2017 | Year-End Report

LivingGoods

The Vision

Our vision is simple: When families need healthcare, it should be accessible and of high quality. When a woman is pregnant, she must receive the support she needs. When children are sick, they must be assessed and treated. Women must be able to make their own reproductive choices, and children must have the care and nutrition they need to thrive. Achieving this vision of universal care will result in saving and improving millions of lives. To get there we need a step-change in how healthcare is delivered to communities. Too many barriers still stand between families and the care they need: cost, distance, knowledge, and supply. We are committed to reducing those

Going Faster and Further

2017 was a banner year for Living Goods, propelling us towards our vision even faster than we had planned. At the beginning of 2017, we projected that we would reach nine million clients by 2020; this projection has now grown almost three-fold, to 25 million people reached by 2021. We've added exciting and influential new funders to our community of supporters, experienced breakthroughs in our partnerships with governments, committed wholeheartedly to a new innovation strategy, positioned ourselves to become a leader in technology for health, and significantly grown our team and capacity.

2018 will be focused on building on this growth and attaining our ambitious goals, while continuing to strike out in vital new directions. We will leverage new funding sources; scale-up successful innovations in how we work, the services we deliver, and the technologies we deploy; and design a new approach for collaborating with governments. Throughout, we will stay focused on what matters most: supporting frontline health workers—the real heroes of our story—to provide the best care possible to families in need.

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The Year in Review: 2017

- **Expanded Living Goods' operations by 45 percent** and, combined with BRAC, served over 6.0 million people across Kenya and Uganda *(see page 15)*
- **Assessed over 1.35 million children** under five for pneumonia, malaria, and diarrhea *(see page 15)*
- Received a catalytic new challenge grant—if matched, it will enable us to reach over **25 million** people across four countries by 2021 *(see page 4)*
- Tested and began rolling out new **comprehensive family planning and nutrition services** *(see page 10)*
- **Deepened our commitment to innovation**—in programs, technology and financing—as a core part of our strategy, and, as a result, tested and scaled-up an expanded nutrition offering *(see page 9)*
- **Increased our ability to contribute meaningful tech innovations and learnings** to the field by refining our mhealth strategy, hiring our first Chief Technology Officer, launching a new Innovation Network in Kenya, and continuing to build our in-house design and development capacity *(see page 12)*
- **Became a go-to community health resource and partner** for senior officials in the Ugandan Ministry of Health and Finance and with local health officials in our target counties in Kenya *(see page 5)*
- Committed to **developing a high impact and flexible approach to supporting the community health networks of others**, including governments *(see page 7)*
- **Transitioned full management of the LiveWell network** in Zambia to our partners at CARE after years of successful support *(see page 8)*

A Catalytic Funding Opportunity

We're excited to share details of a new funding opportunity that will not only propel Living Goods to a new phase in our growth, but will also be a historic investment in the field of community health.

With our partner Last Mile Health, we've received a significant four-year challenge grant from a collective of visionary philanthropists. Together, we'll work with a network of governments and partners, including Medic Mobile, to deploy 50,000 digitally empowered community health workers (CHWs) to reach 34 million people across Africa. To unlock this commitment, we must match it 1:1 via funds from new sources or increased support from existing donors. Achieving the full match would be a 50 percent increase in our four-year budget and a landmark $100 million invested in community health networks. By joining forces, Living Goods and Last Mile Health have an unprecedented opportunity to not only reach millions more people with life-saving health care, but to also significantly influence and shape the direction of community health for years to come.

We have our work cut out for us, but we are more energized than ever by this immense opportunity. We could not have reached this point without our generous, thoughtful, and selfless partners. We are deeply grateful for the encouragement you've given us, the confidence you've shown in us as we've set out for new horizons, the tough questions you've asked along the way, and the smart advice you've given that has pushed us further. We're moving full speed ahead in 2018 to secure funding for the match, forge partnerships, and deliver on our ambitious new goals. We'll strive to remain open and transparent about our learnings, wins, and challenges and will be leaning on our current supporters for continued thought partnership as we enter into this next phase.

