QUARTERLY REPORT

Q2 | April - June 2019

LivingGoods

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Living Goods Quarterly Report

Solid Performance in Kenya, with Opportunities to Bolster Treatments

We are pleased to have **sustained our all-time high postnatal care (PNC) results in Kenya from Q1 to Q2 at 82%**, due to the concerted prioritization and planning around this activity by staff and designated PNC champions in each branch.

While our under-5 (U5) assessment numbers per community health worker (CHW) exceeded targets in Q2 2019 at 20.4, just slightly above the 18.8 per CHW figure we saw in Q2 2017, we are experiencing similar issues in Kenya and Uganda, **with increased assessments not correlating to increased treatments**.

Treatments declined by 29% in the same time period, from 7.9 in Q2 2017 to 5.6 in Q2 2019. Pneumonia treatments were hit the hardest, with a 68% decrease, followed by diarrhea treatments (down 31%) and malaria treatments (down 18%). Overall, the absence of a local policy in Kenya stating that CHWs are expected to dispense antibiotics for sick U5 children with pneumonia, as well as the presence of government health supervisors known as Community Health Extension Workers (CHEWs), who at times advise CHWs to only refer, rather than treat, may partly inform the drop in pneumonia treatments. Some CHEWs also encourage CHWs to only treat with free drugs from health facilities, which may experience stockouts. In contrast, Living Goods' in-stock rate for essential medicines is 100%. We are working to develop agreements as needed at county and sub-county levels to resolve these issues and ensure CHWs can still treat using Living Goods-supplied drugs. We are also **stepping up our advocacy work for treating pneumonia at the community level.**

We have an ongoing effort in Kenya focused on increasing household coverage and finding and treating more sick children as a means of driving impact. This effort was launched in all branches in March 2019 and has started strong, **with household visits per CHW improving 27% from March to June.** Visits to at-risk households (defined as households belonging to the poorest wealth quintiles) also remained largely steady, with a slight increase in June. Meanwhile, our focus on increasing assessments to drive up treatments and impact was launched in our Nambale branch in March and later scaled to our Butula branch in April. In those two branches, **assessments increased by 30% and treatments by 24%—a huge improvement.**

Borrowing from best practices in inventory management, we have also introduced a new 360-degree quality control process to address unverified data. **Initial results have shown a promising reduction of unverified data, from 24% in Q1 to 13% in Q2.** This new process will be further tested in Q3 and Q4 to check its longer-term impact and scalability.

In Kisii County, our technical assistance partnership with the Bobasi sub-county health medical team (SCHMT) is going strong and we made important progress this quarter. **We saw increased CHW activity this quarter, especially around household visits and assessments.** This can be attributed to increased CHEW supervision and a **five-fold increase in compensation for CHWs as a result of increased activity.** In contrast to our direct operations, Living Goods is directly supporting government CHEW supervisors to manage the performance of CHWs through a light-touch approach. In addition, this quarter our tech team made great strides codesigning a workflow with the Bobasi SCHMT that will enable the government to better manage its supply chain. **Government officials accessed mHealth dashboards at an all-time high in Q2, jumping to 65% in Q2 from just 13% in Q1.**

Our Results in Q2 2019

LG UGANDA 3,474 | LG KENYA 1,864 | BRAC UGANDA 2,131
ACTIVE COMMUNITY HEALTH WORKERS

509,491
SICK CHILDREN UNDER 5 ASSESSED

39,216
NEW PREGNANCIES REGISTERED

90,380
SICK CHILDREN UNDER 1 ASSESSED

5,975,200
PEOPLE SERVED

Cover: *CEO Liz Jarman, Machakos Gov. Anyang Nyong'o, Isiolo Gov. Mohamed Kuti, and Kisumu Governor Dr. Alfred Mutua celebrate the historic graduation in of 340 CHWs in Isiolo County*

Significant Learnings in Uganda Inform Program Design

In December 2018, for the first time, we introduced additional incentives to CHWs for sick child assessments, with the goal of finding and treating more sick children. While this approach drove up our assessment numbers, it did not result in proportional treatments. Upon investigation, we realized that CHWs were not always assessing children with clear signs of sickness, such as diarrhea, cough and fever. **We have retrained CHWs to ensure this is clear and they are focused on accurately assessing and treating sick children.** This is part of our new Impact Optimization Plan in Uganda (IOP2), described in detail on page 6.

