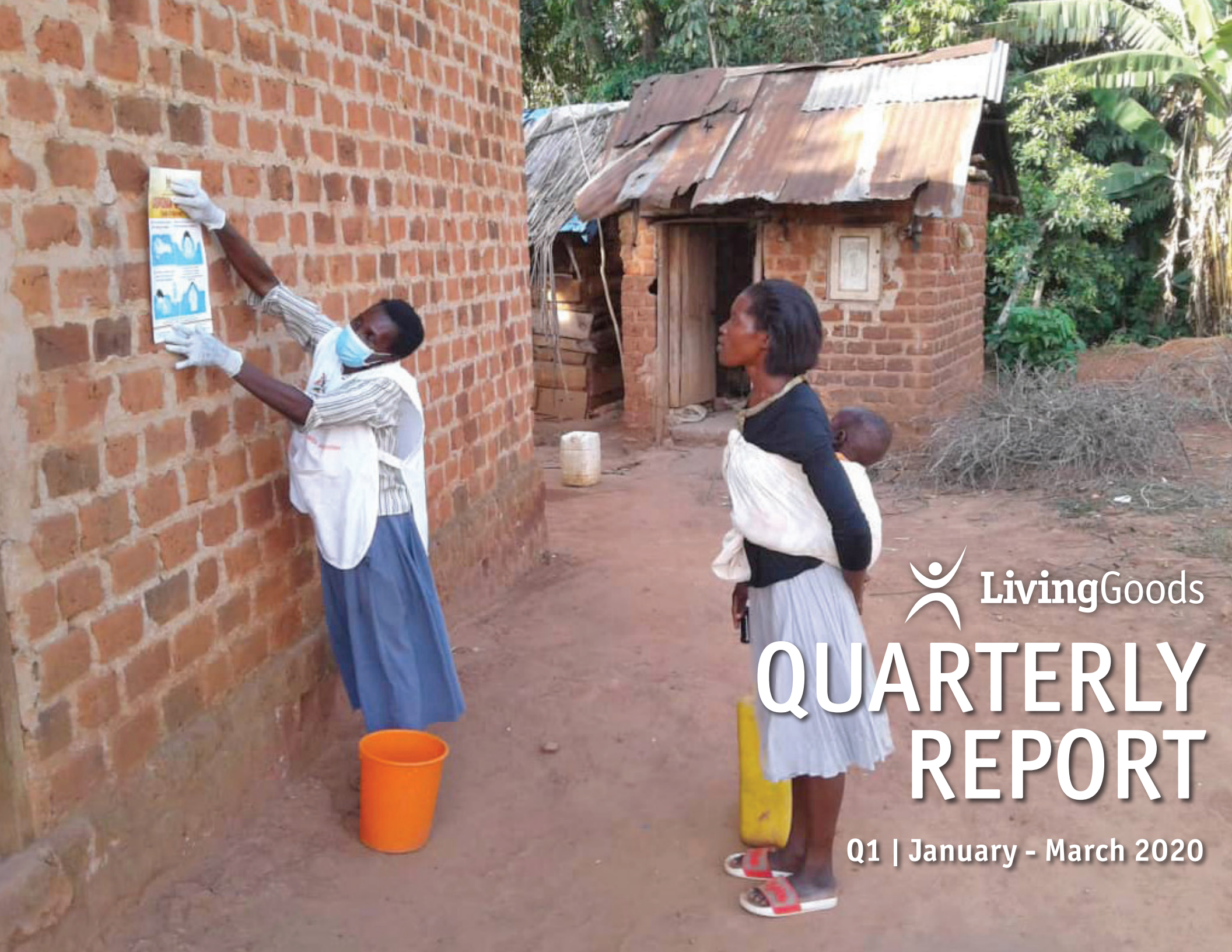

LivingGoods

# QUARTERLY REPORT

**Q1 | January - March 2020**

*CHW Harriet hangs a poster outside the home of a mother she's sensitized on COVID-19 in Mbale, Uganda.*

# Uganda Sees Strong Performance Across All Metrics in Q1

**Our direct operations in Uganda continued to register strong performance in Q1 2020, with improved or stable results across all KPIs.** Under-five (U5) treatments and positive diagnoses were 53% above target in Q1 and under-one (U1) treatments and diagnoses were 63% above target. This performance is attributed to continued emphasis on targeting sick children, improved performance management among community health workers (CHWs), and a stronger supply chain of essential medicines at both the CHW and branch level.