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Learning and Growing Alongside Government Partners

Government leaders are often skeptical of NGOs. Some of our partners have shared stories of NGOs that create parallel or redundant projects or systems—only to leave as soon as the donor funds dry up. It's a serious concern for government leaders, and one that we don't take lightly. Our goal is to co-design community health platforms that complement and strengthen government efforts, rather than replace them. We're still learning as we go, but the most important insight we've gleaned so far is a simple one: listen.

When our government partners in Kenya told us that community health extension workers (CHEWs), paid supervisors who work out of health facilities, would play a critical role in their community health strategy, we responded by engaging CHEWs more than ever before. We've launched an experiment in western Kenya to train government CHEWs on data-driven performance management techniques and to see if they can effectively serve as Living Goods supervisors. Governments have also stressed to us the importance of integrating our data with their systems. In 2017, we began rolling out an impact dashboard customized for government officials, moving us one step closer toward ensuring that our impact metrics are not only factored into national health goals, but also proactively informing the decisions and planning of our government partners.

We're working with government more closely than ever and the work is paying off. Living Goods is becoming recognized as not only a trusted partner, but a source of expertise. In 2017, we had several opportunities to work closely and share learnings with our government partners:

- We transformed the Permanent Secretary General of the Ugandan Ministry of Health, Dr. Atwine, into a true champion for community health. We found so much synergy and excitement in our meetings with Dr. Atwine that she committed to personally bring our vision for community health in Uganda to the Ministry of Finance to gain support for the government's full participation in this effort.
- After key presentations to senior leaders in the Ugandan Ministry of Health, we were asked to join the CHEW working group to help shape the upcoming CHEW policy, which will determine how community health workers across the county are managed and supervised. This committee includes a select number of partners (including UNICEF, USAID, Pathfinder and Amref) as well as key people from the Finance, Public Service, and Health Ministries.
- We joined the Health Sector Budgeting Group in Uganda, and have been asked by the Ministry of Health to contribute directly to the country's community health financing strategy. We were also invited to become a permanent member of the Ugandan eHealth Technical Working Group following a presentation of our tech solution at the eHealth Technical Working Group in early August, working alongside the WHO and UNICEF to inform eHealth strategy in Uganda.
- In Kenya, we deepened our collaboration with two key counties—Busia and Kisii. We worked with them to test new models for CHEWs, discussed arrangements for public-private partnerships, and laid the groundwork to provide technical assistance on mhealth and performance management in 2018.
- After a few hiccups and extended elections in Kenya, we learned that we must embed a Living Goods' government relations lead in every county and district we work in (a process that is completed in Kenya, and in progress in Uganda). This will be key to ensuring ongoing engagement, visibility, and responsiveness in our partnerships with governments.

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Empowering Governments Through Assisted Networks

Historically, Living Goods has been the implementing partner when we work with governments. While we coordinate closely with governments on the policy, parameters, and goals of CHW networks, we have ultimately had responsibility for implementing the work. We've achieved life-saving results with this model, but we can't scale it quickly enough to manage CHWs in every country that needs them.

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We're increasingly hearing from government partners that what they want most from us is to help build their ownership of and capacity for community health. In response, we've worked in close consultation with governments and other partners to come up with a new concept that we call Assisted Networks. We will work with a government or a partner NGO that currently runs their own CHW network (or that wants to start one), and assist them in implementing some of the best practices that we've learned and developed during our years of experience. The goal is not for them to replicate our model, but to strengthen their own community health networks with some of our most high-impact practices and learnings. (These span a range of topics including mhealth, performance management, supervision, and supply chain management.) We want to help launch effective CHW networks, stay with them for as long as our partners need us to, and step aside once they have mastered the process.

In 2017, we took some important initial steps in developing this Assisted Networks concept, and in securing buy-in from partners. We began by testing variations in our model that would help inform our overall approach. We launched a pilot of a simplified version of our model in Kenya to assess how focusing on only the most critical medicines, rather than the full product basket, could work. This pilot is still in the early stages, but we've seen high acceptance of the model from our Community Health Promoters (CHPs) and strong results in terms of health activities. We also piloted the distribution of free malaria tests and treatments to gain learnings that will be vital as we begin supporting governments whose policies require that health commodities be distributed for free.

