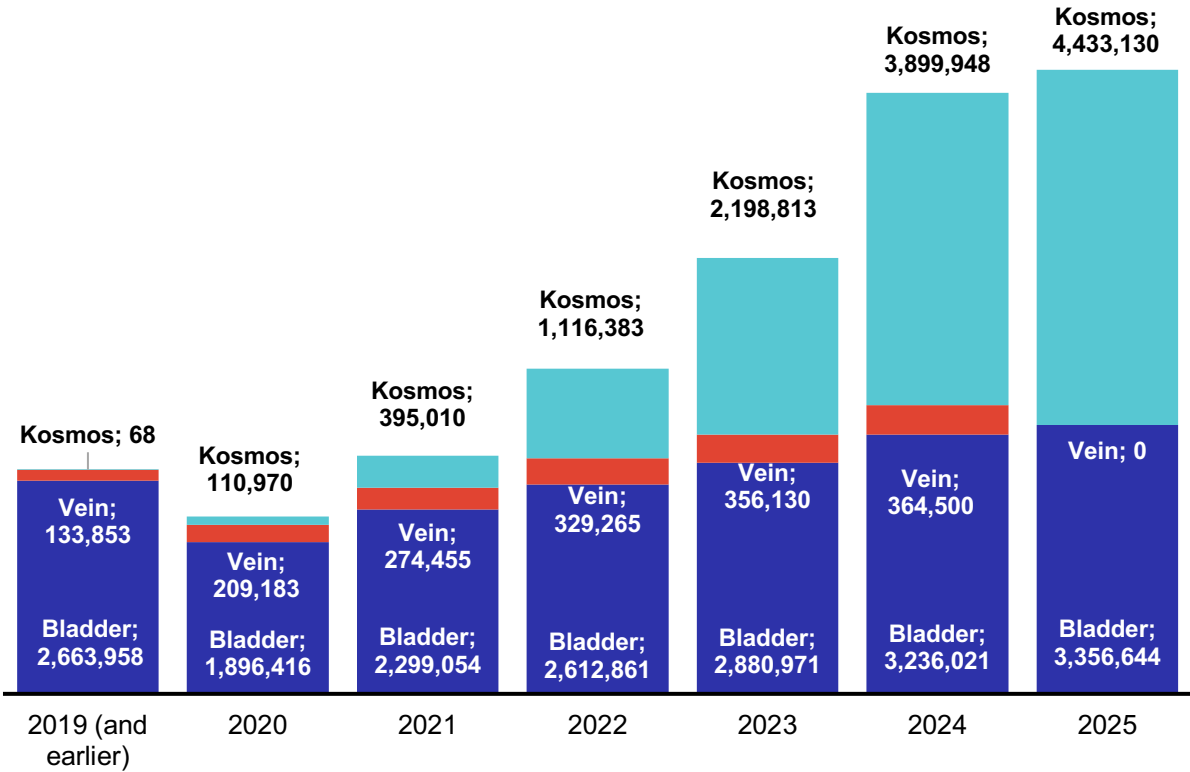




I. FY 2025 IMPACT GRAPHICS

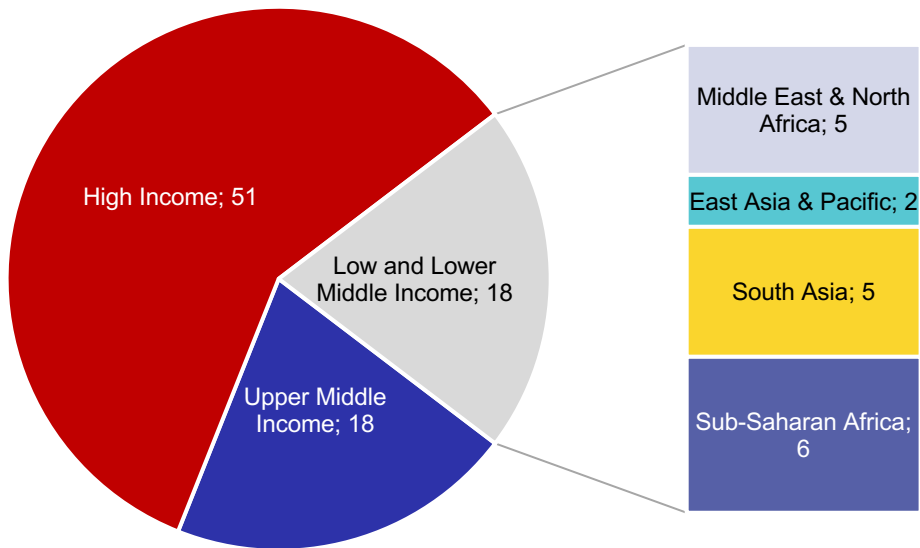
A. Estimated patient scans by year and product^{1,2}
N = 7,789,774 (2025); 32,767,631 (cumulative)



