage the children to make free use of them.* ***Reading has now become an integral part of daily life in these classes.***

PROGRAMMES

ACCESS TO HEALTH

- **Health insurance**
  (Health and social protection mechanisms)
  BURKINA FASO - TOGO - MADAGASCAR

- **Quality of care**
  MADAGASCAR

- **Tuberculosis control**
  MADAGASCAR - INDIA

HEALTH INSURANCES & QUALITY OF CARE





Home visit to a member (Togo)

The lack of financial resources and knowledge leads to people having to go without treatment and to delays in accessing healthcare. Families are falling into poverty in order to pay for treatment, as they are forced to dip into their savings, sell their possessions or take out loans.

ATIA implements a health micro-insurance scheme combined with a medical and social support service in areas where vulnerable families do not have access to health cover. The aim of this combination of services is to ensure the long-term security of vulnerable families' living conditions.

The health insurance premium costs between 1 and 3 EUR per month (to cover four household members). It helps to cover healthcare costs, balance the mutual fund and cover part of the operating costs.

This micro-insurance scheme is complemented by a medical and social support service designed to improve beneficiaries' knowledge and understanding of the scheme and to overcome socio-cultural barriers to accessing healthcare (beliefs, rumours, stereotypes, etc.).

This service includes:

- **routine home visits** and visits in the event of illness.
- **support with hospital visits**.
- **a 24-hour helpline**.
- **an on-site service at the branch.**
- **a medical helpline** to listen, advise and refer.
- **prevention and screening campaigns**.

Alongside the services offered by health insurance organisations to their members, ATIA is developing initiatives with healthcare professionals to improve the quality of care, the appropriateness of prescriptions and the care provided to vulnerable patients in public healthcare facilities.

HEALTH INSURANCES & QUALITY OF CARE

Burkina Faso



Areas: Ouagadougou et Koudougou
Partner: TOND LAAFI

RESULTS 2025

8 881 BENEFICIARY FAMILIES, *so* ***33 914*** *people*

15 374 TREATMENTS COVERED totalling approximately **€155,659**

OVER 55 000 MEDICAL AND SOCIAL SUPPORT *for service users*

191 ***PARTNER HEALTHCARE FACILITIES***

In Burkina Faso, in the outlying districts of Ouagadougou and Koudougou, access to healthcare remains severely limited for vulnerable groups, due to poverty (over 42 per cent of the population lives below the poverty line) and the lack of social protection for the majority of workers in the informal sector. Against this backdrop, the TOND LAAFI programme, developed in partnership with the microfinance institution YIKRI, offers a health and social protection scheme tailored to micro-entrepreneurs and their families, with the aim of **reducing the number of people who go without healthcare and stabilising their economic situation.**

In 2025, despite a decline in the number of the partner's micro-borrowers, **the health insurance scheme maintained a high level of activity**, covering 60 per cent of the costs of 15,374 healthcare services (consultations, hospitalisations and childbirth). The take-up rate for the services has risen significantly, reaching 84 per cent, reflecting **greater uptake of the scheme by families**. At the same time, the programme draws on a network of 191 partner healthcare organisations, ensuring wider access to care and direct billing.

In addition to financial cover, TOND LAAFI offers **local support** (home visits, phone calls, support at hospital), helping to remove non-financial barriers to accessing healthcare, guiding patients and improving treatment follow-up. TOND LAAFI has also stepped up its **prevention initiatives**, particularly regarding malaria and breast cancer, as well as a specific programme aimed at **encouraging men to play a greater role in their families' healthcare.**

LIFE STORY

Having initially doubted the value of supplementary health insurance, ***Bonkougou Lamoussa****, a mother, found herself in a difficult situation when her son was seriously stabbed and had to undergo emergency surgery. TOND LAAFI enabled her to receive a reimbursement of 442,001 FCFA (approximately €674) a few days after his hospitalisation, allowing her to pay off the debts she had incurred for his treatment. Beyond the financial support, she highlights the support provided by the teams, who helped her cope with this ordeal and monitor her son's recovery.*

NEW

This year, the health insurance scheme has **sought partnerships** with other associations and social enterprises in order to **expand its membership base and strengthen its sustainability**. The model has also been adjusted, with a reduction in membership fees for certain groups and a review of how to provide greater support to the most vulnerable families. At the same time, **TOND LAAFI has consolidated its institutional role** by actively participating in national discussions on the introduction of Universal Health Cover in Burkina Faso.

Home visit



HEALTH INSURANCES & QUALITY OF CARE

Togo

Area: Lomé
Partner: LAMESIN NYO

RESULTS 2025

52 PARTNER HEALTHCARE FACILITIES *(vs. 26 in 2024)*

11 718 COVERED FAMILIES, *so over 34 274 people*

22 683 TREATMENTS covered, *so around* ***201 159€*** *spent in treatments*

Since its establishment in 2023, LAMESIN NYO has relied on a partnership with the microfinance institution ASSILASSIMÉ SOLIDARITÉ to **offer low-cost health cover for workers in the informal sector.**

A health micro-insurance scheme covers routine care, hospitalisation and childbirth for members and their families. **The number of families covered and the number of medical treatments reimbursed have doubled compared with the previous year**, due to the opening of two new service areas and the fact that **beneficiaries have embraced this service, which is essential to their health.**

LAMESIN NYO has also continued to **expand its network of healthcare professionals, with 52 contracted facilities** (health centres, hospitals, pharmacies), including 26 new ones this year, which makes it easier for families to access local healthcare.

Medical and social support, meanwhile, helps to **remove non-financial barriers to accessing care:** explaining services, home visits, follow-up calls, support in the event of illness, on-call medical services and preventive measures. A significant change was introduced this year with more intensive and personalised support for the most vulnerable.

FINANCIAL BALANCE

After just two years of operation, **healthcare costs are fully funded by contributions from the beneficiaries themselves** (around €3 per month per family). In other words, the mutual fund is self-sustaining and requires no subsidies, which ensures the model's sustainability.

