LivingGoods

QUARTERLY REPORT

Q2 | April - June 2018

Cover: *Dr. Oleke, Uganda MOH's Head of Community Health, CHEW strategy and VHTs gets a demonstration of mHealth technology from Scovia, a local CHW, during a 2-day field visit to our Lira branch.*

Q2

April - June, 2018

Living Goods Quarterly Report

Kenya Direct Operations Going Strong

This quarter, we slightly exceeded our target for U1 assessments, and were just shy of our U5 target by 3%. Pregnancies ticked up slightly to 1.3 per community health worker (CHW), though this remains 35% below target. The low results were due in large part to significant expansion in three large branches with more than 150 CHWs, which underperformed while new CHWs got up-to-speed. The two branches that expanded to 130 CHWs in Q2 continued to perform well throughout their expansion.

A standout in performance across many indicators was our Funyula Branch in Busia County. This is where we're doing our simple model experiment, with CHWs only selling and dispensing essential medicines, rather than other health-related products. While postnatal care (PNC) visits within 48 hours stayed even at 63% nationwide since last quarter, **Funyula reached an average of 86%, slightly exceeding the 85% target.** We will continue to evaluate the results of our simple model experiment over the coming months, and consider the implications it might have on broader strategy.

Our Results

Q2 2018

NUMBER OF PEOPLE SERVED
6,576,800

ACTIVE COMMUNITY HEALTH PROMOTERS
2,755 LG UGANDA | 1,513 LG KENYA | 3,953 BRAC UGANDA

SICK CHILDREN UNDER 5 ASSESSED IN Q2
358,217

SICK CHILDREN UNDER 1 ASSESSED IN Q2
76,577

NEW PREGNANCIES REGISTERED IN Q2
46,815

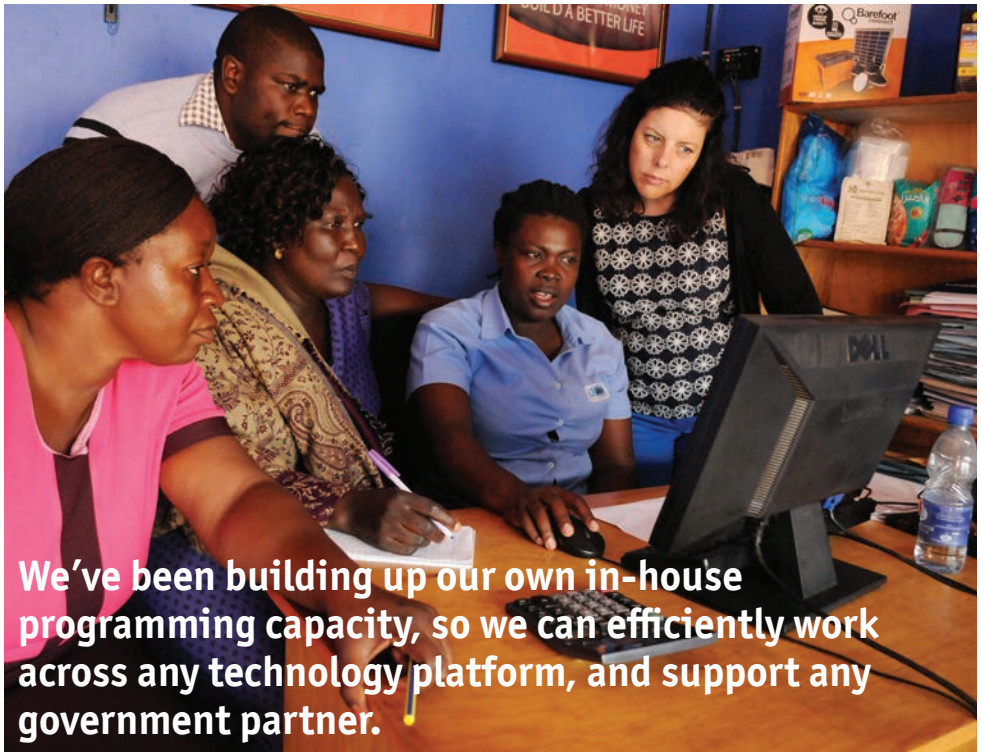
We've started directly supporting all community health units in Kakamega's Malava & Shinyalu subcounties, and will provide technical assistance in the remaining subcounties in 2019.

