

2018 | Year-End Report



2018 was a momentous year for Living Goods. We empowered nearly 9,000 community health workers (CHWs) with the technology and training to deliver quality primary health services to the doorsteps of more than 7 million people. It was also the first year we embarked on a more ambitious plan with our partner Last Mile Health to propel community health forward thanks to support from our Audacious Project funders.

Last year, we also signed a contract with Kenya's Isiolo County government to manage all community health services, and pioneered Uganda's first-ever entirely results-based financing mechanism for community health. We not only deepened the support we provided to communities by introducing expanded family planning and setting the stage for immunization services, but we also partnered closely with the Kenyan and Ugandan governments to develop supportive policies and budgets for community health.

We're an organization that's fanatical about analyzing data—both our own and external. So, a big focus for us in 2019 is heightening how we leverage those insights to optimize the impact of our programs. To that end, we've focused on increasing some of our targets, boosting incentives and supervision for CHWs, micro-targeting support to families with higher mortality risks, and strengthening neonatal services.

In 2019, we're aiming to expand opportunities for being contracted by, and providing technical support to, governments, as well as enhancing our work in innovative health financing. We also hope to expand to a new country in 2019 and have refined our scoping process to focus on fewer countries, but with greater depth. Our goal is to dedicate 90% of that effort on shortlisted countries—making go/no-go decisions more quickly—and seconding or hiring consultants based in-country to expedite information gathering as well as shaping the opportunity.

Cover: In Bwaise, Uganda, CHW Ruth connects with a young mother she's counseled on family planning.

- **Expanded Living Goods' direct operations by 45 percent** and, combined with BRAC, served more than 7 million people across Kenya and Uganda ([see page 3](#))
- **Welcomed Liz Jarman as our new CEO** ([see page 13](#))
- Successfully piloted and **began extending family planning services across our entire Uganda operations** ([see page 8](#))
- **Entered our sixth county in Kenya** after being contracted by the Isiolo County government to manage all community health services ([see page 4](#))
- **Began a new plan to optimize the impact of our programs**, including increasing coverage, incentives, and supervision of CHWs ([see page 7](#))
- Developed and **launched Uganda's first-ever results-based financing mechanism for community health**, which ties 100% of payments to outcomes ([see page 5](#))
- Signed a new partnership with Gavi, the Vaccine Alliance, which will help **expand immunization services for more than 8 million people by 2021** ([see page 9](#))
- **Launched our first campaign for community health** and supported governments to develop supportive policies ([see page 12](#))
- Began **providing technical assistance to the government in Kisii County, Kenya** to more effectively manage their own community health networks ([see page 6](#))
- **Piloted innovations focused on strengthening referrals and predictive analytics** that are extending high-quality diagnostic technologies to the community level ([see page 10](#))
- **Expanded our own internal technical capacity** to develop mHealth software independently ([see page 9](#)) and launched a new Enterprise Resource Planning system ([see page 13](#))

Scaling Impact

In 2018, we expanded our coverage by 45% overall and now reach more than 4 million women and children through our direct networks alone (more than 7.3 million including BRAC). We reached 3,244 CHWs in Uganda, exceeding our target of 3,200. In Kenya, we were just below our target of 1,960, reaching 1,890. For the year as a whole, we added more than 2,000 new CHWs, a rate of growth that outpaced our expansion of 1,532 additional CHWs in 2017 by around 30%.

Amid all this growth, we remained focused on ensuring that our CHWs receive regular, high-quality supervision, and have the right incentives and support in place to ensure they remain active and responsive to their patients. Our per-CHW assessment metrics have remained strong, at nearly the same level as 2017; the small decrease may be due to the large number of new CHWs coming on board who require experience to ramp up their performance. **Reflecting this, we had our strongest under 5 (U5) assessment numbers in Q4**, hitting 19.5 assessments each month per CHW in Uganda, exceeding our target of 18; and 16.9 in Kenya, again, exceeding our target of 16.6. This achievement also comes at a time when our data validation practices are stronger than ever—we recorded our highest rate of data accuracy ever in Uganda in Q4.