However, medical and social support services and the health insurance scheme's operating costs (administration of contributions, etc.) remain activities that require funding.



Introduction of the health insurance scheme to new members



This year, LAMESIN NYO has launched a number of innovative initiatives to improve the quality of care.

Following a study which highlighted irregularities in medical practice (over-prescription, inappropriate use of medicines), ***LAMESIN NYO has introduced new prescribing guidelines, a list of reimbursable medicines and*** *closer dialogue with healthcare providers.*

A committee of 84 professionals helped to disseminate these guidelines and ***promote best practice.***

This work has led to LAMESIN NYO being officially recognised by the Greater Lomé Regional Health Directorate as a public health observatory and a leading player in the improvement of the health system.

HEALTH INSURANCES & QUALITY OF CARE

Madagascar

Areas: Antananarivo, Fianarantsoa and Sainte-Marie
Partner: AFAFI

RESULTS 2025

13 096* BENEFICIARY FAMILIES,** *so around* ***40 459 *people*

17 023 HEALTH TREATMENTS *covered, so around* **55 497€**

289 PARTNER HEALTHCARE FACILITIES

***29 161* INTERVENTIONS** *to beneficiaries*

STRENGTHENING MEDICAL AND SOCIAL SERVICES

At the heart of AFAFI's work lies access to a health micro-insurance scheme covering primary care, hospitalisation and childbirth, which helps to r**educe the number of people going without care and the risk of falling into debt.**

The most common conditions treated are linked to precarious living conditions (respiratory diseases, infections, digestive disorders), which confirms the appropriateness of targeting these beneficiaries.

Medical and social support (home visits, drop-in sessions, support in hospital) **is a key factor in ensuring effective access to healthcare.**

By 2025, the model had evolved significantly: activities were prioritised for those beneficiaries most in need of support, with a focus on individualised follow-up, which proved more effective than routine visits for everyone. This approach enhances the quality of support (advice, guidance, monitoring of hospital admissions) whilst optimising the use of resources.

At the same time, the health insurance is developing practical preventative measures (such as the sale of hygiene and nutritional products) and strengthening its close ties with families.



PILOT PROJECTS WITH THE GOVERNMENT

The pilot health cover schemes in the municipalities of Sainte-Marie and Andranonahoatra provided an opportunity to **test larger-scale models** involving public authorities: up to 43 per cent of the population was covered in Sainte-Marie and more than 1,000 families in the other partner municipality.

These trials have demonstrated the potential for a publicly-led roll-out of health cover, whilst also highlighting certain l**imitations: high costs, targeting of beneficiaries, and a weak culture of financial planning**. A review of the lessons learnt from these trials is currently underway.

EMANCIPATION ON THE HORIZON?

Through its rigorous management and constant search for new beneficiary groups, ***AFAFI has strengthened its financial sustainability (mutual fund and social service costs).***

ATIA has also withdrawn the on-the-ground support provided by its technical adviser, *which demonstrates a successful transfer of skills.*

Training for the teams is continuing, *with a focus on strengthening their capacities and tools.*

AFAFI's objective is to transition, over the next two to three years, to a sustainable model that is independent of ATIA.



QUALITY OF CARE: THE MISSONGA INITIATIVE

Madagascar

Area: Antananarivo
Partner: AFAFI

64 MEETINGS *(vs. 13 in 2024)*

RESULTS 2025

19 GROUPS, *gathering* ***270 DOCTORS*** *(vs. 33 doctors in 2024)*

CONTEXT

Whilst there is no system of continuing medical education in Madagascar, doctors' prescribing practices in Antananarivo are under intense pressure from an unregulated pharmaceutical industry that encourages the use of medicines considered elsewhere to be unnecessary or dangerous, or the use of products outside their official indications.

Added to this is significant pressure from patients, who expect immediate results from their doctors given the cost of treatment.

A METHOD BASED ON COLLABORATIVE LEARNING

The MISSONGA initiative is based on **organising regular meetings between doctors, in small groups** ("waves"), **to discuss specific cases, harmonise practices and promote evidence-based medicine.**

The year was marked by a significant increase in participation, with 270 doctors regularly attending the sessions. There has been strong uptake amongst practitioners, high attendance rates and very few dropouts. The topics covered are directly based on the most common reasons for consultation observed in practice: high blood pressure, respiratory infections, conjunctivitis, bronchiolitis, scabies and ear infections. Cross-cutting themes such as the doctor-patient relationship and evidence-based medicine are also addressed.



A doctors meeting

The sessions enable doctors to **share their experiences, compare their practices and develop protocols tailored to the local context**, drawing on international guidelines.

Beyond the meetings, a **genuine community of practice has taken shape**, with ongoing exchanges between peers – particularly via WhatsApp groups – reinforcing collective learning and the sharing of best practice.

CHANGES IN PRACTICE

The introduction of pre- and post-tests in 2025 has made it possible to measure these changes more accurately: over 90 per cent of participants report an intention to change their practice by taking scientific recommendations into account and improving the quality of their relationship with patients.

MISSONGA thus helps to **reduce inappropriate practices** (unnecessary prescriptions, misuse of medicines) and to **improve the management of common conditions,** with an expected direct impact on the quality of care for the population.

OUTLOOK

The year 2025 also provided important lessons for the programme's future. Faced with the difficulty of recruiting doctors as trainers, the decision was taken to prioritise the quality of the sessions by using a limited number of experienced facilitators.

The programme has also begun to gain visibility, *with doctors from outside the region spontaneously asking to join the initiative, thanks to digital communication (particularly via Facebook) and the unwavering support of the region's health authorities.*

However, several challenges remain: varying levels of participation, reluctance to change practices, and the need to better measure the impact on prescribing in real-world conditions.