Focused Improvements in Uganda

In Uganda, we remained around 10-15% below most key health targets in Q2, including U1 assessments (-12%), U5 assessments (-8%) and pregnancies (-13%). However, **we saw exponential improvement each month and achieved most KPI targets in June**. This was due to efforts taken to sensitize supervisors around the importance of quality control (QC) and systemizing their work, in addition to increasing CHW incentives. Our QC team is working to identify and address key factors constraining improvements to the metric for PNC visits within the first 48 hours, including timeliness, connection issues in rural areas, discrepancies in technical knowledge, and issues of PNC visits that happen, but are not properly recorded.

BRAC's performance steadily improved from last quarter across many KPIs, such as active CHWs (97%), U5 malaria treatment, U1 malaria and pneumonia treatments, and sales. Regional performance variations and CHWs drop-outs affected overall averages. While U1 assessments were 17% below target at 3.3, **there were strong results in U1 diagnoses, at 3.2, well above the target of 2 per month**. Pregnancy registrations remained constant at 2 per month, which is 32% below target. On-time PNC results continue to be very low, at 23% of all pregnancies, though BRAC does note that **when considering just the PNC visits completed, 71% were on-time.** BRAC continues to work with Medic Mobile to identify ways to improve these results in the app.

Note: *A Smart Health system upgrade in April unfortunately resulted in some Living Goods Uganda data being lost, and so the results presented use the surrounding two months as proxies to calculate for the month.*



A Message from Liz Jarman

Dear all,

I'm thrilled to be taking the helm as Living Goods' new CEO at such a pivotal moment for our organization and the broader community health movement.

In addition to our Audacious Project—where we are partnering with Last Mile Health to create unstoppable momentum for community health by massively scaling our operations to support 34 million people by 2021—**our strategic plan is laser-focused on deepening the quality and depth of care we facilitate, and partnering with governments to coalesce their own effective community health programs.** Consequently, my immediate focus is on ensuring we prioritize initiatives that will yield the biggest impact and bring us closer to realizing our vision.

We're excited that governments are increasing their appreciation for how essential community health is to achieving universal health coverage, which makes the moment ripe for enhancing our influence and advocacy efforts, partnering on innovative approaches to health financing, and so much more.

Our experience shows that **effective community health programs are powered by compensated, motivated and well-supervised CHWs**, who have access to a reliable supply of key health treatments, and are supported by cutting-edge mobile technology and data-driven performance management. Technology is so critical that we've been building up our own in-house programming capacity so that we can efficiently work across any technology platform and support any government partner.

In order to stimulate an ecosystem that prioritizes community health, **we are also doubling down on experimentation so that our direct operations can serve as a testbed for innovation** that will enable more partners to join us in ensuring cost-effective, quality healthcare for all.

In this report, I'm excited to share key learnings from our family planning pilots, the official launch of our Results Based-Financing mechanism, the latest on innovations, the launch of our Kenya Investment Case, and so much more.

I look forward to working with and learning from you in my new role as Living Goods' CEO!

Bottom: *During a May visit to Kenya for a quarterly Board meeting, our founder Chuck Slaughter spoke with staff about the journey of building Living Goods from the ground up.*

Furthering Family Planning

After a few months implementing our family planning experiment, we've made some programmatic adjustments that have significantly increased our impact. One thing we tweaked is **switching to a client-centered counseling approach**, where messages are customized to the needs of individual women and their reproductive goals. Initially, clients would be provided with every possible option on family planning and would then need to choose. But, with this client-centered approach, a 25-year-old who wants children later in life, for example, wouldn't need to hear about sterilization options. Consequently, we have adjusted our training and curriculum so that **CHWs can offer more personalized counseling**.