The changes outlined above have already shown some improved results, although **assessment numbers are still not correlating with treatments** to the extent we'd like to see. Focusing only on sick child assessments resulted in more targeted visits and a more effective use of CHWs' time. Consequently, while the number of assessments went down across our direct operations this quarter—from an average of 37 per CHW in April to 31.1 in June—we saw **increasingly high conversion rates from assessments to treatments and positive diagnoses**, moving from 33% in April to 53% in June, indicating an improvement in performance.

We saw good growth this quarter in **U5 treatments and positive diagnoses per CHW, growing from 9 in Q1 to 14.2 in Q2, exceeding the current target of 14.** Similarly, U1 treatments per CHW rose from 1.9 in Q1 to 3.1 Q2, exceeding the current target of 2. In addition, pregnancy registrations have seen an uptick from 2 registrations per CHW in Q1 to 2.6 at the end of Q2. At the same time, our rates for on-time PNC visits within 48 hours have dropped to 63% in Q2 from 67% in Q1—still below our target of 75%—and we are continuously working to improve this critical indicator starting with ensuring we support every pregnancy in the CHW household area.

We are on track with our scaling plans for 2019 and have slightly exceeded our Q2 targets for expansion, with 3,474 active CHWs. We have also **made great progress in scaling family planning across Uganda** and trained 82% of all eligible CHWs by the end of Q2, as CHWs can only engage in this training following six months of service. Performance is generally on track, but we have found that CHWs with more than three months of experience perform better than those newly trained.

Right: *In Uganda, CHW Jennifer meets with 21-year-old Moureen and her 3-month-old daughter, Denise. Jennifer was instrumental in getting Moureen in to a clinic when she had extreme late-term pregnancy pain, requiring an emergency c-section. She is now working to ensure that Denise gets all her vaccines on-schedule.*

Similarly, performance is strongest at our initial pilot branches Bwaise and Mpigi, where the CHWs are more experienced at providing family planning services.

Following **BRAC Uganda's operational restructuring last quarter, they are slowly getting back on track.** Against their target of 3,800, at the end of Q2, they had 2,131 active CHWs, compared to 1,537 last quarter. This underperformance is driving all health KPIs down. This is linked both to the delay in recruiting supervisors and the slower learning curve of new recruits, especially on the technology side. **BRAC's performance has steadily improved since last quarter, though some challenges remain, particularly around on-time PNC visits**, though those have risen to 69% in June. Total U5 assessments in Q2 marked a 163% increase from Q1 but are still well below the target of 174,420. Similarly, BRAC's Q2 pregnancy registrations marked an 80% increase from Q1 but are still significantly below the target of 29,070. We are hopeful that BRAC will continue to make steady progress in all of its performance indicators as it continues to rebuild its network of CHWs. The last batch of new supervisors were hired in July 2019.

Isiolo Program Finally Launched with Largest Graduating Class of CHWs

We celebrated a momentous milestone in our innovative co-financing partnership with the Isiolo County government on July 11 when **nearly 350 newly trained and equipped CHWs graduated—the largest such graduation in Living Goods history.**

Held on the grounds of the Isiolo County Teaching and Referral Hospital, the graduation ceremony was hosted by Isiolo Governor Dr. Mohamed Kuti. Despite delays in obtaining political consensus and overcoming the logistical hurdles for this first-of-its-kind partnership, Gov. Kuti tenaciously persisted in moving the project forward in the months since the contract was initially signed in November 2018. Through this initiative, **Living Goods will strengthen community health services across Isiolo for the next four years, while building government capacity** to sustainably manage community health services for the long-term.