TUBERCULOSIS CONTROL



MADAGASCAR



INDIA



Tuberculosis information session in Mumbai

To combat tuberculosis, a disease exacerbated by poverty, ATIA continues to work towards developing effective, people-centred and replicable intervention models in environments characterised by poverty, misinformation and extremely poor health services for the poorest people.

For more than ten years, ATIA has been working alongside local stakeholders to combat tuberculosis in two of the world's most affected areas: the urban slums of India, particularly in Mumbai and Bhiwandi, and the precarious peri-urban neighbourhoods of Madagascar, in Antananarivo, Antsirabe and Mahajanga.

In both countries, the approach developed is based on the same principles: a community-based approach, personalised support, strong community ties and partnerships with local health organisations.

Thanks to trained social workers, regular home visits, tailored awareness-raising initiatives and targeted social and nutritional support, the programmes run in partnership with NGOs have helped to improve adherence to treatment, enhance screening and significantly reduce stigma.

By addressing medical, social and nutritional aspects simultaneously, these programmes demonstrate their ability to transform access to treatment into effective cures, whilst sustainably enhancing the effectiveness and quality of the work carried out by (public) health workers in the fight against tuberculosis.

TUBERCULOSIS CONTROL

Madagascar

Areas: Antananarivo, Antsirabe, Mahajanga
Partners: RAITRA TIA, KOLOAINA, VAHATRA

989 TUBERCULOSIS PATIENTS *supported throughout their treatment in **3** different regions*

18,100 RESIDENTS *reached in the target neighbourhoods*

RESULTS 2025

*Treatment drop-out rate of **less than 1%***

90/95% of patients successfully completed their treatment *(compared with 70–85 per cent in comparable areas without ATIA intervention)*

Tuberculosis remains a common disease in these areas, closely linked to poverty, overcrowded living conditions and, above all, malnutrition, which is on the rise in Madagascar. Although treatment is provided free of charge, many patients still discontinue their treatment before the end of the required six-month course, which significantly increases the risk of relapse, as well as the risk of transmission within the community and the development of drug-resistant strains.

ATIA and its partners are implementing a **social and community-based approach that complements the existing healthcare system**. The main initiatives have consisted of:

- **to support each patient throughout their treatment in order to prevent them from dropping out.** This support is provided by experienced social workers who encourage patients to take their medication regularly, explain possible side effects and offer psychosocial support tailored to each individual's situation. They also identify and help resolve the practical difficulties faced by each patient.



- **to provide targeted nutritional support to patients suffering from very severe malnutrition.** The aim is to increase their calorie and protein intake in order to promote physical recovery, but also to provide moral support to patients through visits and food aid, however limited. The results observed have shown a gradual improvement: after two months of support, the majority of patients have already begun to regain weight.

- **to improve information and raise awareness within communities to encourage early screening. During neighbourhood meetings, discussions in clinic waiting rooms, home v**isits or public events, people exposed to the disease through their social circle are encouraged to get screened. In the areas where the programme is being implemented, the detection rate for tuberculosis – as well as for related diseases such as HIV infection – has increased significantly, demonstrating the effectiveness of the messages being conveyed.

- **supporting local stakeholders in the public health system: training sessions have enabled com**munity workers (volunteers appointed by local authorities) to improve their knowledge of tuberculosis and HIV; effective awareness-raising methods in community settings, where many people are illiterate; providing psychosocial support for patients and combating stigma, as shame and denial of the disease are barriers to screening and treatment.

These findings show that providing social support to patients helps to improve medical outcomes and reduce the risk of relapse or transmission.

TUBERCULOSIS CONTROL

India

Areas: Mumbai et Bhiwandi

Partners: LSS, NSVK

4,245 TUBERCULOSIS PATIENTS *supported throughout their treatment*

85,3% of patients *have successfully completed their treatment*

RESULTS 2025

632 CHILDREN *referred to a health centre for preventive treatment*

308 patients *who were suffering from severe malnutrition received intensive nutritional support*

23 PARTNER HEALTHCARE FAICILITIES

1,627 vulnerable patients *received regular food parcels*

In Mumbai's slums, overcrowding facilitates the spread of tuberculosis. Poverty and malnutrition make it difficult to adhere to long-term treatment regimens. Despite free medication, many patients stop their treatment, which increases the risk of relapse and the development of drug-resistant strains.

ATIA works alongside the public healthcare system by addressing non-medical barriers such as financial insecurity, malnutrition and isolation, which prevent patients from adhering to long-term, demanding treatment regimens. Its interventions are based on personalised **home-based care, involving regular visits and close support, which helps to ensure adherence to treatment and prevent patients from dropping out.**

Nutritional support is also a very practical way of providing assistance: it is **essential for the recovery of the most vulnerable patients**, helping them to cope with treatment and remain on their care pathway. Some patients suffering from severe malnutrition have received intensive support, whilst others have benefited from regular food distributions.

At the same time, targeted social support has been stepped up: 88 patients facing serious difficulties (loss of income, isolation, family problems) received specific support, which was often crucial in preventing them from having to stop their treatment.

Prevention also plays a key role, with a major innovation introduced in 2025: 632 children at risk of tuberculosis were identified and referred to a health centre for preventive treatment, thereby filling a gap in the healthcare system.

THERAPEUTIC SUCCESSES

The results confirm the model's effectiveness: **85.3% of patients monitored successfully complete their treatment, a high figure in a context where treatment drop-outs are common**. This success is based on a more community-focused approach, which now involves a relative of the patient (treatment observer) to support daily medication adherence. The impact is immediate: more complete recoveries, fewer relapses and a reduced risk of developing drug-resistant forms of the disease, a major concern in India.