Ensuring that new mothers and their children receive a visit from a CHW within 48 hours of birth remains one of our biggest challenges, and one that we worked at steadily throughout 2018. Unfortunately, issues with the Smart Health app have sometimes prevented the accurate capture of on-time visit data. We are now working to resolve these issues, and are also reanalyzing our past performance to ensure we have a more accurate picture of our success rate on this metric. We expect that we are performing at a higher rate than indicated by the data captured so far, and look forward to sharing more in-depth analysis with our partners soon.

BRAC is now fully using the Smart Health app for CHW support and data collection. However, performance has declined slightly

Our Results in 2018



8,934
ACTIVE CHWs



980,382
SICK CHILDREN
UNDER 5 ASSESSED



114,873
NEW PREGNANCIES
REGISTERED



206,575
SICK CHILDREN
UNDER 1 ASSESSED



7,188,000
PEOPLE SERVED

from 2017. One reason for this was that BRAC experienced a significant restructuring during Q4 tied to improving operational efficiency and decentralization of management. This affected CHW activities, particularly in the month of December, and contributed to the flat performance.

While our assessments per CHW increased, we did see a decline in treatments (47% below target in both countries), as well as in pregnancies registered per CHW, at 2 per CHW each month in Uganda, against a target of 3, and 1.1 per CHW each month in Kenya, against a target of 2. Birth rates in both countries have gone down over time,

but while this context is important, we want to ensure that our targets remain ambitious and that CHWs are motivated and supported to achieve them.

We're already taking steps to ensure that we continue to show measurable impact. These include increasing the number of assessments and treatments we expect CHWs to perform, experimenting with new incentive packages, using data to help CHWs target clients who are most at risk, and expanding our platform to encompass a stronger suite of services for issues such as family planning and immunization.

¹ Note that the Uganda and Kenya CHW targets were recalibrated (lowered) during 2018 to accommodate a greater focus on strengthening Living Goods' platform—expanding our family planning and immunization offerings, improving the accuracy of data collected, etc.

ISIOLO GOVERNMENT CONTRACTS US TO TRANSFORM COUNTY'S COMMUNITY HEALTH

Living Goods will lead and coordinate all community health services in Isiolo, Merti, and Garbatulla sub-counties for the next four years.

One of our most exciting developments in 2018 was a partnership with the government of Isiolo County, Kenya. Not only is this the sixth country in Kenya that we're operating in, but it's **the first time a government has directly contracted us to manage all community health services**. Living Goods will lead and coordinate all community health services in Isiolo, Merti, and Garbatulla sub-counties for the next four years.

Starting with an equal cost-share in the first year, the county government will shoulder an increasingly larger share of the price tag for community health throughout the life of the partnership. And, to ensure that community health has the long-term dedicated funding needed to enable government ownership, we will **concurrently support the government to draft and implement supportive policies** for community health.

Despite the signing, there continue to be some political hurdles, which is not unexpected given we're trying to do something unique in Kenya. In the meantime, the county government is updating its local laws and regulations to strengthen their legal framework for the contract, and we hope to recruit and train the first cohort of CHWs in early Q2 2019.

Planning for effective household coverage in such a large area poses new challenges. To address them, we will provide motorbikes to staff to aid with transport. And, in addition to performance-based pay, we will give an extra stipend (\$15/month) to cover transportation costs for CHWs who report activities each month and regularly attend monthly in-service trainings.



In contrast with most of our operations, **CHWs in Isiolo will provide free medications from government stocks** rather than selling them, and we will support the county government in managing their community supply chain and forecasting. To facilitate this, government health supervisors, known as community health extension workers (CHEWS), will be seconded to Living Goods.

Universal Health Coverage (UHC) is part of the Kenyan government's Big Four Agenda, which President Uhuru Kenyatta launched to drive economic and social growth. **Living Goods is one of just two organizations authorized to register families for the National Hospital Insurance Fund program in Kenya** and is partnering with the government to register households in Isiolo, one of the pilot counties.

Above: Living Goods staff register Dr. Mohammed Kuti, governor of Isiolo County, at the far right, for the National Hospital Insurance Fund.

CHANGING FINANCING PARADIGMS FOR COMMUNITY HEALTH

The pilot is aimed at demonstrating a scalable model for facilitating high-impact, cost-effective CHW services that governments, donors, and partners can adopt in the future.