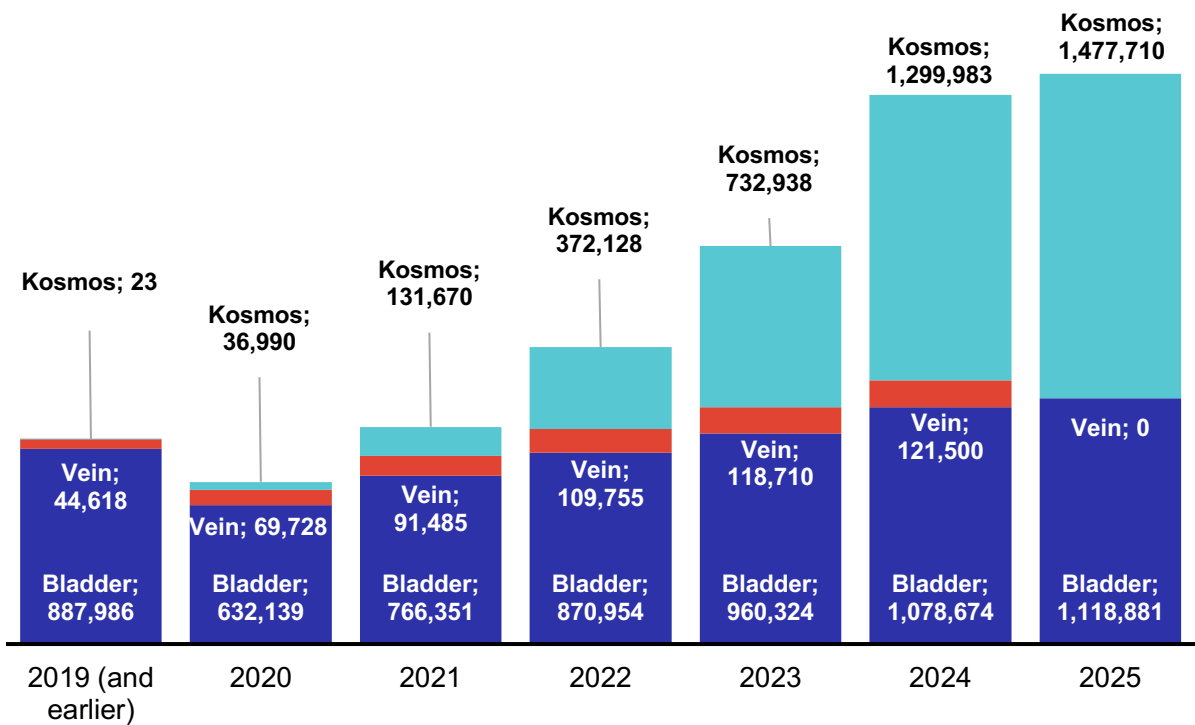
¹ Starting in 2024, Echonous discontinued its dedicated vein product (as the functionality it offered is available in the Kosmos product). By YE 2025, the Kosmos Combo will include a Bladder application; therefore, we expect most sales will fall under the 'Kosmos' category in future reports.

² See appendix for detail and support for estimation methodology

B. Geographies with Commercial Distribution by Type and Region³
85 countries across 6 continents (2025)

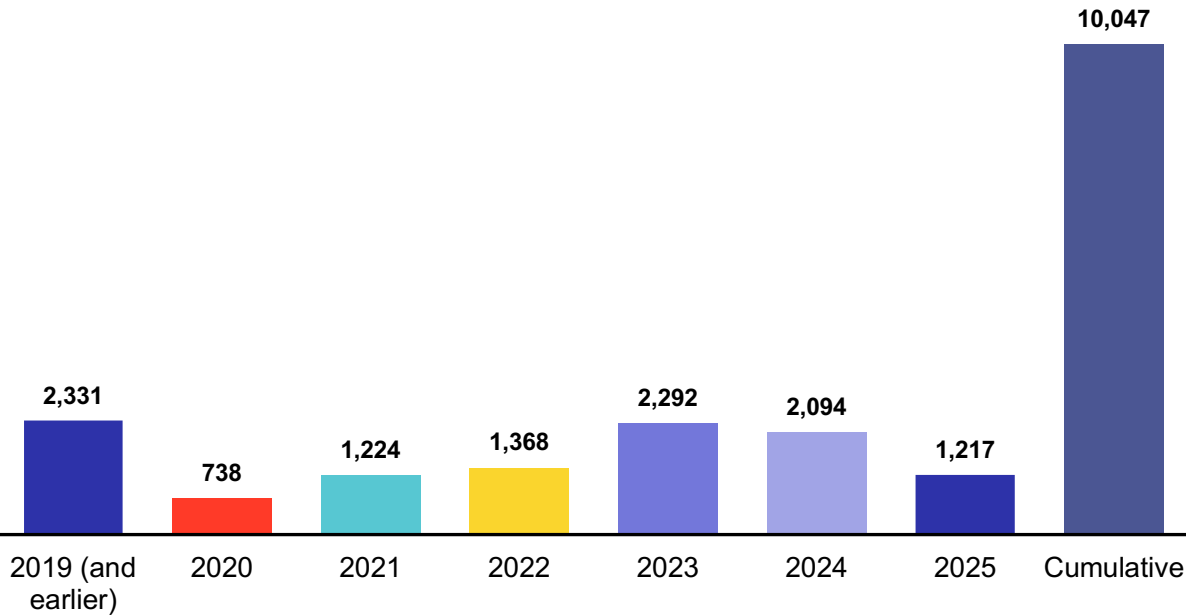


C. Estimated unique patients by product and year⁴
N = 2,596,591 (2025); 10,922,544 (cumulative)



³ New countries added included: Japan, Uruguay
⁴ Precise unique patients are unknown because some portion of scans could involve the same patient (i.e., management vs. diagnosis). For this report’s purpose, we assume that only a third of scans are attributable to “unique” patients.

D. Estimated healthcare professionals trained by year⁵
N = 1,217 (2025); 10,047 (cumulative)



⁵ We have conservatively estimated that only 1 healthcare professional has been trained per unit sold.

Appendix – Impact Metric Assumptions and Estimate Methodology

Estimated Patient Scans by Product and Year

Estimated Scan by Product and Year				
Calendar Period	Bladder	Vein	Kosmos	Total
2019 and Earlier	2,663,958	133,853	68	2,797,878
2020	1,896,416	209,183	110,970	2,216,569
2021	2,299,054	274,455	395,010	2,968,519
2022	2,612,861	329,265	1,116,383	4,058,509
2023	2,880,971	356,130	2,198,813	5,435,914
2024	3,236,021	364,500	3,899,948	7,500,469
2025	3,356,644	0	4,433,130	7,789,774
Cumulative	15,589,282	1,667,385	7,721,190	24,977,857

A. Methodology for Estimating "Unit" Tests⁶

To estimate scans per active unit in the field, we reviewed a clinical study of real-world POCUS usage that sited observed average daily scans per GP between 0.6 and 3.9. We took the midpoint of that to arrive at an assumption of 67.5 scans per month, per device and multiplied that by the active units for each month to estimate scans.