We also made huge strides in building relationships with the government partners that we'll work closely with using an Assisted Networks approach in 2018. In Kenya, we held several multi-day workshops with local government partners from Busia and Kisii counties to discuss where our targeted assistance could be most impactful and to co-design what this approach might look like. We surfaced a need for assistance with implementing mhealth tools and performance management of CHWs (especially with regards to management of stipends) as key areas to focus on in 2018.

Supporting Partner NGOs to Maximize Impact

One of our longest and most vital partnerships has been with BRAC Uganda, with whom we co-developed our CHP model. BRAC continues to operate a network of over 4,000 active CHPs in Uganda, covering 3.2 million people. In 2017, they rolled out the SmartHealth app to all of the CHPs in their network, contributing to a steady increase in their health metrics. In Q4, BRAC took a big step forward by completing all reporting on the mobile platform for the first time. BRAC also embarked on several operational experiments to drive further momentum on health metrics. For example, as part of our expanded nutrition efforts, BRAC launched an experiment designed to increase client uptake of micronutrient powder, based on their remarkable success in Bangladesh. This effort has been in pilot phase since November 2017, and we look forward to sharing the results as they come in. In October 2017, BRAC also began a Sayana Press pilot to enhance their CHPs' delivery of family planning services.

We also continued to support PSI and their Win-Win program in Myanmar. We supported Win-Win to almost double their network in the past year, adding 122 new agents. Win-Win now includes over 200 active agents reaching an estimated 30,000 people. In 2017, we also worked with Win-Win to increase health impact by shifting the basket of products that their agents offer away from consumer goods and towards key health commodities, including pregnancy tests and supplements, children's paracetamol, multivitamins, and a nutritional soup. In Q4 2017, 68% of CHP sales were health commodities, more than doubling from 31% in Q4 2016. 2017 also marked the hand-off of our long and successful partnership with CARE's Live Well program in Zambia. CARE will now take on full management of operations from 2018 onwards. It's been a privilege to support Live Well in putting in place a program that now includes over 250 CHPs, covering over 25,000 people in both deep rural and peri-urban areas. We helped the Live Well team on this handover, including helping them to secure a grant of almost $1 million from GSK and to hire a full leadership team and staff to support Live Well. Even though our formal partnership is over, we continue to exchange learnings with them and are exploring opportunities to work together in new countries.

In 2017, Living Goods increased our commitment to collaboration with partners more than ever before. We jointly launched our new catalytic funding opportunity with Last Mile Health *(see page 4)*, we established a new Innovation Network in tandem with our longtime partners Medic Mobile *(see page 12)*, and we joined alongside other leading community health practitioners in networks such as the CHW15 and the Financing Alliance to help advocate for CHW policy and financing. We will continue to be smart and targeted about how we collaborate with others in 2018.

Testing, Learning, and Innovating in 2017

In 2017, we made a substantial strategic commitment to innovation in our programming, technology, and financing. Innovation has always been a part of who we are—we seek a step-change in the way health care is delivered, and we know that to achieve that goal we can't be satisfied with business as usual.

We need to continually test and question our assumptions, quickly adapt, evolve our approaches, and share learnings widely. Innovation acts as a critical accelerator for this systemic change. It not only drives our own impact, but is crucial to our goal of becoming true community health pioneers who can contribute our learnings and insights to others.

In 2017, we increased our conscious focus on innovation and built out a new, dedicated innovations team. With this team, we have created a new process for identifying and evaluating ideas, and for strategically selecting the most promising ones for testing. This innovation process is built on rapid testing, learning, and iteration in partnership with the CHPs and communities we serve. We first introduce new ideas at a small scale and strive to either fail quickly, or to prove their early success before scaling them up. Even in the cases where an idea fails, our goal is to learn from that failure to improve our operations. Some of our innovations and key insights from the past year are summarized in the following table. Our new approach has been extremely impactful and 2018 will see us maintain this strategy, while using the lessons learned from 2017 to continue to tighten our focus on efficiency and impact.