Governor Kuti was accompanied at the graduation by Machakos Governor Dr. Alfred Mutua and Kisumu Governor Professor Anyang Nyong'o. Collectively, the governors are leading three of the four counties that comprise Kenya's universal health coverage (UHC) pilot, which is one of the four pillars of Kenyan President Uhuru Kenyatta's Big Four Agenda. Others attending the festivities were Isiolo County leaders and residents, and representatives from the national government and Living Goods, including our CEO Liz Jarman, the chair of our Board of Directors Chuck Slaughter, and chair of our Kenya technical advisory board, Prof. Miriam Were.

In addition to helping to operationalize the drive for UHC in Kenya, our partnership in Isiolo is paving the way to better unify and integrate implementing partner data with the government's health database, DHIS2. **Living Goods is the first nonprofit to undertake real-time health data integration in partnership with the government** and the data that CHWs in Isiolo collect with Smart Health, our digital app, will start integrating into DHIS2 by the end of August 2019.

The newly-trained CHW workforce in Isiolo **will distribute pharmaceutical commodities provided by the government—a great learning opportunity for us, as we typically work with our own supply chain.** Ensuring the continuity of medicines in partnership with the government will be an important focus area. Isiolo is also quite demographically distinct from the other counties we have covered. To support working in a large geographic area with a dispersed nomadic population, Living Goods has also contributed 10 motorbikes and a vehicle to the program.

The second cohort of 380 CHWs will begin training in August, to ensure full coverage for about 40,000 households across Isiolo, Merti and Garbatulla sub-counties, with a primary focus on improving maternal and child health.

Pictured: *1) Isiolo Governor Dr. Mohamed Kuti; 2) the Isiolo CHW graduates; 3) Living Goods CEO Liz Jarman; 4) Dr. Miriam Were*

Immunization Pilot Starting Strong

We've made strong progress in operationalizing immunization counseling and referral activities, made possible through the support of Gavi, the Vaccine Alliance. Through the initiative, **CHWs are using GPS-enabled smart phones to track the real-time vaccination status of children for tuberculosis, polio, diphtheria, whooping cough, hepatitis B, measles and other serious illnesses and referring defaulters** to get immunized.

In addition to ongoing baseline survey data collection, **in March we began actively piloting immunization demand generation and referral efforts in two of our branches in Uganda**, designed to bolster the appeal of vaccines and combat misperceptions. Our initial experiments are focused on more sophisticated defaulter tracking, amplifying the life stories of people who have benefitted from vaccinations, and using visual aids that can motivate caregivers to ensure that their children complete the recommended vaccination schedule.

So far, 217 CHWs have been trained in our Masajja and Magale branches to incentivize immunizations and generate facility referrals. We also just began piloting immunization activities at our Shinyalu branch in Kenya in July with 160 CHWs and expect to have a progress report in Q3.

Performance against some of our key indicator targets for the pilot have started out strong. At the end of Q2, **67% of children under age 2 registered by CHWs had updated immunization statuses** (against a target of 75%), only slightly below target. CHWs reported referring 95% of defaulters to facilities for vaccines, but that other factors impeded accessing services (see below). **Ultimately, 58% of referrals were completed—meaning that the families confirmed the child received the vaccine when randomly contacted by us—exceeding our 50% target.**

Feedback provided by CHWs and supervisors engaged in the pilot in Masajja indicated that **there are several systemic issues preventing families from completing immunization referrals for their children.** Vaccines are sometimes out of stock and facilities occasionally turn parents away when a child is older than the recommended age for dosing—unaware they should still immunize. CHWs have also experienced additional challenges tracking the immunization statuses of children of migrant families in urban slum areas like Masajja since they do not stay in one location for long. While these are difficult issues, we will continue working with families to ensure that they have the support and encouragement they need to navigate what can be a challenging process. The data gathered through our project will also be used to support the Ministry of Health to improve upon their immunization services.