In June 2018, we launched Uganda's first results-based financing (RBF) mechanism for community health in partnership with the Government of Uganda, with funding from the Deerfield Foundation. Unlike most RBF programs, which only tie a portion of payments to outcomes, **ours is completely bound to the independent verification of results** provided by Innovations for Poverty Action (IPA). Supporting 330 CHWs who are reaching more than 250,000 people in the Masaka and Kyotera districts, the pilot is aimed at demonstrating a scalable model for facilitating high-impact, cost-effective CHW services that government, donors, and partners can adopt in the future.

Initial results are promising. **We received 109% of expected payment in Q4 2018 and over-performed on U5 child assessments (139%)**. We also saw significant improvements on several metrics from Q3 to Q4, including in-facility deliveries (which increased from 48% to 61%), postnatal care (PNC) visits within 48 hours (which rose from 53% to 86%), and referral follow-ups (increasing from 40% to 91%). At the same time, there was a significant drop in performance on in-facility antenatal care (ANC) visits (falling from 181% in Q3 to 65% in Q4), and under 1 (U1) follow-ups (falling from 73% in Q3 to 47% in Q4).



We are working to better understand what caused the massive drop for in-facility ANC visits and address key challenges within these areas to improve performance going forward. In addition, in both Q1 & Q2, **despite good performance, the error rate was still relatively high**—27% and 24% in Q1 and Q2 respectively. This has implications since we are now required to include penalties for errors in Q3 and Q4 of the RBF. Consequently, payments will be deducted for every unverified result. Given this, we are working towards introducing programmatic changes to improve quality across the board. We're keen to continue with the upward trend in performance we've seen in our first two quarters to further demonstrate the value RBF mechanisms have in driving cost-effective health impacts through community health.

Above: Following meetings on the RBF, Masaka District Health Officer Dr. Musisi observes CHW Nolongongo perform a sick child assessments in Kyotera district.

ENHANCING OUR LEARNINGS AROUND TECHNICAL ASSISTANCE

We are focusing considerable effort into building the capacity of CHEWs and facility staff.

Beyond our support to government at the national level, in 2018, we began providing technical assistance to the Kisii County government so they can more effectively manage their own community health programs. As with our direct operations, **we are providing CHWs and CHEWs with mHealth tools that are directly feeding real-time data into the government's District Health Information System 2 (DHIS2) database**, which we believe will be a real game-changer. We are also focusing considerable effort into building the capacity of CHEWs and facility staff, as they are directly responsible for overseeing CHWs' daily operations, performance management, and supply chains.

Overall, there has been considerable buy-in from the Kisii government, with support coming on several dimensions. Linked facilities have been directly replenishing CHW supplies and we've seen evidence of improved oversight through our supervisor application, with supervisor field visits rising from three in November (8% of CHWs received a visit) to 22 in January (with 27% of CHWs supervised in the field).

Feedback from CHEWs suggests it's challenging for them to find enough time to directly oversee CHW activities alongside their other duties, which disincentivizes them in meeting their targets. To address this, **Living Goods is ramping up how we monitor, mentor, and coach CHEWs**, and we're assessing the optimal CHEW:CHW ratio.

Although the government is committed to managing the supply chain for CHWs to access free government medications, **there have been long stock-outs of needed pharmaceutical products**, such as rapid malaria detection kits, which has negatively impacted the assessment and treatment of cases in the community. We are working to address this with the government and are adjusting our mobile app to replicate key Ministry of Health input forms to avoid confusion around how data is represented on supervisor dashboards.



Meet Zaina

Zaina decided to become a CHW in the summer of 2018, motivated by the desire to help her neighbors while earning some spending money in the process. Working within a highly mobile community in Iganga, Uganda—one of our highest performing branches—it's challenging keeping tabs on all the pregnant women and children under 5. Pictured with a mother who gave birth at home, and whose child has struggled with several illnesses, Zaina goes out of her way to make extra home visits to check in. "I really feel like I have found my purpose—my true calling—by serving my community like this," she said.

Strengthening Impact

OPTIMIZING THE IMPACT OF OUR PROGRAMS

Living Goods invests in research to rigorously evaluate and optimize the health impact that we're having in the communities we serve.