After six months of treatment, this patient has recovered *but will remain under observation for some time.*

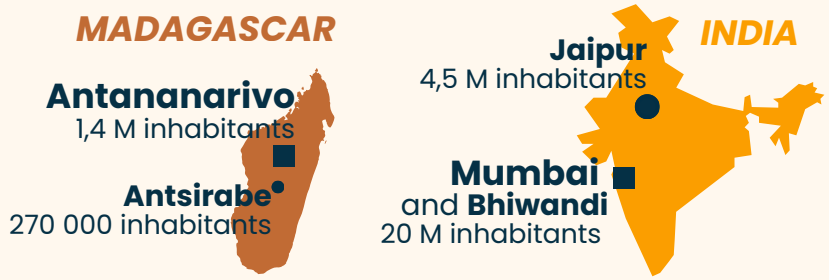


This young patient, the eldest of eight children and suffering from severe malnutrition, *has been diagnosed with a form of extrapulmonary tuberculosis. The team visits her regularly and has asked her father to act as a 'treatment observer', that is, to ensure she takes her medication. Her father (who is unemployed and has to provide for his entire family) was very concerned about his daughter's health.*
Now, in addition to her treatment, the girl is receiving nutritional support in the form of protein powder, as weight gain is essential to her recovery.

SOCIO-ECONOMIC INCLUSION

- **Family support and women’s empowerment**
  MADAGASCAR, INDIA
- **Vocational training and job placement**
  MADAGASCAR
- **Integrated social microfinance**
  MADAGASCAR

FAMILY SUPPORT AND WOMEN'S EMPOWERMENT





Home visit in Mumbai

In the slums of Mumbai, Jaipur (India), Antananarivo and Antsirabe (Madagascar), poverty is multidimensional: domestic violence, economic exclusion, restricted mobility and a lack of official documents.

Our programmes aim to improve the living conditions of highly vulnerable families and are based on a **personalised approach** that takes into account all factors contributing to vulnerability, through **weekly home visits over a period of six months.**

Social workers listen to, advise and guide families – particularly women – to boost their self-esteem, confidence and ability to take action independently, and to help them access various social services.

Support begins with a phase of observation and building trust, followed by **the setting of specific objectives based on their immediate needs.** These objectives may include improving health conditions, access to education, managing household finances, or enhancing women's mobility and independence within their communities.

The results show a significant improvement in addressing families' social and economic problems, through an approach that promotes self-reliance.

Once all the households in a given area have been visited and supported (provided they meet our criteria and have requested assistance), the partners identify a new area and roll out their activities there.

Group activities are offered alongside and in addition to these, for example: groups for women, teenagers and mothers-in-law (in India), as well as training courses and economic activities.

Thanks to the support approach that has been put in place, ***it is each woman who, through her own actions, transforms her own life and that of her family.***

Social workers are ***there to create the conditions for this change****, whilst showing the utmost respect for everyone.*

FAMILY SUPPORT AND WOMEN'S EMPOWERMENT

India

Areas: Mumbai et Jaipur
Partners: LSS, ALERT, KGST

7 957 LISTINGS *for services*

2979 FAMILIES SUPPORTED *from home*

RESULTS 2025 :

+8 PTS TO THE "PAT SCORE" *(target exceeded) => long-lasting improvement of living conditions*

75% OF TARGETS REACHED *in average per family*

EXAMPLES OF TARGETS:

- **Health & childbirth: access to consultations, exam**inations, treatment and pre- and post-natal care
- **Education:** children's schooling
- **Psychosocial support:** tackling domestic violence, improving parenting skills
- **Economy:** saving, employment, financial management
- **Administrative matters:** obtaining identity documents and food vouchers

ECONOMIC INTEGRATION AND EMPOWERMENT

A lack of education and cultural or religious barriers to women's mobility prevent them from accessing training and employment. To address this shortfall, partnerships with local businesses enable them to work from home.



Renu, 37 years-old
Isolated and without an income, and prevented by her husband from working, Renu has regained her self-confidence thanks to weekly visits and women's groups. She has set up her own business and her income has now tripled.

88% *of women were not in employment at the start of the follow-up period.i.*

70% *of women were economically active at the end of the follow-up period (out of 1,716 women assessed at the end of the follow-up period)*

*A **30%** increase in income for women who were already in employment at the start of the follow-up period.*

EDUCATION (Jaipur)



The establishment of the Balshala early learning centre is one of the year's greatest achievements.

30 children *from nomadic communities were taken in and taught discipline, hygiene rules and the basics of the alphabet. More importantly, cases of child begging have fallen sharply. Parents have also begun to make efforts to gather the documents (particularly birth certificates) required for school enrolment.*

COLLECTIVE EMPOWERMENT



35 women's discussion groups provided a forum for collectively addressing issues such as harassment, violence, being forbidden to leave the house, and saving money.

There are also groups for stepmothers and teenagers (both girls and boys) to help foster a harmonious family dynamic.

"You're the first to ask us what we like. From today, we're going to start thinking about that too." ***A mother-in-law***

"If I'd been able to take part in these sessions sooner, my life would have been more peaceful. Now I know my rights and I know my own worth."
Sangeeta

INCLUSION OF PEOPLE WITH DISABILITIES



For the first time, we have collected data broken down by type of disability amongst the families we support.

93 people with disabilities *(52 with physical disabilities and 41 with mental disabilities) were identified and supported*

Field teams have been trained to deal with disability-related issues, and in Jaipur, a partnership with a public body has enabled wheelchairs, walking frames and hearing aids to be ***distributed free of charge to 30 beneficiaries.***

FAMILY SUPPORT AND WOMEN'S EMPOWERMENT

Madagascar

Areas: Antananarivo and Antsirabe
Partner: KOLOAINA

RESULTS 2025

***876* FAMILIES SUPPORTED** *from home*

***2308* PEOPLE** *received at the social services centre*

***9 535* CHILDREN** *have gotten a birth certificate*

***365* TEENAGERS** *have participated to group workshops*

***139* PEOPLE** *received a professional training*

ACCESS TO ADMINISTRATIVE DOCUMENTS

The aim was to reduce the number of children under the age of 12 from vulnerable families who do not have a birth certificate. Thirty community workers were recruited and trained this year. Their work combined 'mobile registration sessions' (which enable a large number of cases to be officially registered at the same time), awareness-raising in local neighbourhoods, compiling documentation with families, and capacity-building for civil registry officials.