During the pilot, we also found that one of the biggest barriers in family planning uptake was misinformation regarding side effects and fears that certain methods might affect women's eggs, lead to sterilization and infertility, or other negative health outcomes. **We needed to prepare CHWs to better answer questions about potential side effects**, particularly with injectables like the Sayana Press, such as irregular bleeding, not having a period, or a delayed return to fertility.

Through the introduction of new activity-based incentives, we've seen a 70% increase in the number of women newly counseled about family planning, refill rates have increased 25% to hit a total of 66%, and we saw a 60% increase in the number of family planning products sold since January.

Initially, the additional time requirements for providing family planning services discouraged some CHWs from fully participating. But, through the introduction of new activity-based incentives, we've seen a 70% increase in the number of women newly counseled about family planning, refill rates have increased 25% to hit a total of 66%, and we saw a 60% increase in the number of family planning products sold since January. **We will be rolling out family planning services across Uganda** over 2018 and 2019, and the learnings will be shared with our teams in Kenya to test similar approaches.

Bottom: *Last Mile Health staff learn more about Living Goods' family planning pilot during a visit to Uganda.*

We've launched our RBF in Uganda!

We finally launched a one-year pilot of the first-ever results-based financing (RBF) mechanism for community health in Uganda. Co-designed in partnership with the GOU and other key stakeholders, it was informed by frequent Advisory Committee meetings chaired by Dr. Sarah Byakika, the Acting Commissioner for Planning within the MOH. **In contrast to other RBF experiments, 100% of the funds will be performance-based**. We believe mechanisms like this decrease the risk of investing in community health, not only for traditional bilateral and multilateral donors, but also for local governments to more effectively finance or contract out the implementation of their own community health programs.

The Living Goods RBF will operate in Kyotera and Masaka disticts. Performance will be tracked using real-time data collected through our Smart Health app and viewed on customized dashboards, after being independently verified by Innovations for Poverty Action. These metrics include the number of visits CHWs make to pregnant women, antenatal clinic (ANC) visits following delivery, women delivering at health facilities, postnatal visits by a CHW within 48 hours and one week of birth, immunization and nutrition assessments for children under one year of age, U5 sick child assessments, and follow-up visits by CHWs. To ensure alignment with government and donor priorities, we tweaked our performance dashboards to track for ANC visits and births at health facilities, which we hadn't previously measured. The Deerfield Foundation is paying for outcomes in this pilot, and Instiglio will serve as the trustee and manager of the outcomes fund to disburse payments against verified results.

Learning from Our Partners' Successes

This quarter, our Community Health Strengthening Team continued in-depth scoping visits to other countries and partner operations to gain insights that will facilitate scaling our approaches to community health beyond our flagship operations in Kenya and Uganda. We had a memorable trip to Liberia to meet with our Audacious Project partner Last Mile Health to see how they work with the government in a low-resource context, while deepening their knowledge about how our model works. **It was valuable to see the differences in how mobile technology is used, with Last Mile Health relying on a Bluetooth data transfer due to limited internet availability.** It was also useful to see how they use data to create Supervisor Scorecards that then enable health managers to track their performance against their peers. The visit also helped us better understand the implications of the massive distances between CHWs in Liberia, which limits opportunities to regularly bring CHWs together and do in-person refresher trainings. We also learned how supervisors can compensate for that by transmitting knowledge and carrying out tests during their visits. It was also great to see how integrated supervisors are with their local facilities, which ensures a true continuum of care for the patients.