Key assumptions Scans Per Provider		
Product	Per Month	Providers Per Unit
Bladder	67.5	1
Vein	67.5	1
Kosmos	67.5	1

Reported Scan Frequency Average Daily Use		
Range	Per GP	Implied Monthly Use
High	3.9	117
Mid	2.3	67.5
Low	0.6	18

⁶ Andersen CA, Brodersen J, Rudbæk TR, Jensen MB. Patients' experiences of the use of point-of-care ultrasound in general practice - a cross-sectional study. BMC Fam Pract. 2021 Jun 18;22(1):116. doi: 10.1186/s12875-021-01459-z. PMID: 34144701; PMCID: PMC8214303. We had previously relied on an older study, [linked here](#)

II. Closing the Distance: The Fight Against Rheumatic Heart Disease on the Frontline of Primary Care in Nepal

A. BACKGROUND

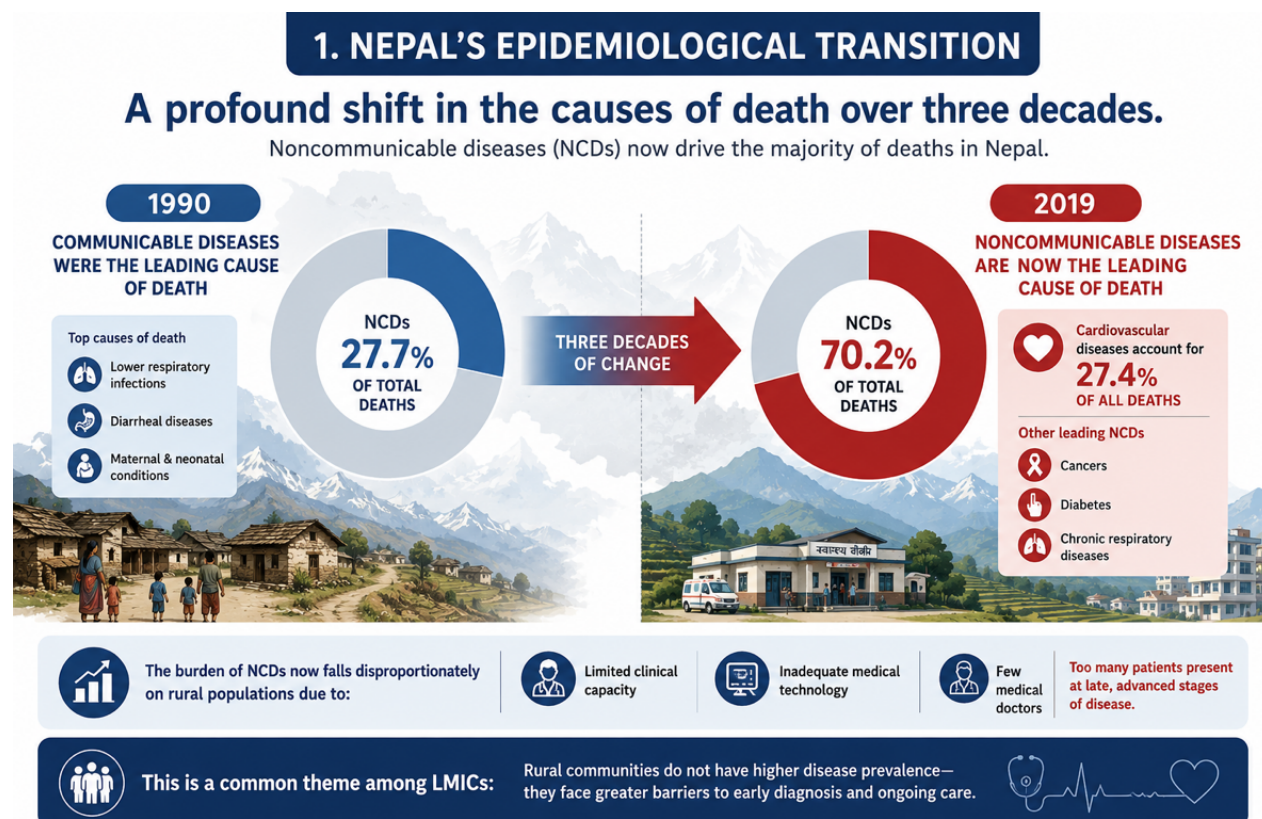
In our 2024 Impact Spotlight, we told the story of Guyana, where satellite connectivity, AI-assisted imaging, and a public-private partnership between the Ministry of Health in Guyana, EchoNous, and 19Labs demonstrated what modern telehealth infrastructure can accomplish in even the most geographically isolated environments. This year's Spotlight highlights a different but equally important context: the mountain villages of Nepal. This country shares several challenges with Guyana and other lower-income nations: a rapid surge of non-communicable diseases (“NCDs”) that are outpacing healthcare systems designed primarily to mitigate the impact of infectious diseases; a workforce stretched thin by migration and underfunding; and communities where delayed diagnosis can mean the difference between a chronic, manageable illness and severe disability.

Although rheumatic heart disease (“RHD”) is preventable, diagnosable, and treatable, it continues to be responsible for hundreds of thousands of premature deaths annually in low- and middle-income countries (“LMICs”). It offers both a window into the structural failures of LMIC healthcare, and a vivid illustration of what cart-grade, AI-assisted portable ultrasound technology can accomplish, when it reaches the communities that need it most. At their root, these LMIC failures are failures of primary healthcare — the first point of contact where early detection, referral, and prevention should occur but too often cannot.

1. The Quiet Epidemic: NCDs and Rheumatic Heart Disease in Nepal

Nepal has undergone a profound epidemiological transition over the past three decades. Overall, the proportion of deaths attributable to NCDs rose from 27.7% in 1990 to 70.2% by 2019, with cardiovascular diseases now

accounting for over a quarter (27.4%) of total deaths⁷. This burden now falls disproportionately on rural populations, where limited clinical capacity, inadequate medical technology, and few medical doctors cause too many patients to present at late, advanced stages of disease. This is a common theme among LMICs, not because rural communities have higher disease prevalence, but because barriers to early diagnosis and ongoing care are so severe.