In the **Bongolava** region, 200 kilometres from Antananarivo, **where KOLOAINA carried out an exceptional intervention this year,** the challenges were considerable: impassable roads following the rainy season, doctors insisting on being paid in advance for the compulsory consultation, security risks in this 'red' zone, and funeral rites that led to entire families being absent.

In total, **32,364 people** were informed of their rights regarding civil status and citizenship.

COMBATING DOMESTIC VIOLENCE

The facilitators of the domestic violence programme have focused on **empowering victims and helping them rebuild their self-confidence.** The approach, based on non-violent communication, aims to break the cycle of violence and create a safe environment for children.

Despite family pressures, spouses' lack of availability and issues such as alcohol consumption – which at times slowed down the process – **187 couples** were enrolled in the programme and **37 perpetrators of violence** were supported this year.

GROUP WORKSHOPS

This year, **the workshops for teenagers have been tailored to different age groups to better meet their needs**. Those aged 14 and over now have a specific workshop focusing on motivation, setting career goals and preparing for entry into the workforce. For those under 14, the focus remains on raising awareness of gender stereotypes, sexual health and violence.

At the same time, **a support group workshop has been set up for women,** combining psychological support and career integration, with a focus on empowerment and the prevention of domestic violence.

TRAINING AND ECONOMIC INTEGRATION



Social workers worked with the women to clarify their goals, address any barriers (e.g. childcare, self-confidence) and check that they met the admission criteria. Support continued throughout the training to help them persevere and succeed.

The training courses were delivered in-house at KOLOAINA (e.g. raffia craft workshops, followed by placement with a partner organisation) **or at a partner organisation's premises** (e.g. sewing and cookery courses, etc.).

2025: KOLOAINA EXPANDED INTO ANTSIRABE

*In **Antsirabe**, the team is trialling an integrated model in which **home-based family support and the management of domestic violence are provided by the same support worker**. The aim is that a single, well-trained support worker can build a stronger bond of trust with families and provide consistent support.*

The first local partnerships (fokontany, police, gendarmerie, health centres) confirm that the project is well established.



VOCATIONAL TRAINING AND JOB PLACEMENT



The aim is to strengthen the technical and behavioural skills of the most disadvantaged, alongside personalised social support, in order to promote their independence and socio-economic integration.



Graduation of apprentice seamstresses

In Madagascar, the majority of economic activities carried out by vulnerable communities in deprived neighbourhoods take place in the informal sector: women work as laundresses, water carriers or childminders; men work as rickshaw pullers, porters, bricklayers, etc. Their incomes are characterised by their low levels (less than one euro a day) and their irregularity.

The integration of this group into the workplace presents challenges due to their low level of education, their lack of vocational skills suitable for the formal sector, and lifestyle habits that are not well aligned with the demands of the formal labour market.

Because **access to employment is a key factor in families' development and improves their situation both economically and socially**, ATIA is committed to vocational training by supporting training programmes that aim to:

- to inspire disadvantaged people, particularly women and young people, to seek employment in order to improve their circumstances;
- to prepare them to adopt behaviour appropriate to the world of work;
- to provide them with basic technical skills to enhance their employability;
- to facilitate their placement in, and retention of, sustainable and decent employment.

Furthermore, **the teams of trainers are constantly developing their skills**, in particular through work placements in companies.

ATIA's vocational training programmes aim to deliver rapid and sustainable results for highly vulnerable groups by providing access to employment, increasing incomes, securing career paths and improving families' living conditions. **The programme is designed to be an effective means of lifting people out of poverty through an educational and social approach.**

VOCATIONAL TRAINING AND JOB PLACEMENT

Madagascar

Area: Antananarivo
Partner: TOHANA

RESULTS 2025

***91* APPRENTICES trained in machine sewing or early years care**

AVERAGE AGE of female apprentices: 24 years

***97* CHILDREN** *welcomed at the nursery*

***88%* OF GRADUATES are in work six months after completing their training**

FAMILIES' LIVING CONDITIONS HAVE IMPROVED BY *+14* POINTS *according to the 'PAT score'*

Once again this year, the TOHANA programme has demonstrated the strength of its integrated model for the integration of vulnerable women, combining socio-economic support before, during and after training, on-the-job learning, healthcare cover, childcare and links with employers.

The programme was organised around seven cohorts of apprentices in 'seamstressing' and 'early years care', with a **drop-out rate kept at 5.7%** – significantly lower than the rates observed in other organisations working with similarly vulnerable groups – confirming the **effectiveness of the preparatory work carried out with our partner KOLOAINA.**

ENTRY INTO THE WORKFORCE

Employment outcomes have remained particularly high despite a fragile economic climate (a slowdown in the textile sector linked to US tariffs): **90 per cent of beneficiaries trained in dressmaking are in work after three months and 88 per cent after six months**, the vast majority in formal factory jobs.

The 12-month post-training support programme is a key factor in ensuring the success of these pathways, even though certain vulnerabilities remain (family commitments, health issues, job insecurity).

THE SOCIO-ECONOMIC IMPACT

The average income of beneficiaries has more than doubled (e.g. 120,750 Ar before training vs. 314,000 Ar after 3 months, which is equivalent to the Malagasy minimum wage), with an improvement in the regularity of savings.

The 'family snapshot' multidimensional monitoring tool shows an overall increase of 14 points in one year (from 22.19 to 36.06), reflecting tangible improvements for families in terms of health, nutrition, hygiene and access to services. **School enrolment stands at 95%,** compared with 80 per cent before the training for certain cohorts, and pre-school enrolment is rising sharply thanks to the stabilising role of the nursery.

As part of the partnership with **JACADI**, TOHANA's apprentices have made and exported **6,254** bags and pouches made from Liberty print fabric, which are on sale in the brand's shops and on its website.