Bottom: *We had a memorable trip to Liberia to meet with our Audacious Project partner Last Mile Health to see how they work with the government in a low-resource context.*

Pushing the Envelope through Innovation

This past quarter, we saw some really exciting developments in our Community Health Innovation Network, funded by the Bill & Melinda Gates Foundation, which promotes ground-breaking ideas that can enable CHWs to more seamlessly integrate with health facilities and bring quality diagnostic technologies to patients, wherever they live.

Closing the Loop on Referrals – Ready for Field Deployment!

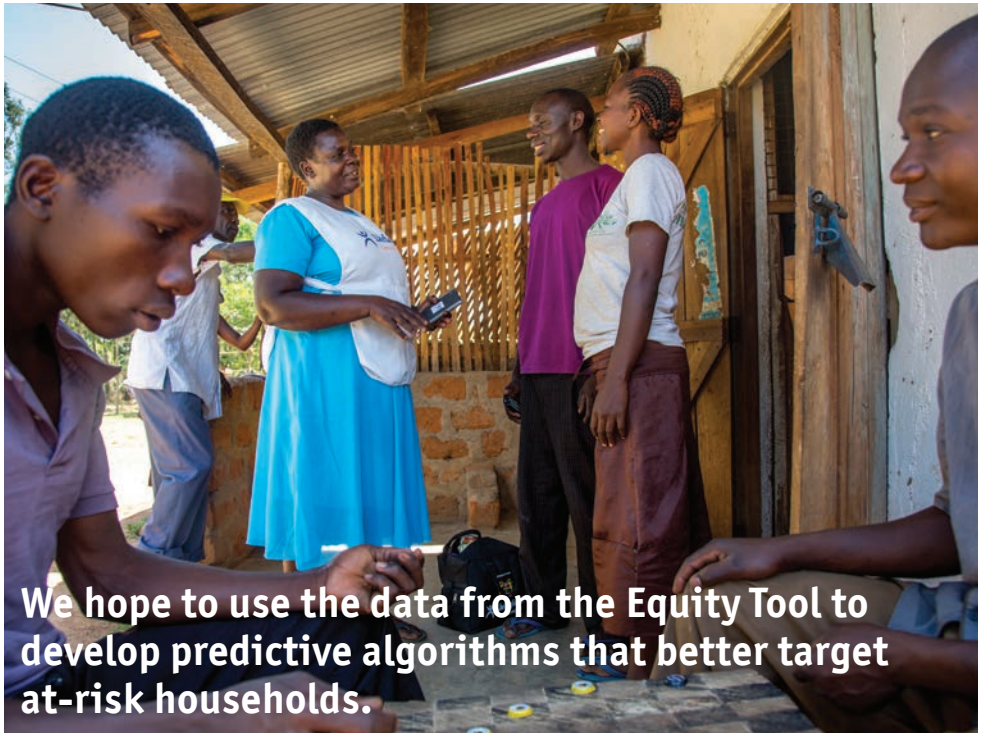
We have completed the development and testing of a digitized Alpha Product prototype for 'closed loop' patient referrals and follow-up between CHWs and health facilities for malaria, diarrhea, pneumonia, undernutrition, antenatal and postnatal care. Moving away from a paper-based system, the prototype includes a Digitized MOH referral form and follow-up processes, including SMS notifications, which is intended to close the gap to track whether clients referred for further care actually visit health facilities and receive treatment, and how follow-up care takes place. As the study progresses, our ultimate goals include evaluating if acute cases referred to clinics receive priority care, how much time and money households can save from receiving effective follow-up at their own homes, the extent to which disease progression can be averted through early referral and treatment, and the overall positive health outcomes for communities. The automated referral and counter-referral process **aims to ensure that 100% of referrals are confirmed via verifiable digital data instead of unreliable self-reported data**, 85% of clients referred are seen at the facility, and that 85% of CHWs conduct appropriate follow-ups.