Unlike many chronic diseases that emerge later in life, RHD often begins in childhood as repeated episodes of rheumatic fever progressively damage heart valves, leading to lifelong disability, heart failure, stroke, pregnancy complications, and premature death. To date, it remains the most common cause of non-congenital heart disease in those under 25. Globally, an

⁷ In the interest of more informal readability, literature references are provided at the end of this Report without sentence-by-sentence attribution. Should readers want specific references pertinent to information provided, they are encouraged to contact TEAMFund.

estimated 55 million people live with RHD, causing approximately 360,000 deaths annually, the overwhelming majority of which are in LMICs.

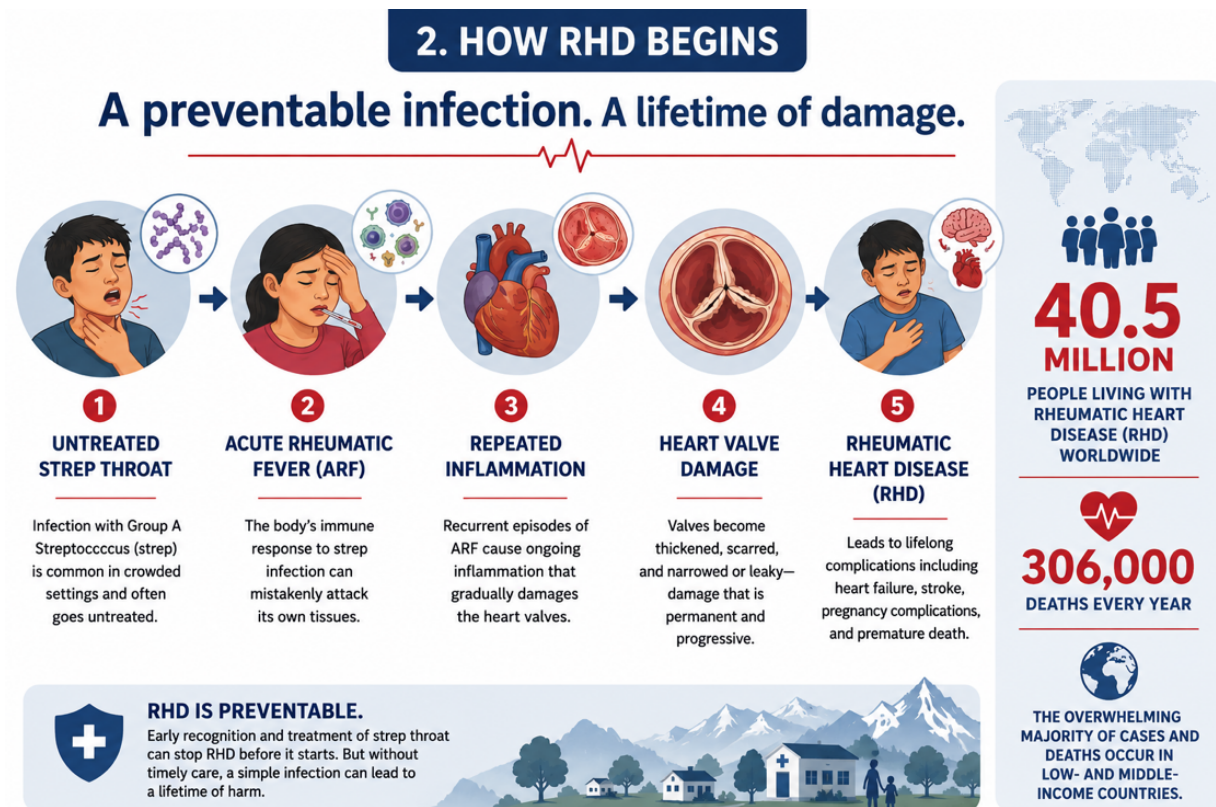
RHD develops due to recurrent acute rheumatic fever triggered by untreated Group A Streptococcus infections, which are common in settings defined by overcrowding, poverty, and limited primary care access. Social determinants of exposure and access, supply chain fragility, and low patient and healthcare worker awareness all contribute to routine untreated strep throat, leaving children vulnerable to progressive, irreversible valve damage. As a result, the economic burden of RHD is borne not only by healthcare systems but by entire families and communities over many decades.

For affected households, the disease frequently creates a cycle of poverty and ill health. Children with symptomatic RHD often miss school due to illness, medical appointments, or hospitalization, reducing educational opportunities and future earning potential. As patients reach adolescence and adulthood, progressive cardiac disease can limit physical capacity, restrict employment options, and reduce lifetime productivity. Family members may also lose income while providing care or accompanying patients to distant healthcare facilities.

Because early-stage RHD is often clinically silent, physical examination alone may miss significant valvular disease. The combination of a lack of imaging infrastructure and insufficient healthcare staff can delay diagnosis until patients present with advanced complications. A 2025 systematic review found a national RHD prevalence of 3.1% in Nepal, with a six-fold disparity between Kathmandu (1.1%) and non-Kathmandu regions (7.2%) revealing the urban-rural divide due to healthcare disparities, including diagnostic scarcity. Where diagnosis is delayed, considerable impact is felt not just by patients but by the broader economy as well, with effects compounding over the years.

- 1) **Patient health** - Delayed diagnosis can cause irreversible valve scarring, pulmonary hypertension, lifelong disability, heart failure, and complications during pregnancy that increase maternal mortality.

- 2) **Economics** - Most patients are diagnosed with RHD after it is severe and irreversible. In South Africa, for example, annual costs of RHD care at a tertiary hospital in 2017 were estimated at \$3,900 per year for patients with advanced disease. Estimates suggest RHD costs the Eastern Mediterranean region \$5.8Bn in economic burden in 2020.