Proceeds from sales are donated to TOHANA.





THE AKANY-KIDS NURSERY

This is a key element of the programme: it provides apprentices with childcare, whilst also supporting their children's development through tailored educational activities (see photo opposite) and fostering **progress in cognitive, motor and social skills.** **Thirty-five** parenting workshops have also been organised to strengthen families' parenting practices (early learning, health, nutrition, etc.).

Perle Francia' story, 28 years-old

Perle Francia, a single mother of two, was living in extremely precarious circumstances after suffering domestic violence. She joined TOHANA as an apprentice seamstress. After five months of training, ***she found a job in a factory and radically transformed her living conditions:*** *her children are now in school, her basic needs are met, and she has achieved financial independence.*

She has also set up a side business *in livestock farming and is starting to save up to buy a plot of land, with the aim of building a house for her family.*



VOCATIONAL TRAINING AND JOB PLACEMENT

Madagascar

Area: Antananarivo
Partner: ECFORME

RESULTS 2025

2670 CIVIL REGISTRY DOCUMENTS *obtained to improve the employability of young people and adults*

30 WOMEN *trained in self-employment and immediately in work*

364 TRAINED INTERNS

- ***87%*** *of women*
- ***44%*** *of single mothers*
- ***71%*** *of less than 25 years-old*

ECFORME offers short training courses (averaging six weeks) to vulnerable people in deprived neighbourhoods, particularly young people and women, so that they do not have to go without pay for too long.

These training courses all include a section on professional conduct, designed to **provide trainees with the basics of the behaviour expected in the workplace:** punctuality, personal hygiene, politeness, attendance, reliability, an explanation of an employment contract and how to manage a monthly salary, etc.

The technical component then enables them to learn a trade in one of the following sectors:

- **Data entry operators** (young people with A-levels);
- **Domestic staff** (often single women with dependent children);
- **Care assistants** (mature individuals motivated by a career in the service sector);
- **Industrial machinery/cutting and sewing** (for factory work);
- **Self-employment** (those with a business plan for self-employment).

In 2026, ECFORME will become KETRIK'ASA ('strategy for finding work') in order to better meet the needs of its service users and develop new approaches (e.g. work integration schemes, real-world training).

ENTRY INTO THE WORKFORCE

The employment outcomes are generally strong despite a challenging economic climate. The programme has achieved an **employment rate of 50.5%** with performance varying across different sectors: 55 per cent in IT, 40 per cent in home care services and 21 per cent in dressmaking.

Furthermore, **self-employment is an effective complementary too**l, particularly for the most vulnerable groups. A new, ultra-short course (2 days) enabled 30 people to learn how to cook quickly and cheaply; they then set up a street food stall, allowing them to generate an immediate income.





Cookery classes, using basic equipment, which realistically reflect the conditions in which the young women will subsequently work.

Training in table service



This year, a partnership with the Sandrata programme (Action Education) has enabled **136 single mothers** to receive training.

Furthermore, ECFORME carried out a **large-scale initiative to facilitate access to administrative rights, in partnership with KOLOAINA, to enhance the employability of the beneficiaries**: 13,300 people were made aware of the initiative; 2,295 civil status certificates, 209 identity cards and 166 marriage certificates were obtained for the families.

INTEGRATED SOCIAL MICROFINANCE





A self-employed businesswoman running her own business

To help vulnerable families improve their living conditions, ATIA is involved in setting up local microfinance institutions that offer a range of integrated services.

In these regions, 90 per cent of the population lives in poverty and relies on precarious informal work. Social microfinance programmes aim to bring about a sustainable improvement in families' living conditions by simultaneously addressing access to employment, healthcare and social services. In this context, characterised by isolation, low incomes and limited access to basic services, these programmes offer an integrated model combining microcredit, social support and healthcare cover.

Economic services:

- Micro-entrepreneurs receive training and individual support to estimate their expenditure and income and to complete a loan application.
- The initial loans are for a small amount, around 60 EUR, and do not require collateral.
- Those who manage to repay their loans and whose business is growing can continue to borrow increasing amounts.
- A compulsory savings scheme is introduced alongside the repayment process

Health services:

- Micro-entrepreneurs and their families are automatically enrolled in the health insurance scheme and receive medical and social support.

Social services:

- Those who wish to do so can receive family support to resolve social issues either before or alongside their business project.

CONSEQUENCES :

> Beneficiaries set up or expand an income-generating activity;
> They build up savings;
> Their overall standard of living improves (health, housing, children's education, etc.);
> They gain self-confidence.

INTEGRATED SOCIAL MICROFINANCE

Madagascar

Area: Mahajanga
Partner: MAMPITA

RESULTS 2025

3 495 BORROWERS *including* ***85%*** *of women*

4 138 LOANS *given*

549 FAMILIES SUPPORTED *on the social side and* ***80%*** *of social targets reached*

415 ECONOMIC TRAININGS

3 811 HEALTHCARE TREATMENTS *reimbursed*

The MAMPITA program has continued to expand to support the economic activities of more entrepreneurs. These loans have enabled them to develop businesses in areas such as commerce, agriculture, fishing, and handicrafts. The economic impact has been significant, **with an average 57% increase** in income from the funded activities. Support is reinforced through economic training, individualized social and economic monitoring, health insurance, and a mandatory, secure savings program that strengthens households' ability to weather economic shocks.



Home visit to complete the loan application

NEW

The year 2025 was marked by **geographic expansion with the opening of a new branch in Maevatanana,** a more rural area along the road to Antananarivo.

In 2025, MAMPITA reaffirmed the strength of its business model and its progress toward financial sustainability. **The microcredit segment achieved a self-financing rate of 75%**, up from previous levels, reflecting a growing ability to cover its costs through its own revenues. Portfolio quality is also very satisfactory, with a repayment rate of **97%** indicating a low level of delinquencies.