Closed Loop HIV Self-Testing (HIVST) Baseline Survey:

It is crucial that HIV-positive patients know their status to ensure proper access to treatment, care, and prevention services. In support of Kenya's Be Self-Sure HIVST strategy, we completed a survey to support the distribution of HIV self-testing kits through CHWs in Bomachoge Chache subcounty, and are working to establish protocols that will simultaneously benefit clients and help the government accelerate HIVST across Kenya. We also formally joined the National HIV Testing Services Technical Working Group this quarter and presented our concept.

Conversations with a range of stakeholders, such as these construction workers, helped us develop our vision for scaling HIVST with the support of CHWs in Bomachoge Chache subcounty.

Bottom: *Joining CHWs like Caroline Moraa Nyarangó on their daily rounds helped us figure out the workflow for the new digitized closed loop referral system.*



We hope to use the data from the Equity Tool to develop predictive algorithms that better target at-risk households.

Ensuring Equitable Service Delivery

By embedding a simple survey called the Equity Tool into the Smart Health App, we've begun empirically validating that households of different economic levels are accessing services at rates roughly proportional to the demographics of each area. In line with government data, we found that women in higher income groups were exponentially more likely to deliver in health facilities than those who were poorer. However, one of the most important findings was that within the lowest wealth quintile, **70% of women assisted by Living Goods-supported CHWs were giving birth in health facilities, compared to the national average of only 30%**.

But, moving beyond the understanding of who's receiving health care, we believe there's great potential for using the data we gather to predict additional targeted support. This quarter, **we're focusing on analytics around neonatal mortality and morbidity through health facility delivery** as well as early detection of danger signs in the first 28 days of life, in addition to prevention and timely care for children under five. By using our existing data analytics to develop community risk profiles, we can better target CHW interventions, and even predict negative outcomes by building an algorithm into our mobile tools to direct CHWs to address these at-risk households.

Direct Operations: A Testbed for Innovation

Beyond our formal Innovation Network, we have brought increasing structure into innovation across Living Goods, with a formal committee and internal teams vetting potential experiments that will help us scale faster and more efficiently. Some of the newest concepts that we moved from the pilot to design phase in June include:

1. **Last mile distribution:** Creating new product distribution channels that decentralize storage to increase availability.
2. **Peer supervision:** Hiring proven CHWs to help supervise others through a peer-driven performance management effort.
3. **Incentives:** While making an impact in their communities is still the greatest imperative for most CHWs, we're exploring models for increasing and simplifying take-home financial incentives.

Although making an impact is the greatest imperative for most CHWs, we're exploring models for increasing and simplifying take-home financial incentives.

Proving the Value of Investing in Community Health

At the global level, we sent our first delegation to the annual World Health Assembly (WHA) in May. Leveraging the momentum from the WHO's new Community Health Worker guidelines under review, we co-hosted two events, submitted recommendations to the WHA on mHealth and health systems strengthening, and held in-depth meetings with Ugandan and Kenyan Ministry staff, WHO staff, and other partners.

The first event, **"Diverse Pathways and Partnerships to Universal Health Coverage"** focused on the role of innovative financing to achieve UHC, with notable speakers including Dr. Jane Aceng, Uganda's Minster of Health; Dr. Alex Azar, the U.S. Secretary of Health and Human Services; and Dr. Mariam Claeson, the Director of the World Bank's Global Financing Facility. We also hosted **"The Future of Health Financing: The Role of Blended Financing in Providing Sustainable Solutions for Community Health Programs,"** a flash-talk reception that brought together governments, civil society, and the private sector. Underwritten by Johnson & Johnson, it featured the Honorable Dr. Wilhelmina Jallah, Liberia's Minister of Health; Dr. Alma Crumm Golden, the Deputy Assistant Administrator of the USAID Bureau for Global Health; and Dr. Angela Gichaga, the CEO of Financing Alliance for Health.

Our first-ever delegation to the annual WHA enabled us to influence new Community Health Worker guidelines and advocate for innovative financing.