2. A Sector Under Pressure: The Case for Efficient, AI-Embedded Technology

The workforce and rising NCD burden challenges have unfolded against a backdrop of accelerating disruption to global health financing. Preliminary OECD projections indicate a 23.1% decline in official development assistance from major donor countries from 2025 to 2026, with countries historically more dependent on aid (e.g., sub-Saharan Africa) facing potential declines of 16-28%. Countries are now faced with the need to

cover the costs of health programming, and to do so as cost-effectively as possible by prioritizing those at high risk and/or highest need for care.

The convergence of significantly diminished aid support and escalating NCDs demands a fundamental rethinking of how early screening and triage should be extended to primary care, with reliance on community health workers, nurses, and lay staff who are already on the ground and serving in frontline clinics. RHD is one of the few major cardiovascular diseases for which highly effective, low-cost preventive interventions already exist. Early diagnosis of streptococcal infections, treatment with inexpensive antibiotics, and secondary prophylaxis with penicillin can prevent disease progression and avert the need for costly surgical intervention. Investments in community screening, frontline healthcare worker training and portable echocardiography with AI enablement offer an opportunity to shift care from expensive late-stage treatment toward affordable prevention and early detection.

Without point-of-care solutions, advanced RHD is among the most expensive cardiovascular conditions to manage. Hospitalizations for heart failure, long-term medication requirements, anticoagulation monitoring, repeated diagnostic testing, and complex valve surgeries place substantial demands on limited healthcare, and particularly surgical, resources. In many LMICs, a single valve replacement procedure can consume resources equivalent to years of preventive care for hundreds of at-risk children.

The Nepal example illustrated in this Spotlight shows why portable, AI-enabled testing at point-of-care is key to affordable prevention and early detection. With only an estimated 150 radiologists nationally, nearly all of whom are concentrated in Kathmandu, rural facilities have little meaningful imaging support. This is precisely the gap that AI-assisted, portable point-of-care ultrasound (“POCUS”) is positioned to address. As discussed below, AI-driven guidance features enable healthcare workers with limited formal ultrasound training to conduct testing for early detection of RHD under remote specialist supervision. Device durability is also a matter of importance, particularly in Nepal's high-altitude villages where equipment

must perform reliably in challenging environments, including extremes in temperature, humidity, and inconsistent power availability.

In the following sections, we highlight how the Kosmos system by EchoNous helps healthcare professionals overcome these barriers by combining cart-grade imaging, handheld portability, and embedded AI guidance to reduce diagnostic barriers in rural settings by expanding diagnostic reach and strengthening primary healthcare.

B. TACKLING THE PROBLEM

1. Bringing Cardiac Screening to Nepal's Most Remote Communities -- Introduction

Healthcare workforce gaps are a constant challenge in the remote villages of Nepal, where patients with undetected heart disease may go years without seeing a physician. The central challenge is not whether these patients exist, but whether a sustainable, scalable system can be built to find them. A University of Washington-led program operating in Nepal for more than two decades serves as a case study for addressing these challenges. Its evolution offers a roadmap for a model that is both sustainable and scalable.

2. A Transformed Program

For more than two decades, a University of Washington-affiliated cardiac program has conducted annual field missions to Nepal, initially focused on supporting the early development of cardiac surgery capacity in Kathmandu. As surgical infrastructure in the capital gradually matured, the program shifted to identifying patients who needed surgical treatment or advanced cardiac care. In rural Nepal, this capability was almost nonexistent due to the infrastructural and health workforce shortage challenges described in section A.

Working in partnership with the Jayanti Memorial Trust, a Nepali NGO with deep roots in community health, the mission began increasing its focus on rural districts where disease was going undetected. The primary clinical target was RHD, which, as previously noted, is a disease that strikes

predominantly in childhood and young adulthood, progresses silently, and is almost entirely preventable if caught early. Beyond RHD in younger populations, over the years, the team has also encountered the full spectrum of unmet cardiac need: valvular heart disease in older patients (much of which is caused by RHD), congenital heart disease in children, and a growing burden of coronary disease in aging rural populations.

Reaching these communities is itself a logistical undertaking. One district visited in 2024 required a one-hour flight followed by a 3½ hour drive on unpaved roads. The communities served often have no resident medical personnel or facilities to support routine or advanced care. Social workers travel with the team specifically to coordinate patient identification; manage logistics; and ensure that patients identified with cardiac disease are tracked, transported to Kathmandu for confirmatory echocardiography testing, and connected to follow-up care, including surgical intervention where necessary. Some patients seen on return visits have been post-surgical, completing a longitudinal arc of care that began with a single screening in a remote village.



3. The Problem with the Old Model

For years, the screening program depended on large, cart-based ultrasound machines carried into rural communities by teams led by international cardiologists. The teams discovered that the machines were sensitive to the heat, humidity, and electrical instability that characterize Nepal's rural environments, resulting in routine equipment failure, with replacement purchases required nearly every other year. Due to the length of time required per patient, the pop-up clinics conducted by the screening teams regularly ran until one or two in the morning. The entire operation rested on the presence of one or two visiting cardiologists: highly trained specialists whose availability was the binding constraint on how many patients might be seen.

The throughput gains from running multiple systems in parallel helped at the margins, but the fundamental bottleneck remained. A model entirely dependent on visiting specialists traveling with fragile and costly equipment to remote communities was not a long-term solution. To create a more sustainable future for RHD and other cardiovascular diagnosis in rural Nepal, both the medical technology and staffing shortages would need to be addressed.

4. Expanding Diagnostic and Screening Capability at Point of Care

The physicians found that the Kosmos platform addressed several of the structural weaknesses that had undermined the historical cart-based model. Kosmos' battery life and thermal stability addressed historical operational fragility issues, and onboard storage has eliminated the need to offload data mid-clinic, which is a meaningful advantage where connectivity is unreliable or absent. Portability has allowed two devices to be deployed simultaneously in separate rooms, with a supervising cardiologist moving between them and stepping in when a finding warrants closer examination — effectively multiplying the reach of a single specialist.