These results, achieved despite the vulnerability of the target populations, are the product of **close monitoring and enhanced social and economic support for beneficiaries**, which helps ensure the stability of their activities and contributes to the institution's financial sustainability.

LIFE STORY

***Narindra**, a mother of four, started out with a small grocery store that brought in about €64 a month. Thanks to successive loans from MAMPITA, she has gradually expanded her business, diversified her product offerings, launched a wholesale operation, purchased a motorcycle, and invested in a plot of land. Her savings now total €180, and her husband has joined the family business, providing long-term stability to the household's income.*



This fisherman, a father, applied for a loan to repair his canoe, which allowed him to resume his work and regain his livelihood.

INTEGRATED SOCIAL MICROFINANCE

Madagascar

Area: Manakara
Partner: SAHI

RESULTS 2025

2 625 PERFORMING LOANS *granted*

248 TRAININGS *in financial management*

2,080 MICRO-BORROWERS
74% *of whom are women*

308 FAMILIES RECEIVED SUPPORT
in the social sphere and ***85%*** *of social objectives were met*

By 2025, SAHI had provided microloans to 27% more entrepreneurs than the previous year, enabling them to start or expand income-generating activities—the vast majority of which are led by women. These loans are consistently accompanied by financial management training and follow-up visits, ensuring the funds are used effectively. The program also encourages savings to strengthen households' resilience in the face of unforeseen events. At the same time, **agricultural lending** (for farming, storage, and collection) **has grown significantly**, meeting the needs of rural areas and enabling farmers to improve their incomes and food security.

Social support and individualized home visits—averaging 21 visits per family—enabled us to address a variety of issues (income, health, administrative documents, schooling). The results are significant: **72% of the objectives were achieved by the end of the support period and 85% six months later, with a measurable improvement in living conditions** (hygiene, nutrition, access to water, and schooling).

In addition, social outreach services (957 visits) and group workshops (950 participants) provide practical support to families—including children and adolescents—through educational activities and self-confidence-building exercises.

With regard to health insurance, the scope of coverage has been expanded this year to include primary care at certain branches, in order to provide better coverage for the families of microloan borrowers.

A new branch was opened in Lokomby in 2025, serving more rural communities, which led SAHI to adapt its model to new agricultural activities.



Rice farmer who received a seasonal loan

LIFE STORY

Sylvin*, a carpenter, has seen his business transform thanks to successive loans obtained through SAHI: the amount of his loan increased from 300,000 to 2,500,000 ariary (equivalent to €60 to €500), which enabled him to purchase equipment, open his own workshop, and even hire an employee. SAHI supported and guided him after a burglary left his household in a vulnerable situation, giving him the means to bounce back and continue growing his business.*

Home Visit to a Self-Employed woman





Children from a school supported by KOZAMA (Madagascar)

ATIA 2025

ORGANISATION AND FINANCE

HUMAN RESOURCES

AT THE HEADQUARTERS:

PROGRAMMES MONITORING :
Area Managers
Administrative and Financial
Managers of programmes

x7

SUPPORT :
Management and coordination of donor relations

x3

ON THE FIELD:

PROGRAMME MANAGERS & TECHNICAL ADVISORS
ATIA (expatriates and local)

x6

LOCAL ADMINISTRATIVE TEAMS

x5

LOCAL PARTNER TEAMS x502



ATIA SECTORS:
- education
- social
- economic
- health systems and quality of care
- tuberculosis

As part of its cost-optimization efforts, ATIA operates with a small team at its headquarters and directs as many resources as possible to its partners for on-the-ground activities.

ROLES AND FUNCTIONS :

AREA MANAGERS HEAD OFFICE
- programme **management**
- **support and monitoring** of partners
- **support and monitoring** of the Programme Manager
- **fundraising**

FIELD PROGRAMME MANAGERS
- programme **implementation/ support** for programme **implementation**
- **support and capacity-building** for the partner

LOCAL PARTNER ORGANISATIONS
- **implementation of programmes** in the countries where we operate, with technical and financial support from ATIA
- **100 per cent of staff are local**

ADMINISTRATIVE AND FINANCIAL MANAGERS HEAD OFFICE
- **financial management** of programmes
- **second-level support for** partners and field RAFs

ATIA LOCAL ADMINISTRATIVE AND FINANCIAL TEAMS
- administrative and financial **monitoring of programmes**
- **first-line support** for partners
- local administrative and financial **coordination**

MANAGEMENT AND ROLES ATIA SUPPORT:
Cross-functional support and operational tasks at head office and in the field

FINANCIAL DATA 2025

In 2025, ATIA and its partners received **€3.5 million** in donations, grants and income from activities, all of which was allocated to the delivery of programmes.

This amount includes both head office and field expenditure recorded in France (€2.6 million) and field expenditure recorded locally by partners (€0.9 million).

Every expenditure, from the very first euro, both at head office and in the field, is subject to several levels of accounting and financial control.

Each organisation, in France (ATIA) and in the countries where we operate (partner NGOs), is audited annually by an accountancy firm or an independent auditor.

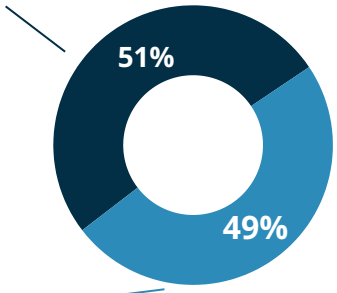
ATIA ensures the transparency and quality of financial management required by donors and beneficiaries.

Administrative and staff costs are kept to a minimum, and expenditure is pooled wherever possible.

Efficiency in all activities is always a priority, with particular attention paid to the cost per beneficiary and impact assessment.