Bottom: *Dr. Oleke (in suit), Uganda MOH's Head of Community Health, CHEW strategy and VHTs, spent two days learning about Living Goods' approach to performance management.*

In Kenya, the Ministry of Health's Community Health Technical Working Group ratified findings of an investment case for community health that Living Goods played a fundamental role in helping to develop. Using the Living Goods approach as their model, the study showed that **investments in community health have a 9.4-fold return on investment—coming from the increased productivity and reduced disease burden that these investments enable.** Importantly, the study looked at costing across all levels of the community health system—not only at the CHW and facility-based level. We're scheduling a launch event as well as targeted advocacy activities for both local and national-level policymakers and donors in Q3, policy briefs for both district-level and national legislators, and a detailed infographic and op-ed.

The Ugandan Government has committed US $1 million to launch a Community Health Extension Worker (CHEW) strategy that will train 1,500 CHEWs, starting in September 2018, while the Ministry of Health is developing a Community Health Strategy. We're working in lockstep with a range of officials to support the development of both the strategy and an investment case for community health, too. Beyond meetings with the MOH's Commissioner of Community Health, **we were thrilled to facilitate an immersion visit for the MOH's Head of Community Health, CHEW strategy and VHTs** at our Lira branch to learn about the impact of our interventions and how we use mHealth technology to manage performance. The need to develop the Investment Case in tandem with the Community Health Strategy will ensure we're working seamlessly with MOH priorities.

Staffing

Beyond our biggest staffing news, with Liz Jarman officially stepping into her new role as CEO on June 15, a number of outstanding staff joined us this quarter.

Notably, in Kenya, we finally welcomed a new country director, Thomas Onyango, and Serah Malaba came on as our new Senior Advisor to Government. In Uganda, we are delighted to welcome Dr. Diana Nsubuga as our Deputy Country Director, Community Health Partnerships, and Nathan Tumuhamye as our Senior Manager of Global Innovations.

We're thrilled to welcome Thomas Onyango (second from left) as our new Kenya Country Director.

Massively Scaling our Internal Tech Capacity

Our experience building the Smart Health App with our partner Medic Mobile was transformative in enabling us to appreciate how essential technology is for scalable, impactful community health efforts. Smart Health will continue to power our direct operations and allow us to be innovative as we scale and we will continue to work closely with Medic Mobile. However, as we look to support the community health networks of partners and governments, we know it's impossible for one platform to serve every scenario, or the requirements of different countries and regions. **Consequently, we're becoming more technology agnostic in our approaches and have been evaluating how we can customize other key technology systems in the community health domain**, including ONA's OpenSRP this quarter and CommCare by Dimagi early next year. We are committed to helping partners go through the process of gathering technical requirements, and selecting and implementing the right platform. We wanted to reduce our reliance on external developers too, and so built up our in-house capacity, with five new software developers. Medic Mobile is helping us to learn how to develop on their platform. This quarter, we rolled out a GPS tool to help validate CHWs' activities, optimized health workers' daily routines through the App's workflow, contributed insights into the technology needed for our Results-Based Financing plan, and even introduced an exam module for CHWs.

Enhancing Our Internal Efficiency

The finance, supply chain and procurement components of our new Enterprise Resource Planning system went live in July, and we successfully piloted a new tablet-based Point-of-Sale (POS) system for coordinating the distribution and sale of medicines and products in Q2, which we will be rolling out across the organization. **The use of tablets for POS transactions will enable us to expand our radius of coverage around each branch, support the activities of more CHWs, and facilitate our branches and supply chain teams to monitor our inventory and supply chain of medicines and products in real time.** As a result of this more streamlined approach to selling and stocking CHW supplies, we are now exploring the viability of additional supply chain innovations, such as mini-hubs at the homes of CHWs in more remote areas. We will run this new POS system in parallel to our legacy system until we're confident that all aspects relating to finance, supply chain and field ops are in order.