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2017 Innovations Results & Learnings

The Innovation	The Results	The Impact
Free Malaria Commodities		
We conducted a small-scale trial with distributing free malaria tests and treatments, involving all the CHPs in our Malaba branch in Kenya. To make up for lost CHP revenue on sales, we boosted their incentives on key health metrics.	During the trial, the number of malaria assessments conducted doubled, and the number of treatments tripled. CHPs were still highly incentivized to distribute the free commodities, there was a marked uptake in life-saving treatments, and we didn't see a significant impact on the rest of the CHPs' workload.	This trial allowed us to develop and demonstrate the flexibility of our model, which is important as we consider assisting governments and operating in policy environments where health commodities are required to be free. The ability to distribute certain commodities for free, if a reliable long-term supply is secured, also opens up new avenues for increasing our cost-effectiveness and health outcomes moving forward.
Expanded Nutrition Offering		
We conducted a trial (and subsequent scale-up) of expanded nutrition services, including more in-depth counseling, tracking of children's diet using the SmartHealth app to proactively catch early warning signs for malnutrition, and more intensive deployment of antenatal services including provisioning of iron folate supplements and malaria prophylaxes to reduce low birthweight.	During the trial, there was strong demand from clients, and strong engagement from CHPs. We also gained several important insights into how to scale this program, including the need to address both knowledge and financial barriers to adequate child nutrition. We also discovered a need to spread out nutrition trainings to ensure that the information is adequately absorbed by CHPs.	Given these results we have already scaled up our expanded nutritional offering to all CHPs in Uganda, and are planning to do the same in Kenya by end of 2018. This result also helps build our confidence that CHPs can take on a relatively broad portfolio with the support of the SmartHealth app and their managers. Going forward we will be closely tracking indicators such as child diet and growth to evaluate the effectiveness of this scaled-up program.
Expanded Family Planning Offering		
We are conducting a trial of more comprehensive family planning services in two branches in Uganda, involving 60 CHPs. This includes more client-led counseling, referrals to partners for long-term methods, and the provision of three new modern contraceptives: Sayana Press (which can provide three months of protection with a single injection and can be administered to clients in their home by the CHP), the progesterone-free birth-control pill, and the emergency contraception pill. To support this, new functionality has been added to the SmartHealth app, including guidance for counseling and a system for tracking client refill dates and issuing reminders on client follow-ups.	So far, we have seen that clients have been able to access a much broader range of family planning services, with no drop-off in CHPs' non-family-planning metrics. We've also learned a lot about how to adjust incentives to encourage CHP engagement in a new health area, and about how to make the app flow better as we add new functions to it.	Plans are already in place to scale up our new family planning offerings to all CHPs in Uganda by the end of 2018. We are also in the process of looking at ways to expand this offering to Kenya.

2017 Innovations Results & Learnings

The Innovation	The Results	The Impact
Result Based Finaning (RBF)		
We conducted a RBF feasibility study, and subsequently started designing a new RBF mechanism in Uganda. The goal is to first create a way to start having governments fund elements of their CHW networks directly, and second to draw funding into the community health space by allowing donors to closely link their funding to measurable impact. We are aiming to launch the mechanism by Q3 2018.	The reception from both donors and government has been enthusiastic. We have secured our first funder to run a trial of the results-based financing mechanism in 2018, as well as support from the Ugandan government to partner with us in co-designing and implementing it.	Aside from helping to increase overall levels of funding for the community health sector, this kind of mechanism will also serve as an important bridge to increased government funding of community health. By making it easier for governments to track where their funds go and the impact they are paying for, community health becomes a more attractive investment for limited healthcare budgets.
Supervisor App		
We created and launched a new app that helps supervisors enter, track, and visualize their CHPs' performance for the first time via their tablet. It also allows country offices to better track supervisors' activities.	This app was rolled out to all supervisors, and has provided a much more detailed picture of their activities and of how they work with CHPs. For example, we've learned that we need to increase our focus on having supervisors coach low-performing CHPs. We've also heard great things from supervisors themselves about the amount of time saved by digitizing the tracking and reporting of CHP supervision field-visits. However, we still see many areas for improvement, including increasing supervisor training and uptake for the app.	These kinds of insights will help us to provide more specific and detailed training and coaching to our supervisors moving forward. Overall, the presence of a dedicated supervisor app enables us to get smarter about how and when we provide supervision, and helps our supervisors become more efficient in allocating their own time.
Disease Outbreak		
We tested a community-based disease surveillance app to help prevent outbreaks of diseases such as Ebola and cholera.	We had great uptake from CHPs in the field, but we found that it was difficult to create a strong link between the data they were collecting and the health facility-based surveillance units that would, ultimately, have to act on it.	While linkages with surveillance units could absolutely be strengthened, our conclusion was that in the geographies where Living Goods is present such an investment of time and effort would not be cost-effective. However, the uptake by CHPs was very encouraging, and could point to the viability of this approach in environments where the threat of outbreaks is very high.