Top: *In Masajja Uganda, one of the immunization pilot branches, CHW Jennifer speaks with a young mother whose son has a minor fever following a vaccination.*
Bottom: *A mother in Masajja gets ready to share her child's health records with a CHW.*

Launching Our Improved Impact Optimization Plan

Our first Impact Optimization Plan (IOP) was rolled out in Uganda in Q4 2018, with the goal of saving more lives by reaching more children and mothers. We focused on tactics that included boosting targets for coverage, assessments and treatment, microtargeting the most vulnerable, improving CHW incentives and supervision and strengthening monitoring of our work.

However, the results from the first IOP indicated that while the plan did increase our impact in some areas, **we were still not meeting the ambitious targets we had set for ourselves.** We saw a sharp increase in assessments, but treatments and positive diagnoses grew more slowly. We also did not see a sufficient increase in household coverage.

Consequently, we are launching a new version of our impact optimization plan (IOP2) in Q3 2019. This new plan incorporates our learnings to-date and allows us to test new approaches to drive impact.

IOP2 has one set of interventions focused on core elements that are being implemented immediately. This includes improving how CHWs manage their territories, strengthening the quality of supervision, ensuring the quality of the data that CHWs provide and driving community demand for CHW services.

The second set of interventions under IOP2 are **tests that are designed to be quickly scaled if they show positive results,** including:

- **Incentives for CHWs to target households identified as at high risk for childhood mortality.** At-risk households are defined as being those with a pregnant mother, a child under age one, or who have been identified as having gaps in accessing health care previously, including historically poor health-seeking behavior. CHWs will be given an ambitiously high percentage target for coverage of at-risk households in their catchment and receive an incentive based on their achievement of that target
- **Free services (such as a free assessment or treatment) to incentivize new clients and increase the number of new families with sick children treated**
- **Free services and sick child treatments offered to the poorest households, for whom the cost would be a barrier to accessing CHW services.** Formative research suggests that in most cases, this is not more than five households per village. Since children in these very poor households are at higher mortality risk and often delay care-seeking due to cost, we believe this to be a cost-effective investment.

Going forward, we will closely monitor the results from IOP2 and may make further adjustments as needed; we will also work to ensure that our partners and funders are kept up-to-date with our results and learnings.

We anticipate completing these experiments by September. For those which prove effective, we will begin scale-up in October. **In Q4, we also plan to experiment with the use of machine learning to help generate customized task lists for CHWs and supervisors, ensuring both are prioritizing high-impact activities.**

Going forward, we will closely monitor the results from IOP2 and may make further adjustments as needed; we will also work to ensure that our partners and funders are kept up-to-date with our results and learnings. We remain committed to being nimble, to failing fast and to scaling just as fast when we succeed.

Left: *Living Goods Uganda Technical Advisory Board members Professor Francis Omaswa and Dr. Peter Khisa Wakholi assess our operations in the field.*

CHW Guidelines Approved at the World Health Assembly

Community health featured prominently throughout the 72nd World Health Assembly in May, resulting in the **approval of the CHW Guidelines as part of the "Community Health Workers Delivering Primary Health Care: Opportunities and Challenges" resolution.** This resolution directs countries and partners to allocate sufficient resources for the advancement of CHW programs, under the direction of the CHW Guidelines. Living Goods has continually worked to support and encourage implementation of the CHW Guidelines in order to more broadly support national governments' inclusion of community-based primary health care and issued a statement when they were released. The approval of these guidelines marks an important step forward in greater involvement of community-based health care in health systems to ensure affordable and accessible health care for all.

Bringing CHW Voices to the WHA

Through their work delivering services door-to-door, **CHWs understand first-hand the complexities of community health and can be impactful advocates at the county, national and global levels.** To amplify their voices, the global advocacy team is supporting CHWs to be powerful and effective advocates for community health. One such CHW is Rita Nakakande, who has been receiving support from Living Goods in Uganda for more than five years. In May, **Rita attended the WHA and shared her experiences at a side event co-hosted by Communities at the Heart of UHC campaign members** Living Goods, Last Mile Health, Pathfinder International and the What to Expect Foundation.