Most significantly for RHD screening, Kosmos is one of the only portable ultrasound systems to offer Continuous Wave Doppler, an ultrasound technique that transmits and receives sound waves along a single line.

This technique allows the measurement of blood flow at any point along that line, making it uniquely suited to quantifying high-velocity jets, such as those produced by narrowed or leaking valves characteristic of RHD.

Without it, a portable system can suggest the presence of valvular disease but cannot quantify it, a distinction that matters enormously when the goal is not merely to flag patients, but to triage them accurately for prophylaxis, medical management, or surgical referral. That clinical precision delivered via a device light enough to carry into a village created a new opportunity for task-shifting among rural healthcare staff.



5. Training the Next Cohort: Task-Shifting on the Front Lines

In rural and remote communities across LMICs, the chronic scarcity of trained specialists means that waiting for expert care to arrive is, for most patients, functionally equivalent to receiving no care at all. Task-shifting enables and empowers workers with shorter, more focused training, to conduct defined clinical functions, reducing the demand for highly qualified specialists. The World Health Organization has highlighted the importance of task-shifting as one of the most important strategies for extending diagnostic and treatment capacity in LMICs, operating alongside strategies

to increase the total number of frontline healthcare workers. By equipping nurses and other clinical staff with the right tools and protocols, countries and programs can unlock enormous latent capacity within existing health systems.

AI-assisted technology and telehealth have enormous potential to reduce technical barriers to performing disease detection in the field. With AI, historically complex diagnostic tools are made sufficiently simple to allow for scaling-up task-shifting at the community level. This is the basis of primary healthcare strengthening: not building parallel vertical programs, but embedding diagnostic capacity into the existing frontline workforce so that communities are served continuously, not just when a visiting specialist arrives.

The task-shifting potential of Kosmos was tested in earnest during the program's most recent field deployments. ICU nurse practitioners from the University of Washington, and experienced clinicians with some point-of-care ultrasound familiarity but no formal echocardiography training, completed a Kosmos-focused training program with EchoNous, before joining the fall mission. In the field, they conducted screenings using a streamlined protocol: nurse practitioners worked independently, conducting three-to-four targeted views per patient, completed in under ten minutes, with the objective of identifying abnormal findings that would prompt a cardiologist to step in for more detailed assessment.



The results are currently being analyzed as part of a graduate student dissertation, with a manuscript drawing on the program's accumulated screening data under review. Early indications suggest the task-shifting model is functioning as intended: non-specialist operators, equipped with AI-assisted guidance and real-time image quality feedback, are identifying suspected RHD at rates substantially higher than passive surveillance data from the same regions would predict, which is consistent with the global literature on active echocardiographic screening versus passive clinical reporting.

6. Towards a Sustainable Model

The current model represents a significant advance over what came before, but the program is clear-eyed about where it stands. A team of visiting specialists conducting annual screenings is not the sustainable, locally owned system that the underlying problem demands. Although Nepal does not currently have a formal nurse practitioner role, the Ministry of Health, in recent years, has been developing a clinical nurse specialist designation. This health personnel category could, in time, serve as the foundation for a trained cadre of local screeners capable of conducting

community-based echocardiographic surveillance year-round, without depending on the arrival of an overseas team.

The Jayanti Memorial Trust's infrastructure provides the backbone on which a system could be built, including: 1) patient registries; 2) transportation coordination; and 3) linkage to formal confirmatory echo and surgical care in Kathmandu. The vision is a smaller, more nimble operation: local providers conducting screening continuously, with visiting specialists focused on training, quality assurance, and complex case management rather than constituting the entire operational capacity of the program. Kosmos, with its AI-embedded guidance and demonstrated task-shifting potential, is the tool that makes that vision technically plausible. The work now is to build the human infrastructure around it — and the program's stepwise progress suggests that this vision can be accomplished.

C. LOOKING TO THE FUTURE

1. A Problem Without Borders

The challenges documented in this report — a preventable cardiac disease striking predominantly the young; a specialist workforce too scarce and too concentrated to reach those most in need; and a laudable, but still unsustainable, NGO and visiting-physician infrastructure, are not unique to Nepal. They describe the condition of rural healthcare across much of the developing world.

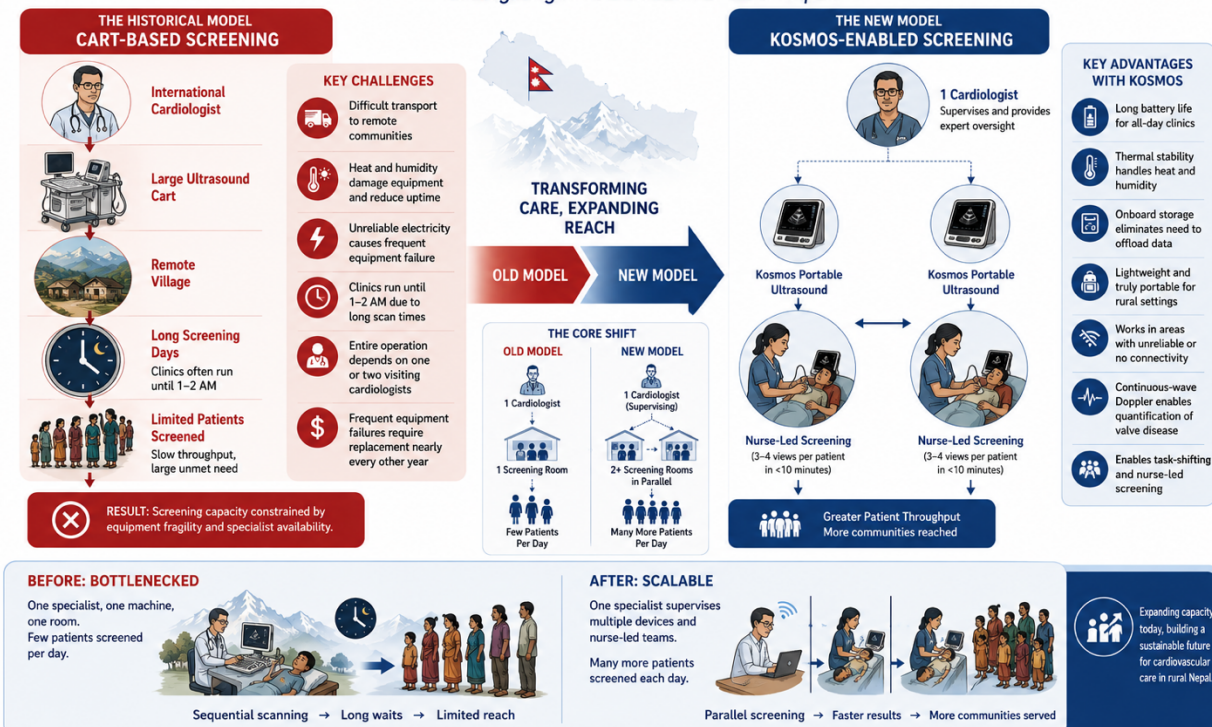
Rheumatic heart disease disproportionately impacts people in LMICs. The countries with the largest estimated numbers of RHD cases globally include India (13.17 million), Pakistan (2.25 million), and Indonesia (1.18 million), with Sub-Saharan African nations also reporting substantial incidence rates among children and youth. High RHD prevalence has been reported in the Democratic Republic of Congo, Ethiopia, and Nigeria, where diagnostic infrastructure is among the most severely constrained anywhere. In Africa, RHD accounts for up to 34% of hospital admissions related to cardiovascular disease, and is the most frequent cause of cardiovascular morbidity among children and youth. Unfortunately, the absence of routine screening across much of the world means that the overwhelming majority