Using Technology to Transform Community Health

In 2017, we began positioning ourselves to more effectively spread our mhealth learnings to others and contribute valuable innovations to the growing body of work on tech for health.

We hired our first Chief Technology Officer who will play a key role in identifying new possibilities, shaping our vision for mhealth, responding nimbly to tech challenges and opportunities, and integrating new technology developed by third parties. We also reached a milestone by securing funding from the Bill & Melinda Gates Foundation to launch a new Innovation Network in Kenya, with our longstanding partner Medic Mobile. This Innovation Network will be a live R&D site to test and develop transformative new technologies in a real-world community health environment—from new diagnostic tests to 3D body scanning to machine learning.

We also began to experiment with predictive analytics—harnessing the wealth of health and income data that our CHPs gather via the mobile app to better target increased services and support to high-risk clients. For example, when we know that a pregnant mother is highly likely to give birth at home—based on predictive factors such as household wealth assessed through targeted questions—we can build reminders into the mobile app that will prompt her CHP to provide increased counseling to encourage her to give birth in a facility. We made huge progress towards this goal by implementing a new *Equity Tool*

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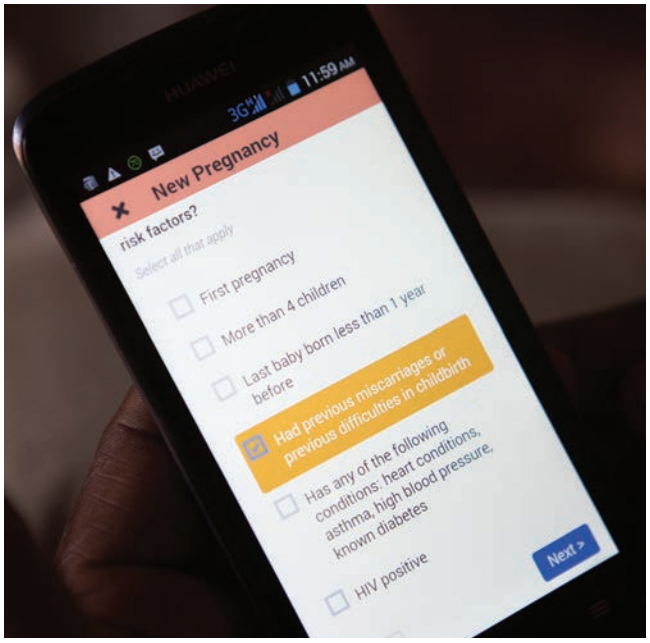
in the household registration feature on the mobile app. This guides CHPs to ask a set of questions that will help us better assess household wealth quintiles and risk factors. This smart and targeted use of mobile data will better prioritize and direct a CHP's time to continue to improve health outcomes for our most at-risk families.

We see huge potential and countless opportunities to continue leveraging technology to achieve the step-change needed to improve healthcare. Just as advances in technology have positively transformed other sectors—from banking to transportation—they will also allow us to take quantum leaps in how we deliver healthcare. Living Goods is resolved to be at the leading edge of this movement. We have a key role to play in driving tech innovation for community health forward. We not only understand what it takes to build cutting edge tech tools themselves, we also know how to make them work on the ground for the people who use them. After all, new technology is only as good as the people who use it and must be designed and informed by realities in the communities we serve.

Over the next four years, we'll continue to build our internal capacity by creating a robust team of engineers, designers, and product managers to support these efforts. We'll also actively seek out and partner with external experts such as private sector innovators and thought leaders in mhealth as well as health ministries and other government agencies. We're eager to benefit from outside expertise in areas such as data science, machine learning, and diagnostic technology and will leverage the new Innovation Network to do so.