"My hope is to inspire global and country leaders to invest in community health programs and community health workers. We know our communities, we are from them, we care about them and we are part of the solution for achieving universal health coverage. I am committed to continuing my work to raise awareness and deliver health services that reach the last mile."

—Rita Nakakande

Right: *Dr. Diana Nambatya Nsubuga, Living Goods Uganda Deputy Country Director; Rita Nakakande, a Living Goods Uganda -supported CHW; Dr. Jane Aceng, Uganda's Minister of Health; and Crystal Lander, Living Goods Director of Advocacy.*

Prioritizing Community Health at the HLM-UHC Multi-Stakeholder Hearing

On April 29, Living Goods attended the multi-stakeholder hearing for the High-Level Meeting on Universal Health Coverage (HLM-UHC) convened by the President of the UN General Assembly. More that 600 delegates representing Member States attended, including UN entities, civil society organizations and representatives of the private sector, as well as broader communities. At the hearing, **a statement submitted by Living Goods, in partnership with the Communities at the Heart of UHC campaign, the Frontline Health Workers Coalition and the Community Health Impact Coalition, was selected to be read on the floor.** Living Goods is continuing to generate high-level political will and commitment for prioritizing quality community health programs as part of national and global UHC strategies.

Official Statement:

We believe that only by prioritizing quality community health delivery in building stronger health systems for UHC can the global community ensure we leave no one behind.

Women Deliver 2019 Conference

In early June, **Living Goods joined more than 8,000 leaders, advocates, implementers and journalists from 165 countries in Vancouver, Canada for the 2019 Women Deliver conference.** The conference, held every three years, is the world's largest meeting on the health, rights and well-being of women and girls. It is an important platform to highlight the power of CHWs not only to improve health outcomes for women and girls, but also to achieve UHC. At the conference, Living Goods staff were able to meet with donors, collaborators and partners to raise the visibility of Living Goods' work. Additionally, Living Goods had a booth in the exhibit hall where participants could have a **hands-on experience with our Smart Health app, see what it's like to be a CHW with virtual reality glasses** and pick up materials to learn more about our work.

Building Support for Community-Based Primary Health Care in Kenya

Living Goods was recently awarded an advocacy grant to strengthen community-based primary health care (PHC) in Kenya. **Through this grant, we are working to support Kenya's Council of Governors to budget and plan for community-based PHC.** Additionally, Living Goods is hosting several briefings throughout 2019 to convene key decision-makers and civil society organizations to strengthen funding and policies for community-based PHC, with a focus on including the voices of CHWs in these discussions. With this work, **Living Goods aims to secure supportive and sustainable community-based PHC policies at the county level**, establish investments in UHC and have a body at the county level advocating in one voice for policies to ensure that health care reaches the most vulnerable populations for years to come.

Top left: A visitor to the Living Goods booth at Women Deliver uses virtual reality glasses to learn more about our work.
Bottom left: Living Goods Kenya Deputy Deputy Director Ruth Ngechu, Uganda Country Director Emilie Chambert and Linda Etim, Senior Advisor, Global Policy and Advocacy, Bill & Melinda Gates Foundation at Women Deliver.
Bottom right: Living Goods participated in a four-day workshop at the Kenyan MOH's PHC secretariat to draft their new PHC strategy, expected to be launched later this year.

Closing in on New Country Expansion

We've seen numerous positive developments this quarter as we work to scale our impact across Africa and are encouraged that the **Sierra Leonean government has approved us seconding a monitoring & evaluation expert to support the government's CHW Hub** while we await word about the status of the World Bank-funded opportunity we applied for in December 2018.