of those affected, are never identified until their disease has progressed to advanced, surgical-stage presentations.

Data scarcity problems further complicate efforts to understand the true disease burden. Large portions of Central Asia, West Africa, and rural South and Southeast Asia have no published echocardiographic prevalence data at all — not because RHD is absent, but because the screening infrastructure required to detect and record it does not exist. A systematic review and meta-analysis in East Africa found RHD prevalence of approximately one in seven people across the region, a figure almost certainly understated given the reliance on hospital-based rather than community-based detection. The true population burden in LMICs remains unknown, but it seems clear that where active echocardiographic screening has been deployed in high-burden settings, detected prevalence often exceeds passive surveillance estimates.

3. FROM SPECIALIST BOTTLENECK TO SCALABLE SCREENING

Reimagining RHD detection in rural Nepal.



2. The Limits of the Current Paradigm

The visiting-specialist model that characterizes programs like the University of Washington's Nepal mission deserves recognition for what it is: an extraordinary commitment of time, expertise, and resources by individuals who travel to some of the world's most challenging environments to provide care that would otherwise not exist. If not for this program, the patients screened in the remote communities would likely not have received an echocardiogram in their lifetime. The longitudinal follow-up and support infrastructure maintained by the Jayanti Memorial Trust likewise represents an extraordinary commitment to care, iteratively and pragmatically adapted to local conditions.

But this model's dependence on annual overseas missions and NGO largesse highlights a great challenge in global health for all chronic diseases. Patients with chronic cardiovascular conditions like RHD require continuous routine monitoring that includes regular assessment of valve function, prophylactic antibiotic regimens maintained over years, and timely escalation when disease progresses. NGO transportation networks and visiting physician programs can bridge critical gaps, but they were not designed, and should not need to serve, as the primary vehicle for routine RHD surveillance and care across entire rural populations. Even when travel and hospital expenses are paid for, frequent travel to tertiary hospitals can result in lost income for patients, making it less likely for them to attend routine check-in appointments. Patient-centered care that involves expansion of tertiary-level care into rural districts is also not the answer: it represents not just a healthcare challenge but an infrastructure and financial challenge as well.

Because these constraints will continue to be significant barriers going forward, solutions must be directed at the primary care level, in reliance on the right AI-enabled technology, plus appropriate training of local healthcare staff, working synergistically to improve early detection and triage of RHD and cardiac care more generally.

3. The Inflection Point for POCUS

The evolution of POCUS over the past decade has been substantial, but the introduction of AI-embedded guidance features represents something

qualitatively different from incremental hardware improvements. AI enablement reduces the expertise required to both acquire images and extract clinically meaningful findings from those images.

Continuous Wave Doppler makes quantitative RHD assessment possible in the field. Most portable ultrasound systems lack this capability entirely, forcing field programs to choose between portability and diagnostic completeness. But Continuous Wave Doppler still requires a trained operator to correctly position the doppler gate, interpret the resulting waveform, and accurately measure the velocity gradients that determine disease severity. This can be a barrier in programs or settings where only nurses or community health workers operate without specialist oversight.

The Kosmos Auto Doppler feature addresses that barrier directly. By automatically identifying the target cardiac valve, placing the sample gate at the appropriate location, recording the velocity waveform, and auto-tracing it, Auto Doppler ensures consistency for the most technically demanding step in quantitative valve assessment. A trained nurse who can acquire a standard parasternal long-axis view with AI image guidance can, with Auto Doppler, obtain a clinically interpretable mitral valve gradient without a cardiologist in the room.

The implications of these AI advances for rural care are potentially transformative. A validated screening protocol, guided by AI image quality feedback, and completed with automated Doppler measurements, becomes executable by a trained community health worker or nurse. While this cannot act as a surrogate for specialist care, it does support primary healthcare triage that identifies the patients who need to be transported to a facility where specialist care is available, particularly when supplemented with access to specialists via telehealth platforms. The cost of that triage, measured in staff time and equipment, is a fraction of the cost of transporting every symptomatic patient to a regional hospital for evaluation. Furthermore, it is a fraction of the cost of missing a diagnosis in a child who is subclinical RHD goes undetected until they present with severe symptoms that require surgery later in life.