Building for Accelerated Growth

Using our strategic plan as a roadmap, we substantially expanded our business development, community health strengthening, advocacy, and innovation teams in 2017.

We are building a C-suite and senior management structure to support our growth. We hired our first Chief Technology Officer, Chief Development Officer, and Chief Strategy Officer, as well as a new Director of Research, all based in East Africa. We also added a Director of Advocacy, based in Washington, D.C. We're basing our hiring strategy around our forward-looking vision, rather than our past needs—hiring proactively for the growth we've projected in the coming years.

In addition to these specific key new hires, we dedicated more resources to our internal systems—recognizing that these also need to scale to support our growth. In particular, we've laid the groundwork for a new enterprise resource planning (ERP) system that promises to streamline our day-to-day processes, from human resources to field operations.

The ERP system has required input from every team across the organization; it has been a challenging, yet unifying, experience. When the system is deployed later this year it will not only integrate all of our systems—it will also help us streamline inconsistencies that we could accommodate when we were smaller, but which would constrain us as we grow. Most importantly, it will help us to stay as cost-effective as possible, so that we can continue to focus our funding on direct operations and impact.

Healthcare as Close as a Neighbor

[I've known] Rita since I moved in this village a year ago. Since then anytime I have a problem I go to her house. She cares about people and is very good. I feel relieved there is someone like her in our village. You see the heath center is very far from here and I don't have transport. Some time ago my little girl had diarrhea and high fever and I had to run to Rita so scared because the fever wouldn't diminish. Rita tested her for malaria and she was positive. She treated her straight away and after two days my daughter was already much better."

~ Sara, Living Goods Client, Uganda

Accelerating Reach & Deepening Impact

People Served
6,064,000

Active Community Health Promoters

2,280	1,250	4,040
LG Uganda	LG Kenya	BRAC Uganda

Pregnancies Registered in 2017
212,000

Sick Children Under 5 Assessed in 2017
1,350,000

Sick Children Under 1 Assessed in 2017
140,000*

*Metric does not include BRAC

Our 2017 metrics tell a story of sustained high-quality care, even as we expanded into new service areas, pursued an ambitious innovation agenda, weathered elections in Kenya, and significantly grew our team. Living Goods outperformed our already ambitious scale targets. Over the course of the year, we added more than 1,100 new CHPs across Kenya and Uganda to extend our reach to more than 880,000 additional women and children. We now reach almost 3 million people through our direct networks alone (more than 6.0 million including BRAC Uganda) and support 35 field offices.

As we scaled, performance against key health metrics held strong. Notably, in Uganda, our CHPs exceeded their target for registering pregnancies, and both Kenya and Uganda met our targets for total assessments of children under five, the most critical measure of our impact on child health. In addition, on-time referral follow-ups—a core health metric that ensures acutely ill children have sought and received care—exceeded our target by 15 percentage points.

Treatments, however, remained below target across the year, with a decline in CHP activity over the holiday season dragging overall performance down. In large part, this dip in treatments reflects how we've done a better job of motivating CHPs to diagnose more accurately. We've continued to incentivize assessments, rather than treatments—which encourages CHPs to correctly diagnose children. We have also been able to ramp up the use of accurate malaria

diagnostics in Uganda. Before, a child might have been treated for malaria based solely on symptoms. Using more accurate diagnostics means that treatments have gone down, even as care has improved. We plan to keep these targets steady for 2018, recognizing that by doing so we're setting the bar higher for impactful treatment.

On-time postnatal care visits are trending upwards with a 20% increase from Q1 to Q4 in 2017, but remain below target. We saw two main challenges. First, instances of misreported pregnancies were skewing the data, especially in Uganda; clients may report being pregnant, but later find out they are not or lose the pregnancy, without informing their CHP. Moving forward, we'll track antenatal care visits within the mobile app, which will improve data accuracy. The second challenge was that babies are not always born on the date they are due. When a CHP registers a pregnancy, the app automatically generates an expected due date based on the estimated date of conception. If a child is not born on or near that date, the CHP may find themselves unavailable for the necessary follow-up. To resolve this issue, going forward we will be implementing a mandatory weekly check-in on all pregnant women starting at week 36. By keeping CHPs in close touch with women nearing term, we will ensure that CHPs can visit newborns within 48-hours of birth and provide the care necessary in this vital window.