We are also in the process of **finalizing a Memorandum of Understanding with the government of Burkina Faso**. Over an initial six-month period of support, Living Goods would assist the Ministry of Health to make its national community health strategy "implementation ready" by refining, prioritizing, budgeting and operationalizing the strategy. Living Goods would focus specifically on digital health, supportive supervision and performance-based incentives. **With 17,000 CHWs in Burkina Faso receiving monthly stipends, we are excited by this opportunity's potential for scale** and the government's commitment to professionalizing its community health program and achieving Universal Health Coverage.

Above: *Strategic Partnerships Manager Justin Loiseau meets with a Ministry of Health official in Burkina Faso to discuss supporting the country's national community health strategy*

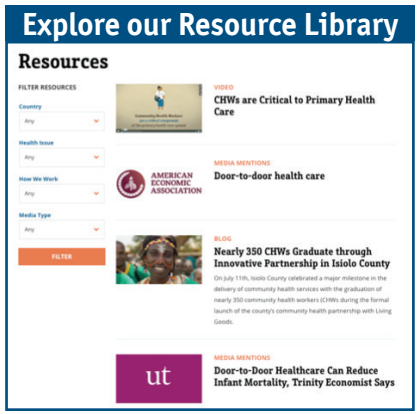
In Rwanda, we are also seeing positive and rapid developments following a series of meetings between Living Goods staff and Ministry officials, including one in January between our founder and board chair Chuck Slaughter and Dr. Patrick Ndimubanzi, Rwanda's Minister of State for Health in charge of Primary Healthcare. In May, the Hon. Dr. Diane Gashumba, Rwanda's Minister of Health, invited our staff to Kigali with a request to support the Ministry to digitize its community health program. In June, members of our Community Health Strengthening and Technology Teams conducted an initial scoping trip to Kigali and held a series of meetings with MOH and key partners including UNICEF, IntraHealth, the World Bank, the Global Fund and The Ihangane Project.

We have also engaged in **exciting conversations this quarter with Ethiopia's Federal Ministry of Health (FMOH) to support their Health Extension Program (HEP).** We are looking at ways to leverage their electronic community health information system as a means of supporting the performance management of health extension workers. We are in the process of finalizing a concept note outlining our proposed scope of support, which would include seconding staff to the HEP to advise on the review and roll-out of tech-enabled performance management at scale and to support the FMOH to think through a performance-based financing pilot.

Above: *A Living Goods delegation from our Community Health Strengthening Team and IT departments meet with Rwanda's Director General of Planning Health Financing and Information Systems, Dr. Parfait Uwaliraye, and team.*

We've Launched our New Website!

The Living Goods team is thrilled to announce the launch of our brand new website! **There is a huge amount of new content on the new site—much more than our last—and nearly all of it is brand new content never seen before.** The new site has discrete country pages, health issue area pages, breakdowns of our impact numbers and research initiatives, deep overviews about all the ways in which we work and so much more.



One of our most dynamic and exciting pages is our ever-growing resource library, which houses everything from Living Goods fact sheets to media mentions, stakeholder reports and more. If you have a question about Living Goods, you'll likely find the answer there. You can easily view the site on your phone or tablet—and you can easily share any and all pages to social media. We even have the latest from our Twitter, Instagram and other social media properties streaming right into our home page.

www.livinggoods.org

When Violet's 7-month-old Quintashire wouldn't stop crying for several days and had a persistent runny nose, the 25-year-old mother of two didn't think twice about what to do next: she called her neighbor, CHW Jerusha Manoa for help.

Jerusha, 49, has only been a Living Goods-supported CHW in Kenya's Kisii County since December 2018, but it's already changed her life. She says the work is hard, as she spends a minimum of two hours a day supporting her neighbors—and often far more—but it is also enormously fulfilling. "I love it because I'm reaching and assisting people. Before I wasn't even known by anyone, but now Living Goods has fulfilled my dream. I wanted to become a nurse, but now it feels like I'm one of them."