**On-time postnatal care (PNC) visits increased from 61% in Q4 2019 to 70% in Q1,** though it is still slightly below the 75% target. A key factor driving this achievement is that all upcoming expected delivery dates and missed PNCs are now shared with the branch teams at the beginning of each month to drive timely CHW follow-ups with new mothers and pregnant women nearing their delivery dates. Meanwhile, the **percentage of women delivering in a facility was 93% in Q1, above the target of 85%.** This is attributed to continued follow-ups by CHWs to counsel pregnant women and prepare them for facility delivery.

A total of **80% of defaulters completed necessary immunizations in Q1, above the target of 60%.** This performance is attributed to regular immunization-related support to CHWs and branch teams during the in-service trainings and continued optimization of workflows. The reasons for non-completion of referrals among defaulters include lack of transport, lack of vaccines at referral sites, and concerns about side effects.

**We trained 300 CHWs in family planning (FP) in Q1 instead of the expected 600 CHWs.** This was in order to prioritize the rollout of the new version of our Smart Health app and to hold Sayana Press practicum and refresher trainings for CHWs who missed them in Q4 2019 when stocks were limited. The new version of the Smart Health app will resolve many existing limitations, including delayed syncing, slowness, and the inability to remove families who had moved away. All FP trainings were suspended mid-March due to COVID-19 *(page 5)*. Our referral numbers are lower than we'd prefer for longer-term and permanent methods, and we are working to secure lists of referral clinics from potential partners to improve those efforts.

**BRAC's performance was below target across most KPIs in Q1 due to the low number of active CHWs**, with only 3,195 against a target of 3,500. Training of new CHWs had been planned for March but was delayed due to COVID-19. The low rate of CHW activity is due in part to a low supervisor-to-CHW ratio in some branches, though BRAC is working to recruit new supervisors remotely. Synchronization challenges, app load failure, and damaged phones also contributed to the low number of active CHWs and related underperformance across KPIs. **BRAC anticipates that the Smart Health app upgrade in Q2 2020 will alleviate some of these functionality challenges** to improve CHW activity moving forward. Beginning in April, BRAC will start to distribute performance-linked incentives to all CHWs, which is expected to drive increased CHW activity.

# Q1 2020 Results

**10,106**
COMMUNITY HEALTH WORKERS

**46,874**
NEW PREGNANCIES REGISTERED

**134,478**
SICK CHILDREN UNDER 1 ASSESSED

**717,805**
SICK CHILDREN UNDER 5 ASSESSED

**7,790,233**
PEOPLE SERVED

*Cover: CHW Harriet hangs a poster outside the home of a mother she's sensitized on COVID-19 in Mbale, Uganda.*


*Community sensitization on COVID-19 in Isiolo's county Kenya's Merti sub-county.*

# New Incentives and Increased Targets Drive Q1 Performance in Kenya

**Our direct operations in Kenya started off strong this year**, with improvements across many KPIs. New pregnancy registrations per CHW rose nearly 40% from 0.8 per month in Q4 2019 to 1.1 per month in Q1 2020, against the target of 1. Similarly, U5 assessments increased 19% and U5 treatments and positive diagnoses rose 29% from our Q4 2019 KPIs.

We launched a revamped impact optimization plan for Kenya in February based on our learnings from Uganda, though some elements will now be paused due to COVID-19. However, it has driven several improvements, including providing CHWs with **a new incentive structure for assessments and maintaining their in-stock levels of high-impact items.** Another improvement came from increased targets, which were adjusted to better account for CHWs' activities depending on whether they operate in malaria-endemic or non-endemic regions.

Our new incentive for keeping essential medicines in stock has been a key driver of improved CHW performance on treatments. We have identified CHW stockouts as a consistent barrier to providing treatments to patients. With this new incentive, **CHW in-stock rates have increased by 27% from Q4 2019 to Q1 2020, which means more patients are receiving immediate, convenient treatments** without needing to be referred to a facility.