4. Looking Forward

The internal pressures that drive shortages of healthcare workers in LMICs are not likely to change in the short term, nor are the enormous health and societal costs that come from RHD burdens and unacceptably high rate of late-stage presentation. Going forward, as LMICs consider approaches for expanding RHD screening/early-detection capacity for rural and other underserved populations, long-term sustainability will turn on several features that seek to both identify and treat Strep A infections, and to identify RHD before it can reach an advanced stage of disease. To do so, government, technology, and local healthcare systems will need to work in concert to support:

- National digital infrastructure investment, with connectivity linking remote facilities to specialist care in urban areas;
- Expanded procurement, warehousing, and supply-chain strategies for Strep A interventions, particularly rapid diagnostics, routine stocking of low-cost antibiotics, and awareness campaigns for healthcare staff and at-risk populations.
- National investment in frontline screening/early detection of RHD, drawing on iterative field learnings from NGOs and other groups that have focused on these issues, like Jayanti Memorial Trust and the University of Washington.

Public programs focused on RHD screening/early detection will need to have at least three important component parts:

- Portable RHD screening technology that is AI-enabled, to allow for both community-level screening and task-shifting to frontline workers. In the context of RHD screening, Kosmos stands out as one of the only, if not the only, POCUS devices with Auto Doppler AI. The technology should also have capacity for connectivity with public digital health ecosystems, now being built out throughout LMICs;
- Training of local workforce sufficient to sustain task-shifting and RHD screening workflows at the primary care level over the long term; and

- standardized workflow to support the continuum of care to:
 - Ensure adequacy of training;
 - Triage patients who require specialist care/surgical interventions in urban centers (vs. those that can be treated locally);
 - Build-out patient registries, to improve population prevalence data and related surveillance; and
 - Handle all other critical aspects of care management for this chronic disease.

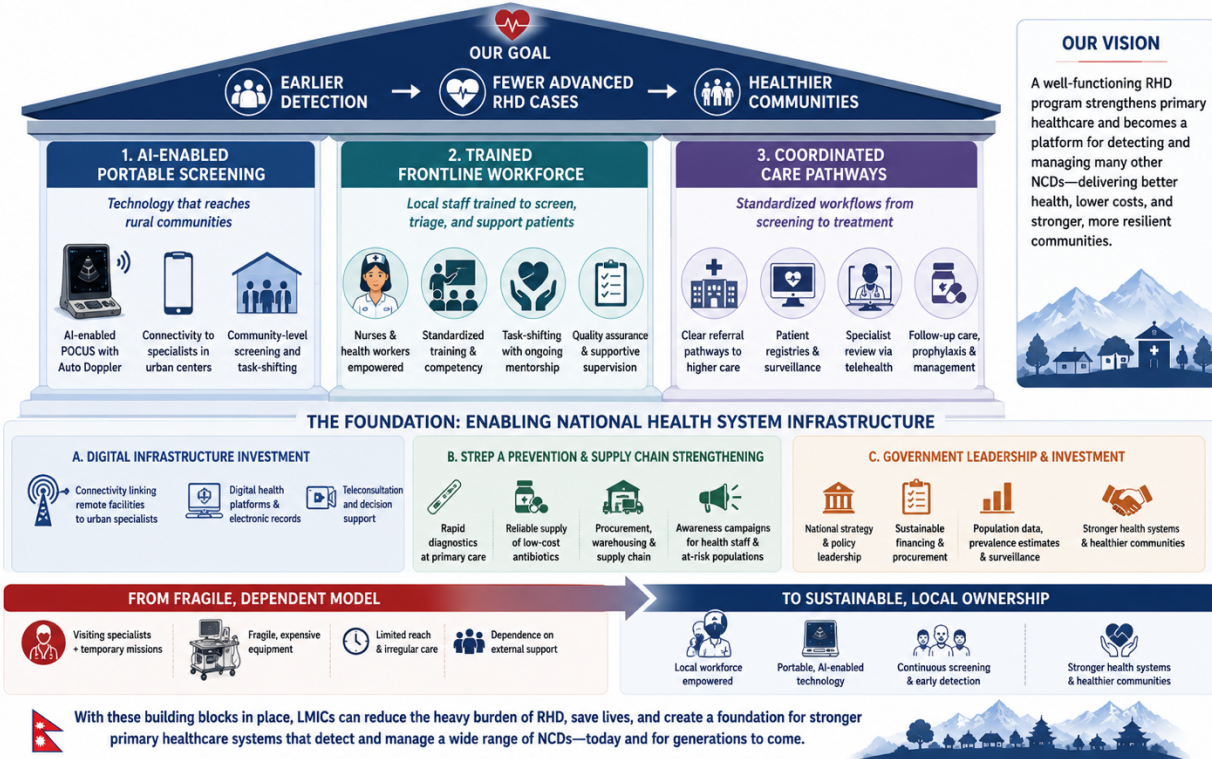
Only with these features will LMICs begin to address their RHD challenges more cost-effectively; reduce the heavy health and societal toll of their RHD burdens; and move away from dependence solely on large international donors, bilateral and multilateral support, non-profits, and NGOs.

Partnerships, especially from expert groups like Jayanti Memorial Trust and its visiting cardiologists, are of high continued value and should be encouraged, but ultimately governments must maintain directional control over their healthcare systems and related challenges.

A well-functioning RHD program at the community level is, in practice, a demonstration of primary healthcare strengthening in action. The same trained frontline workers, AI-assisted diagnostic tools, and care coordination protocols that make early RHD detection possible, are the building blocks of a broader primary healthcare system — one capable of identifying, triaging, and managing a wide range of NCDs that today go undetected until they become costly to treat.

4. LOOKING FORWARD: BUILDING A SUSTAINABLE NATIONAL RHD PROGRAM

From isolated screening missions to an integrated national system for early detection and care.



In the meantime, we applaud the impact-minded teams at Jayanti Memorial Trust and the University of Washington for their work over the last two decades to improve access to cardiac care for underserved populations of Nepal. Their nimble, iterative approach to adapting to local practicalities, and their persistence over the years, have provided important learnings for all LMIC governments seeking to handle their RHD challenges more effectively.

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