Thankfully, Jerusha's assessment with the Smart Health app confirmed that Quintashire was not dealing with anything serious and it was just a minor cold. However, she commited to returning in 48 hours to ensure the baby was completely recovered and to providing a referral to the health clinic if needed.

Living Goods Q2 2019 KEY METRICS

	Living Goods-Uganda Direct Operations			Living Goods-Kenya[1] Direct Operations			Living Goods-Kenya Technical Assistance[2]		
	Q2 2019 Target	Q2 2019 Actual	Q2 2018	Q2 2019 Target	Q2 2019 Actual	Q2 2018	Q2 2019 Target	Q2 2019 Actual	Q1 2019
Impact Metrics - Monthly									
Pregnancies Registered/CHW	3	2.6	2.6	2	1.0	1.3	2	1.2	0.6
U5 Assessments/CHW	18	35.2	16.5	18/12	20.4/14.7	16.1	12	13.4	7.5
U1 Assessments/CHW	4	7.6	3.5	4/3	3.9/3.3	3.7	3	2.7	1.4
U5 Treatments and + Diagnoses/CHW	14	14.2	7.9	14/9	10.7/3.1	8.1	9	5.4	3.4
U1 Treatments and + Diagnoses/CHW	2	3.1	1.8	2/1	1.5/0.7	1.5	1	0.9	0.7
% On-Time Referral Follow-Up	80%	83%	76%	80%	79%	82%	80%	92%	86%
% On-Time Postnatal Care Visit	75%	63%	47%	75%	82%	70%	75%	53%	45%
% 'High-Impact' Items in Stock[3]	100%	96.6%	98.9%	100%	100%	100%	N/A	N/A	N/A
Impact Metrics - Total[4]									
Active CHWs	3,307	3,474	2,755	1,930	1,864	1,395	185	180	185
Population Served	2,645,600	2,779,200	2,204,000	1,544,000	1,491,200	1,116,000	148,000	144,000	148,000
Total Pregnancies Registered	24,532	24,276	18,176	9,537	5,289	5,676	N/A	584	308
Total U1 Assessments	32,710	70,948	23,631	17,503	19,432	15,709	N/A	6,399	2,745
Total U1 Treatments and + Diagnoses	16,355	28,998	12,510	7,966	6,306	6,424	N/A	1,278	536
Total U5 Assessments	147,193	328,916	111,034	76,408	97,495	70,747	N/A	2,553	1,213
Total U5 Treatments and + Diagnoses	114,484	133,148	54,766	58,905	36,740	35,560	N/A	417	202
Cost-Effectiveness Metrics									
Sales/CHW per month (USD)[5]	$30	$16.33	$26.93	$30	$17.58	$15.48	N/A	N/A	N/A
Net Cost per Capita Served (annualized)[6]	$2.20	$1.57	$1.96	$3.47	$3.54	$3.74		N/A	N/A

NOTES

[1] Living Goods-Kenya has two assessment and diagnosis targets: malaria endemic / malaria non-endemic

[2] Currently the technical assistance CHWs in Kenya work only in malaria non-endemic areas, thus all assessment and treatment targets listed are for malaria non-endemic.

[3] As we are working with the government supply in our TA model we do not track stock outages for TA CHWs, but we hope to introduce technology in 2020 to do this.

[4] Since we are still testing approaches to technical assistance, we have not set total targets yet for impact metrics.

[5] TA CHWs do not sell commodities.

[6] We are still working on capturing cost-per-capita data for our TA program and expect to include this in our next report.

Living Goods-BRAC Q2 2019 KEY METRICS

	BRAC-Uganda			
	Q2 2019 Target	Q2 2019 Actual	Q1 2019	Q2 2018
Impact Metrics - Monthly				
Total Pregnancies Registered	29,070	9,651	5,354	22,963
Total Under-5 Assessments	174,420	83,080	31,554	176,436
Active CHWs	3,800	2,131	1,537	3,953
Population Served	3,040,000	1,704,800	1,229,600	3,162,400
% On-Time Postnatal Care Visit	75%	54%	32%	23%