We also maintained our strong PNC performance at 84% compared to the 75% target. This is due to concerted efforts by analysts to send expected delivery date reports to branches at the beginning of every month and ensure CHWs are proactively prioritizing the clients who need them.

**Our technical assistance (TA) test branch in Kisii county's Bobasi sub-county encountered significant difficulties in Q1.** A decline in supportive supervision was the biggest factor affecting CHW performance, with 35% of the county's supervisors—or CHEWs—transferred out by government, with new ones introduced in March. Meanwhile, challenges with the government supply chain were compounded by the onboarding of 240 new CHWs in February—the largest yet under TA—and the county was not prepared to handle that quantity of CHW commodities. Although treatments dropped given the shortfall in commodities, CHWs capitalized on referrals, with completed referrals at 98%, against a target of 80%. This trend is expected to continue as long as commodities remain insufficient or inconsistent. Finally, a Smart Health app upgrade in March meant that many CHWs did not have smartphones during this period. At this point, COVID-19 had reached Kenya and related concerns resulted in a decline in household visits. **We are working to reverse this trend by lobbying for a strengthened government supply chain**, petitioning for more supervisors under the Universal Health Coverage (UHC) funding released in February, and engaging in ongoing capacity building for government and CHEWs.

**Our new incentive for keeping essential medicines in stock has been a key driver of improved CHW performance on treatments. We have identified CHW stockouts as a consistent barrier to providing treatments.**

**Isiolo county saw improvement across many KPIs in Q1 2020**, although it faced similar struggles to Bobasi with the government supply chain and competing priorities from government supervisors, particularly because of COVID-19. We are working closely with the county government to resolve this moving forward and ensure the sufficient allocation of essential commodities. **U5 assessments per month increased nearly 30% from 2.8 per CHW in Q4 2019 to 3.6 in Q1 2020**, against a target of 4—the highest level of assessments yet.

U5 treatments and positive diagnoses also increased 43% from 1.4 to 2 per CHW, meeting the target. Performance was below target for both U1 assessments and U1 treatments and positive diagnoses. As a result, we will increase focus moving forward on U1 activities as well as on pregnancies registered. These factors contributed to low U1 treatments in Q1 and a high rate of referrals at 97% against the target of 80%. On-time PNC fell slightly to 40%, below the target of 75%. This is attributed to reduced supervision and delayed incentive payments, which decreases the motivation and activity level of CHWs.


*Uganda Minister of Health Dr. Jane Ruth Aceng receives a donation of PPEs from Living Goods Country Director Emilie Chambert and other staff.*

# Living Goods' Response to COVID-19

**Living Goods' work in reproductive, maternal, newborn, and child health (RMNCH), FP, and immunization is more important than ever before.** Community-based care is essential, particularly in highly-constrained systems. We also know that the mortality threat of easily treatable diseases like malaria can quickly increase while already limited resources are laser-focused on the COVID-19 response. During past outbreaks and other health crises, existing illnesses and conditions are often neglected, leading to a massive loss of life.

Although reported COVID-19 cases in our areas of operations started later than in other parts of the world—and numbers remain low—there is evidence of community spread. We anticipate that infections are significantly higher due to limited testing, asymptomatic cases, and people who do not seek health services when they are ill. Consequently, **we expect the health system and formal facilities to face extreme strain**—making the sustenance of effective community-based care even more critical. Our efforts involve:

## Supporting MOH and Local Government Efforts

- *We are seconding staff to health ministries* in Uganda, Kenya, Burkina Faso, and Sierra Leone to support their COVID-19 responses *(page 6)*.
- *Supporting ministries in devising guidelines* that enable CHWs to play an effective role in national and local responses, as well as guidance on their communications strategies.
- *Coordinating locally and globally with other health organizations* to share COVID-19 data, best practices, and more.

## Protecting CHWs & Living Goods Staff

- *Training Living Goods-supported government CHWs in adjusted "low- and no-touch" protocols* so CHWs can safely continue their core work and supervisors can follow remote performance management techniques *(page 7)*.
- *Providing the CHWs we support directly or through BRAC with personal protective equipment (PPEs)*, including gloves, masks, and portable sanitizer, as well as advocating that governments include CHWs in PPE procurement calculations.
- *Increasing compensation to the CHWs we support* to reflect their increased workload and risk, as well as potential income disruption
- *Assisting in the implementation of daily symptom checks* for CHWs, Living Goods staff, and their families.
- *Integrating new COVID-19 workflows into our existing Smart Health app* and adjusting existing workflows to account for the new low- and no-touch protocols.