BREAKDOWN BY ORIGIN OF FUNDS RECEIVED:

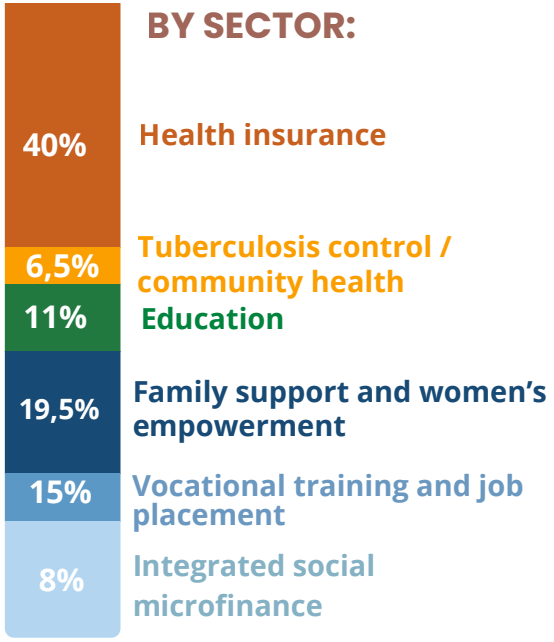
PUBLIC FUNDS (51%)
France, Monaco, European Union, Germany.



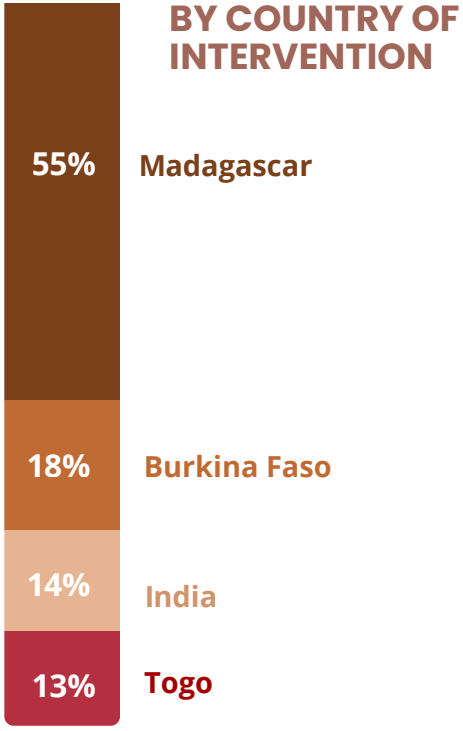
PRIVATE FUNDS (49%)
Foundations, associations, companies and corporate funds, endowment funds, private donations and local revenue from activities (health insurance and microcredit)

BREAKDOWN OF EXPENSES:

BY SECTOR:



BY COUNTRY OF INTERVENTION





Mental arithmetic game (Marofarihry, Madagascar)

ATIA
OUTLOOK FOR 2026

OUTLOOK FOR 2026

Despite an uncertain geopolitical and financial climate characterised by a reduction in public funding, ATIA plans to stay on course with its activities in 2026 by diversifying its sources of funding, particularly from private donors.

In 2026, **Health insurance schemes** will trial new membership models (new target groups, adjustment of contributions) and a programme to improve the quality of care will be developed in Togo. Support for AFAFI will continue as it moves towards financial sustainability and self-reliance, as part of the final phase of technical and financial support from ATIA, which is scheduled to run until 2027.

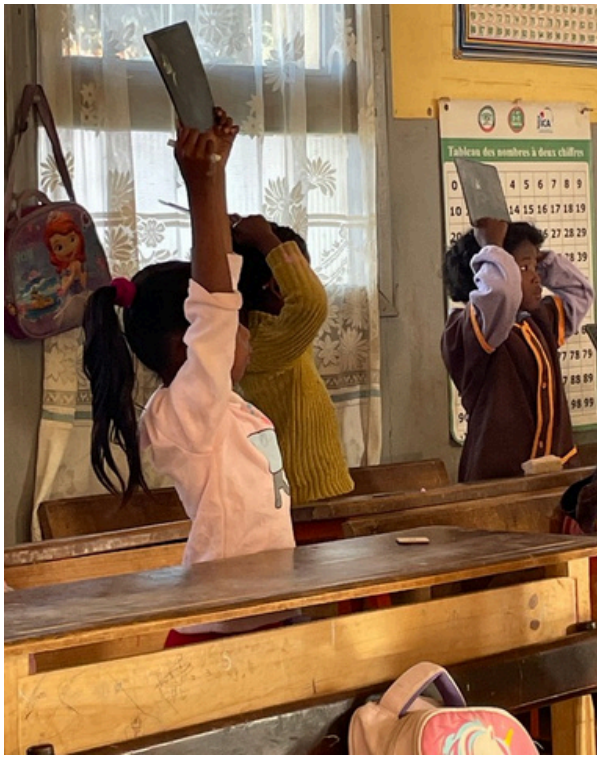
The two social microfinance programmes in Madagascar will continue to expand to reach more beneficiaries, whilst striking the right balance between financial sustainability and social impact amongst the most vulnerable communities.

Social programmes providing family support and empowering women in deprived neighbourhoods in India and Madagascar continue to meet significant needs and will continue their activities at least at the current level. Economic integration initiatives and group workshops will continue to be rolled out in 2026, and new geographical areas will be explored.

In the field of education, KOZAMA will consolidate its presence in the new districts of Antsirabe and Itasy in Madagascar and continue to manage several public funding schemes directly.

The fight against tuberculosis will continue in India in highly vulnerable areas not yet covered by government services. In Madagascar, our health partner RAITRATIA is set to take a decisive step forward: expanding its work to five regions, establishing institutional collaboration with the Ministry of Health, broadening its focus to include the three main infectious diseases and maternal and child health, and strengthening the skills and knowledge of health centre staff.

Finally, **the vocational training sector in Madagascar** is set to undergo a major transformation with the creation of KETRIK'ASA, a new partner organisation dedicated to helping people from disadvantaged neighbourhoods gain access to employment, which incorporates work placements into its training programmes from the outset.



Remedial classes (KOZAMA)

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