BRAC Uganda continued to improve across their health metrics, aided by the fact that this year they rolled out the mobile app to all CHPs in their network—starting in Q4, all of BRAC's reporting was conducted through the app. In a key metric, they increased under-five assessments by over 34%. With the shift to mobile, however, BRAC's on-time postnatal care visits declined. Anecdotal data suggests that this decline was caused by the app allowing a more accurate measure of performance, rather than reflecting less actual activity on the part of CHPs. In 2018, BRAC will be focused on maintaining their momentum on health metrics and growing the use of technology across their CHP network.

Finally, as we continue to make health our first priority, sales have declined across Living Goods and BRAC. We intentionally retained our ambitious sales targets in 2017 to push ourselves. But given that this trend has held for over four years now, we are cutting sales targets for 2018 by 50% to better reflect that reality. As we add more government CHWs to increase collaboration and integration with the local government system, initial performance will continue to drag numbers down. Government CHWs are typically unpaid volunteers who are not experienced in sales. In addition, expanding our operations to more rural areas and poorer communities, where purchasing power is lower, may also be impacting sales. Our price competitiveness for high-margin products (like solar lights and cook stoves) has declined, due to an increase in competitors in the market. Fortunately, and most importantly, low sales have not had a significant negative impact on CHP attrition or on our health metrics. Sales remain a factor in offsetting our costs, but we will not prioritize sales performance over health impact.

Impact Dashboard

Living Goods Full Year 2017 Metrics

	Living Goods-Uganda			BRAC- Uganda*			Living Goods-Kenya		
	2017 Target	2017 Actual	2016	2017 Target	2017 Actual	2016	2017 Target	2017 Actual	2016
Impact Metrics							*malaria endemic / non*		
Pregnancies Registered / CHP per month	3.0	3.4	7.9	3.0	2.8	2.8	2.0	1.4	2.1
Under-1 Assessments / CHP per month	4.0	4.3	5.0	-	-	-	4 / 3	4.2 / 3.3	4.1 / 3.2
Under-1 Treatments / CHP per month	4.0	2.4	3.8	4.0	4.0	3.6	4 / 3	1.9 / 0.8	2.5 / 1.5
Under-5 Assessments / CHP per month	18.0	18.6	18.7	-	17.7	-	18/12	17.1 / 9.7	15.8 / 9.1
Under-5 Treatments / CHP per month	14.0	10.9	15.3	14.0	13.9	11.8	14 / 9	9.9 / 3.9	10.8 / 3.9
Active CHPs	2,281	2,288	1,682	4,065	4,042	3,908	1,157	1,250	744
Total Pregnancies Registered	57,328	72,778	101,578	138,745	123,398	103,898	19,451	16,123	8,415
Total Under-1 Assessments	76,437	91,675	69,742	-	-	-	37,444	48,667	15,888
Total Under-1 Treatments	76,437	51,968	48,308	184,994	175,134	135,894	37,444	22,656	8,775
Total Under-5 Assessments	343,968	398,384	264,083	-	760,503	-	166,309	198,234	58,365
Total Under-5 Treatments	267,531	232,975	202,031	647,477	608,201	443,923	128,866	114,139	35,049
% On-Time Referral Follow-Up	65%	80%	60%	65%	89%	-	65%	81%	41%
% Postnatal Care Visit in first 48 hours**	85%	51%	51%	85%	73%	89%	85%	55%	43%
% of 'High Impact' Items in stock	100%	100%	100%	100%	98%	96%	100%	100%	99%
Sustainability Metrics									
Wholesale Sales (USD)	$1,082,975	$686,612	$505,427	$1,646,325	$474,105	$722,474	$341,292	$243,251	$108,908
Sales / CHP per month (USD)	$56.25	$28.19	$34.75	$33.75	$10.81	$19.39	$35.00	$19.10	$27.29
Sales / CHP per month (local)	188,438	100,683	117,110	113,063	38,696	65,280	3,500	1,944	2,731
Initial Wholesale Margin	22.0%	14.7%	24.0%	10.9%	15.0%	7.5%	21.0%	20.3%	19.9%
Final Wholesale Margin	20.5%	13.7%	22.1%	9.9%	15.0%	7.5%	19.0%	19.7%	17.4%
Population Served	1,825,109	1,830,400	1,345,600	3,252,000	3,233,600	3,126,400	925,600	1,000,000	595,200
Net Cost per Capita Served (annualized)	$1.88	$2.02	$1.72	$1.08	$1.53	$1.14	$3.35	$3.88	$3.41