## Maintaining Essential Health Service Delivery

- *Providing CHWs in our catchment areas with free essential health commodities* through our supply chain, including ACTs, paracetamol, amoxicillin, and zinc/ORS in formulations appropriate for sick children. These will be dispensed using no-touch protocols.
- *Increasing cell phone data and airtime stipends to the CHWs* we support to enable remote communication.

*Saul Bisaso, and other Living Goods staff, supporting the MOH's toll free call centers in Uganda.*


*CHW Jackline Nansasi pinning a COVID-19 poster on a wall in her community while wearing PPE.*

## Interrupting COVID-19 Transmission

- *We have now trained all Living Goods staff and the CHWs we support in COVID-19 prevention*, early case detection, reporting procedures, and personal safety measures. In addition, we are providing similar training to an additional 12,700 CHWs across the six Kenyan counties where we currently operate, as well as Kisumu, where we plan to work soon (*page 7*).
- *Creating an e-learning platform for Living Goods-supported CHWs and our staff* to minimize travel and contact while simultaneously exploring how we might support training for national COVID-19 responses.
- *Working to develop an effective two-way SMS messaging platform* to assist the CHWs we support with additional information about essential health service delivery.
- *Assisting in government efforts to deploy physical information, education, communication (IEC) materials* (e.g., posters) in CHWs' communities and helping to train CHWs in IEC strategies. By the end of April, we supported 15,700 CHWs and the families they support with 2.2 million SMS messages; in Uganda, we reached 7,700 CHWs and the families they support with 250,000 SMS messages.
- *Exploring options for customizing and testing an automated SMS/messaging self-help tool* for patients who suspect they may have COVID-19.
- *Where needed, supporting governments to integrate COVID-19 data into their existing health databases* at the national and sub-national levels.
- *Supporting government in procuring and deploying sanitation improvements* for CHW and their communities, including handwashing stations and triage tents at health facilities.



*Annet, a CHW in Massaja, Uganda, working on immunization efforts. We will need to pause scaling these efforts given the challenges of gathering CHWs for trainings during COVID-19.*

# What We're Pausing in Light of COVID-19

Given the urgency of continuing our core RMNCH work and the need to begin new initiatives that address this unprecedented pandemic, **we have made the difficult decision to pause activities that would either be ineffective or impossible under the current context.** Although significant groundwork was made on the following fronts up through Q1 2020, we believe this is the right and only decision we can make, as we must double-down our focus on Kenya and Uganda and the communities we're already serving. Here's what we are pausing and why:

- *New country expansion:* It is not feasible to pursue new country expansion while staff cannot travel and governments and potential partners do not have the bandwidth to engage.
- *Expansion in our current countries:* We will not grow Living Goods and BRAC's CHW numbers or hold replacement classes for natural attrition in Uganda and Kenya due to the risk of COVID-19 spread when assembling and training new cohorts.
- *Pausing new initiatives, including further roll-out of FP and immunization services.* Given the challenges of convening CHWs for intensive trainings, we will have to pause training CHWs on how to support new service areas.
- *In-person data collection for planned research:* We will pause all research that requires in-person data collection, given the risk of COVID-19 spread. Most notably, this will impact our endline surveys for our second Randomized Controlled Trial as well as our immunization efforts. Also stalled is planned research related to our innovations, including on CHW compensation structures and new supervision approaches. We are currently determining the best way forward to collect the necessary data for these research projects, which may include phone-based data collection and/or delayed in-person surveys.