Beyond the specific modules we're rolling out through this system, the most transformative part of the new ERP might be the analytics it will provide, which will help us drive more effective operations across our organization. To this end, we're in the process of setting up real-time dashboards customized for the needs of various departments. By expanding our focus on performance management across all operations, tied to key metrics, and using these to hold ourselves accountable, we will become an even higher performing organization, able to support community healthcare at a significantly larger scale.

Living Goods Q2 2018 Key Metrics*

	Living Goods-Uganda***			BRAC-Uganda			Living Goods-Kenya		
	Q2 2018 Target	Q2 2018 Actual	Q2 2017	Q2 2018 Target	Q2 2018 Actual	Q2 2017	Q2 2018 Target**	Q2 2018 Actual	Q2 2017
Impact Metrics**									
Pregnancies Registered / CHW per month	3.0	2.6	3.6	3.0	2.0	3.1	2.0	1.3	1.4
Under-1 Assessments / CHW per month	4.0	3.5	4.5	4.0	3.3		3.7	3.7	4.7 / 3.6
Under-1 Treatments / CHW per month	2.0	1.8	2.8	2.0	3.2	4.1	1.8	1.5	2.1 / 0.8
Under-5 Assessments / CHW per month	18.0	16.5	19.0	18.0	15.7	18.6	16.6	16.1	19.1 / 9.1
Under-5 Treatments / CHW per month	14.0	7.9	12.4	14.0	13.4	13.5	12.7	8.1	10.9 / 3.7
Active CHWs	2,782	2,755	1,911	4,065	3,953	3,586	1,680	1,513	1,060
Total Pregnancies Registered	20,722	18,176	18,398	32,927	22,963	46,001	8,559	5,676	4,110
Total Under-1 Assessments	27,629	23,631	22,592	43,902	37,237		15,920	15,709	13,264
Total Under-1 Treatments	13,814	12,510	14,354	21,951	36,083	44,771	7,831	6,424	5,930
Total Under-5 Assessments	124,330	111,034	96,446	197,559	176,436	206,027	69,841	70,747	53,228
Total Under-5 Treatments	96,701	54,766	62,973	153,657	150,284	148,898	55,334	35,560	30,257
% On-Time Referral Follow-Up	80%	76%	80%	80%	77%	89%	80%	82%	80%
% Postnatal Care Visit in first 48 hours	85%	47%	51%	85%	23%	91%	85%	70%	61%
% of 'High Impact' Items in stock	100%	98.9%	100%	100%	97%	98%	100%	100.0%	100%
Sustainability Metrics									
Wholesale Sales (USD)	$230,241	$189,173	$159,936	$244,500	$154,760	$104,320	$94,347	$66,155	$62,084
Sales / CHW per month (USD)	$30.00	$26.93	$27.69	$20.00	$14.18	$9.43	$20.00	$15.48	$21.89
Sales / CHW per month (local)	111,000	99,843	98,887	74,000	51,495	33,497	2,040	1,547	2,227
Initial Wholesale Margin	18.0%	20.8%	17.6%	13.0%	16.5%	15.0%	18.0%	24.7%	19.2%
Final Wholesale Margin	17.2%	18.5%	16.6%	12.0%	16.5%	15.0%	15.9%	24.7%	18.2%
Population Served	2,225,000	2,204,000	1,528,800	3,252,000	3,162,400	2,868,800	1,344,000	1,210,400	848,000
Net Cost per Capita Served (annualized)	$2.00	$2.23	$2.25	$1.12	$1.02	$0.99	$3.12	$4.00	$3.18

* Note 1: *Note 1: These results and targets represent the Living Goods direct network implementation only, as assisted networks don't launch until later.

** Note 2: LG-Kenya has three assessment and diagnosis targets -- malaria endemic / malaria non-endemic / free malaria branches. The targets shown in the dashboard represent the weighted average across these.

*** Note 3: Some LG-UG data was lost due to a systems upgrade in April. We have therefore used an average of the two surrounding months.