*BRAC's data is from paper reporting in early 2017, with reporting from the mobile system completed in Q4.

**The new mobile system now calculates on-time PNC visits differently to better capture all pregnancies, and so results to previous periods and across mobile / non-mobile users are not comparable.

Impact Dashboard

Living Goods Q4 2017 Metrics

	Living Goods-Uganda			BRAC- Uganda*			Living Goods-Kenya		
	Q4 2017 Target	Q4 2017 Actual	Q4 2016	Q4 2017 Target	Q4 2017 Actual	Q4 2016	Q4 2017 Target	Q4 2017 Actual	Q4 2016
Impact Metrics							*malaria endemic / non*		
Pregnancies Registered / CHP per month	3.0	3.0	4.4	3.0	2.6	2.3	2.0	1.2	2.1
Under-1 Assessments / CHP per month	4.0	3.7	5.4	4.0	-	-	4 / 3	3.8 / 2.9	3.6 / 3.1
Under-1 Treatments / CHP per month	4.0	1.9	2.7	4.0	4.3	3.2	4 / 3	1.9 / 1.0	1.2 / 1.7
Under-5 Assessments / CHP per month	18.0	16.7	21.9	18.0	17.5	-	18/12	16.5 / 11.4	13.3 / 8.1
Under-5 Treatments / CHP per month	14.0	8.7	12.7	14.0	15.7	9.8	14 / 9	10.1 / 4.4	6.4 / 2.8
Active CHPs	2,281	2,288	1,682	4,065	4,042	3,908	1,157	1,250	744
Total Pregnancies Registered	16,600	18,211	20,106	34,756	26,789	26,893	5,641	4,279	3,454
Total Under-1 Assessments	22,134	22,816	24,859	46,341	-	-	10,859	13,183	5,815
Total Under-1 Treatments	22,134	11,645	12,464	46,341	44,927	36,891	10,859	6,541	2,472
Total Under-5 Assessments	99,602	102,698	100,158	208,535	181,361	-	48,233	57,054	21,422
Total Under-5 Treatments	77,468	53,877	57,951	162,194	163,385	113,928	37,373	34,064	10,122
% On-Time Referral Follow-Up	65%	82%	77%	65%	89%	-	65%	84%	54%
% Postnatal Care Visit in first 48 hours**	85%	59%	31%	85%	39%	91%	85%	61%	39%
% of 'High Impact' Items in stock	100%	100%	100%	100%	99%	98%	100%	100%	100%
Sustainability Metrics									
Wholesale Sales (USD)	$332,007	$185,083	$160,305	$487,800	$150,927	$128,859	$98,722	$69,986	$42,023
Sales / CHP per month (USD)	$60.00	$27.05	$34.53	$40.00	$14.55	$11.12	$35.00	$17.17	$25.31
Sales / CHP per month (local)	201,000	97,363	120,555	134,000	53,021	38,734	3,500	1,750	2,530
Initial Wholesale Margin	22.0%	10.3%	23.9%	12.0%	14.8%	11.5%	21.0%	24.3%	21.3%
Final Wholesale Margin	20.5%	9.0%	22.2%	11.0%	14.8%	11.4%	19.0%	24.3%	20.0%
Population Served	1,825,109	1,830,400	1,345,600	3,252,000	3,233,600	3,126,400	925,600	1,000,000	595,200
Net Cost per Capita Served (annualized)	$1.88	$2.02	$1.72	$1.08	$1.53	$1.14	$3.35	$3.88	$3.41

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