*Living Goods staff seconded to the Kenya MOH are supporting the Division of Community Health in areas spanning M&E, digital heallth, communications, and advocacy.*

# MOH Secondments Scaled in Response to Pandemic

**For the past several years, Living Goods has embedded key staff into national MOHs and local health departments** as a key means of providing targeted technical support. We have now substantially ramped this assistance up to provide the government with critical surge capacity to respond to COVID-19. Highlights of our government support include:

## Uganda

We began seconding two staff to the Ugandan MOH's departments of Community Health and Health Promotion, Education, and Communication at the beginning of 2020, with the goal of supporting the development of the Uganda Community Health Strategy and Policy—a key output of the National Community Health Acceleration Roadmap launched in 2019. But, in light of COVID-19, **these staff are now providing TA in developing key documents**, such as the CHW Operational Guidelines and Guidance for CHWs, and IEC materials disseminated to CHWs and communities. These guidelines have been shared with other implementing partner organizations like BRAC and at the district level. Additionally, we **assigned more than a dozen staff with medical backgrounds to support the MOH's national COVID-19 emergency call center.** Given the travel restrictions and a pause on all major services in the country, these toll-free lines have been essential for Ugandan citizens to request support, including transport to health facilities.

## Kenya

Since 2017, we've had one staff member seconded to the MOH's Division of Community Health to coordinate and provide technical support, while also identifying strategic opportunities for Living Goods to support government priorities. In the wake of the pandemic, **we've now embedded six staff to support national COVID-19 coordination efforts and seconded seven staff to the MOH's Division of Community Health** to provide technical guidance to enable planning and coordination of community health interventions that mitigate its effects. Working across areas spanning monitoring and evaluation (M&E), digital health, communications, and advocacy, they are also embedded across eight technical working groups and supporting the development of COVID-19 guidelines on pediatrics, MNCH, service continuity, service delivery protocols, and harmonizing IEC materials. We also **seconded six staff across four counties to provide planning and operational support.** Through our work at the county level, we've reached more than 600,000 households with prevention messages.

## Sierra Leone

**Two team members are embedded in the Ministry of Health and Sanitation (MOHS) and Directorate of Science, Technology, and Innovation** to support an interactive COVID-19 messaging systems for Sierra Leoneans and the integration and analysis of various COVID-19 data that will provide government with timely and actionable information. This includes helping the MOHS to integrate both SMS and COVID-19 call center data into DHIS2, as well as data visualization and analytics support to inform the country's emergency COVID-19 response. We are also working to finalize the implementation of Praekelt's COVID-19 messaging platform and integrating this with RapidPro, an SMS-based digital health tool developed by UNICEF several years ago. We are also identifying a range of technical solutions to support early detection, tracking, and escalation of case outbreaks from the community to the national level, which we hope to support implementation of going forward.

## Burkina Faso

**We currently have two team members providing full-time support to the MOH's COVID-19 response.** Our digital health consultant has been giving extensive support on development, maintenance, and training for Regional MOH staff on DHIS2-based tools for contact tracing, call center alerts, and tracing from border entry points. They are also supporting the development of the interoperability layer between DHIS2 and tools that UNICEF has created to do contact case registration, population self-checks, and case identification and follow up. Our performance management consultant is a member of the community-based risk communication task force and is currently supporting the MOH to develop a proposal for reprogramming unspent Global Fund money to ensure that CHWs are equipped with the knowledge, skills, and PPE to safely support the frontline COVID-19 response.

*In Uganda, essential medicines are loaded up for delivery to CHWs.*

# Adjusting RMNCH Protocols for COVID-19

Sustaining essential health services at the community level will be critical to avoiding preventable deaths during the COVID-19 pandemic. Together with our government partners, **Living Goods is now equipping and supporting CHWs to modify their delivery of care using adjusted low- and no-touch protocols.**

This move is guided by several assumptions. First, we anticipate that community transmission of COVID-19 will rise in Uganda and Kenya. Second, while we have secured and are currently providing our CHWs with basic PPE, there is a global shortage of PPE and a lack of consistent access. We are working with partners to advocate for a reliable supply of appropriate PPE for CHWs and can adjust our protocols accordingly. Third, Living Goods-supported CHWs are equipped with digital tools that enable them to provide many health services virtually.

In consultation with the MOHs of Uganda and Kenya, WHO, UNICEF, and other technical experts and partners, we have modified the delivery of care, ensuring that **CHWs begin all health activities and assessments by screening for COVID-19-related symptoms.**

CHWs will primarily provide phone-based support to their communities instead of proactively visiting households in person. When a patient comes to a CHW's home, the assessment will be conducted outside at a minimum distance of six feet. **Most health service protocols are being adapted to maintain a safe distance, with all activities managed according to country guidelines.** CHWs are also sending regular SMS messages to households reminding them to call if their child is sick so they can provide support on-demand.

Maintaining essential RMNCH service delivery is absolutely critical during the pandemic. **We will adjust our protocols based on the phase of the epidemic in specific locales**, access to sufficient PPEs, government guidelines, and other operational factors like levels of phone connectivity.



# Updates on Kisumu Partnership in Kenya

**Following months of discussions in late 2019, in Q1 we worked with the leadership of Kenya's Kisumu County to co-create what would have been our second co-financed partnership for community health.** This exciting development presented an opportunity for Living Goods to support a second UHC pilot county in Kenya, following Isiolo, to strengthen health service delivery by supporting an initial 1,000 CHWs in three of Kisumu's sub-counties, which would have been followed by a county-wide rollout.

Guided by learnings from our Isiolo and Bobasi TA experiences, we spent much of the quarter holding a series of engagements with Kisumu government officials to design, budget, and plan for our entry into the county. However, although plans to formalize the partnership had progressed to an advanced stage, in mid-March, we suspended the joint planning and entry operations as the country began to grapple with the COVID-19 threat.

Recognizing the dire needs in the lakeside county—a malaria-endemic region with among the highest maternal and U5 mortality rates, and some of the highest disease burdens in the country—we quickly shifted focus to support the county's most pressing needs in response to the pandemic.

**We have now extended support to all 2,600 CHWs in Kisumu** by equipping them with MOH-approved IEC messages and including them in our SMS outreach and education support we've provided to CHWs in the other six Kenyan counties where we operate. In addition, we have donated public handwashing stations, soap, and equipment to support the county government.

*Living Goods joined other partners in Kisumu County at a COVID-19 event presided over by Governor Prof. Anyang Nyong'o. He thanked us for PPE donations, collaboration on IEC materials, and support in sensitizing CHWs on COVID-19, while expressing his desire for continued partnership going forward.*

| Q1 2020 KPIs[1] | LG Uganda - Direct Operations | | | BRAC Uganda | | | LG Kenya - Direct Operations [2] | | | LG Kenya - TA (Bobasi)[3] | | | LG Kenya - Gov't Co-financing (Isiolo)[4] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 2020 External target | Q1 2020 Actual | Q1 2019 | Q1 2020 External target | Q1 2020 Actual | Q1 2019 | Q1 2020 External target | Q1 2020 Actual | Q1 2019 | Q1 2020 External target | Q1 2020 Actual | Q1 2019 | Q1 2020 External target | Q1 2020 Actual | Q2 2019 |
| **Impact Metrics - Monthly** | | | | | | | | | | | | | | | |
| Pregnancies Registered | 2 | 2.2 | 2.0 | 2 | 2.0 | N/A | 1 | 1.1 | 1 | 1 | 0.7 | 1 | 1 | 0.7 | 1.5 |
| Under-5 Assessments | 32 | 34.6 | 25.6 | 32 | 27.4 | N/A | 24/8 | 24.1/14.9 | 19.3/13 | 12 | 7.5 | 7.9 | 4 | 3.6 | 1.6 |
| Under-1 Assessments | 6 | 7.3 | 5.5 | 6 | 3.9 | N/A | 4/2 | 4.2/3.5 | 3.8/3.1 | 3 | 1.8 | 1.3 | 1 | 0.7 | 0.4 |
| Under-5 Treatments and Positive Diagnoses | 16 | 24.4 | 9.0 | 16 | 8.2 | N/A | 12/4 | 10.7/3.9 | 8.3/3.6 | 5 | 3.6 | 4.3 | 2 | 2 | 1.2 |
| Under-1 Treatments and Positive Diagnoses | 3 | 4.9 | 1.9 | 3 | 1.5 | N/A | 2/1 | 1.6/0.8 | 1.5/0.7 | 1 | 0.9 | 0.8 | 1 | 0.4 | 0.2 |
| Referral Completion: % referrals confirmed at facility | 80% | 95% | 80% | 80% | 78% | N/A | 80% | 92% | 91% | 80% | 98% | 88% | 80% | 97% | N/A |
| On-Time Postnatal Care Visit | 75% | 70% | 67% | 75% | 67% | 32% | 75% | 84% | 82% | 75% | 65% | 43% | 75% | 40% | 43% |
| Facility Delivery: % facility delivery | 85% | 93% | 92% | 85% | 99% | N/A | 85% | 94% | 77% | 85% | 98% | 96% | 65% | 88% | N/A |
| IZ: % defaulters completing necessary immunizations[5] | 60% | 80% | N/A | 60% | N/A | N/A | 60% | 76% | N/A | 60% | N/A | 95% | 60% | N/A | N/A |
| In Stock: % of 'High Impact' Items in Stock (branch)[6] | 98% | 96% | 98% | 98% | 90% | N/A | 98% | 97% | 100% | N/A | N/A | N/A | N/A | N/A | N/A |
| **Impact Metrics - Total** | | | | | | | | | | | | | | | |
| Active CHWs (3-month active) | 4,186 | 4,203 | 3,228 | 3,500 | 3,195 | 1,537 | 1,932 | 1,727 | 1,868 | 420 | 322 | 132 | 720 | 659 | 338 |
| Population Served[7] | 3,348,800 | 3,362,400 | 2,576,000 | 2,800,000 | 2,556,000 | 1,229,600 | 1,545,600 | 1,381,333 | 1,494,667 | 210,000 | 161,000 | 65,750 | 216,000 | 329,500 | 64,414 |
| Total Pregnancies Registered | 21,260 | 25,743 | 19,383 | 17,850 | 14,868 | 5,354 | 4,612 | 4,296 | 5,323 | 1,071 | 665 | 251 | 1,836 | 1,301 | 950 |
| Total Under-1 Assessments | 63,781 | 83,859 | 53,729 | 53,550 | 29,411 | N/A | 16,501 | 18,927 | 19,339 | 3,213 | 1,065 | 279 | 1,836 | 1,217 | 966 |
| Total Under-1 Treatments and Positive Diagnoses | 31,890 | 56,150 | 18,627 | 26,775 | 11,445 | N/A | 7,277 | 6,044 | 7,098 | 1,071 | 475 | 165 | 1,836 | 776 | 138 |
| Total Under-5 Assessments | 340,163 | 399,470 | 248,272 | 285,600 | 208,256 | 31,554 | 83,428 | 98,947 | 90,476 | 12,852 | 4,511 | 1,427 | 7,344 | 6,621 | 799 |
| Total Under-5 Treatments and Positive Diagnoses | 170,082 | 281,703 | 86,696 | 142,800 | 62,290 | N/A | 39,766 | 38,270 | 39,747 | 5,355 | 2,398 | 959 | 3,672 | 3,580 | 163 |
| Total Unwanted Pregnancies Averted[7] | 3,710 | 2,831 | 299 | N/A | N/A | N/A | 1,285 | 343 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **Cost-Effectiveness Metrics** | | | | | | | | | | | | | | | |
| Income per CHW | $20 | $17 | $7.97 | $8 | $6 | N/A | $20 | $14 | $7.60 | $20 | TBD | N/A | $30 | $27 | N/A |
| Net Cost per Capita (YE annualized)[8] | $2.69 | $2.66 | $1.62 | $0.54 | $0.59 | N/A | $3.99 | $5.15 | $3.22 | $0.81 | $0.82 | N/A | N/A | N/A | N/A |

## NOTES

[1]We added five new external KPIs in 2020: Referral completion, facility delivery, immunization defaulters with completed referrals, unwanted pregnancies averted, and CHW income. Note that we are replacing referral follow-ups with referral completion as it is a better proxy for ensuring that high-risk cases have received care. We are also including CHW income instead of sales as we have less focus on sales strategically.
[2]Living Goods Kenya has two assessment and diagnosis targets: malaria endemic and malaria non-endemic.
[3]The Bobasi and Isiolo CHWs in Kenya work only in malaria non-endemic areas, thus all assessment and treatment targets listed are for malaria non-endemic.
[4]The earliest data we have for Isiolo County is from Q2 2019.
[5]BRAC does not provide immunization (IZ) services. Isiolo has not yet started providing IZ services.
[6]CHWs in Isiolo and Bobasi acquire their commodities directly from government health facilities.
[7]BRAC, Bobasi, and Isiolo have not yet started providing FP services.
[8]We are excluding Isiolo in Q1 due to ongoing budget discussion.