Following the impressive results from our first randomized controlled trial (RCT) in 2013—which showed a 27% reduction in U5 mortality—Living Goods and our partner BRAC began a second RCT in Uganda in 2016. Our goal is to evaluate the impact our approaches are having on child mortality when operating at a much larger scale and with a lower disease burden. This RCT uses a stratified cluster design covering more than 12,500 treatment and control households across 13 Ugandan districts.

We received some preliminary findings from the RCT in October about indicators such as CHW service coverage, and the magnitude and direction of mortality. **While the preliminary findings show no directional impact in U5 mortality, they indicate a 22% directional reduction in neonatal mortality.** The neonatal directional result is promising, as mortality rates among newborns are stagnant and comprise more than 40% of child deaths. This suggests our work may have a tremendous impact on the lives of children born into areas with Living Goods or BRAC-supported CHWs.

We have begun several efforts to deepen the impact of our programs, including increasing coverage, microtargeting support to the most vulnerable, improving CHW incentives and support, focusing more on neonatal care, and providing a more comprehensive basket of services that includes family planning and immunization services.

As child survival improves in Uganda, our ability to demonstrate incremental impact on child mortality inevitably becomes more difficult. However, **several months into this new impact optimization plan, trends show higher levels of performance around treatments,** although we have more work to do. We have already increased the treatment market share by 16 points, without any compromise on the quality of data. We also recently finalized a test of a new workflow for the app that we hope will reduce technological barriers to accurate data capture.



Meet Casmil

Casmil, a CHW who works out of our Suneka, Kenya field office, spent more than a decade as a government community health worker before he started receiving support through Living Goods. “It’s like night and day, having the digital tools to aid with assessments, and being able to actually treat people who are ill on the spot.” Although Casmil had received training when he initially began serving his community, he said it was challenging keeping his skills fresh. He says it’s much easier to do his job effectively thanks to regular monthly in-service refresher trainings, the supportive supervision he receives, and the ways the app helps him optimize the time he spends supporting his neighbors each day.



SCALING FAMILY PLANNING ACROSS UGANDA

CHWs are playing an important role in sharing accurate information about family planning options and potential side effects.

Following a year-long family planning pilot with about 60 CHWs in our Bwaise and Mpigi branches in Uganda, **we began expanding this successful innovation across the country in Q4**. CHWs are providing two types of daily birth control pills: condoms and the long-lasting injectable Sayana Press, along with referrals for longer-term and permanent options. During the pilot, we found that one of the biggest barriers to family planning was misinformation regarding side effects and fears that certain methods might affect future pregnancies or have other negative health outcomes. To address this, **we worked to better prepare CHWs to field questions about potential side effects**, particularly with Sayana Press. As the pilot progressed, we also developed a client-centered counseling approach in which CHWs began customizing messages to the needs of individual women and their reproductive goals.

In addition to training all CHWs in the original two branches, we conducted a training-of-trainers session so that, as part of this expansion, an additional 12 branch staff would be equipped to supervise family planning. **By the end of Q4, we had trained an additional 146 CHWs to deliver these**

Pictured: The family planning pilot executed by CHWs like these women from our Bwaise, Uganda branch was so successful, we are scaling it across our operations.



services, bringing the total number of CHWs trained to nearly 200. We have also identified seven additional branches for the next phase of the roll-out, and **plan to train 800 CHWs on family planning by the end of Q1 2019**. We'll continue sharing all of our learnings with our colleagues in Kenya to support extending services to the country later in 2019.

Initially, the additional time required to also provide family planning services discouraged some CHWs from making as many initial and follow-up visits as planned. But after the introduction of new activity-based incentives, **we've seen a 70% increase in the number of women newly counseled about family planning**, refill rates have increased 25% to hit a total of 66%, and we saw a 60% increase in the number of family planning products distributed since March 2018.

Pictured: Justine, a CHW in Bwaise, Uganda administers the injectable Sayana Press to a young woman she just counseled on family planning options.

SHOOTING FOR MASSIVE INCREASES IN IMMUNIZATION COVERAGE

We expect to roll out immunization interventions to all CHWs in our network starting in July 2019 to reach a total of 5,000 across Kenya and Uganda by the year's end.

In partnership with GAVI, the Vaccine Alliance, we've made progress in designing a program in Kenya and Uganda that will help expand immunization services for more than 8 million people by 2021.

During the pilot phase, starting in February 2019, Living Goods will train 240 CHWs each in Uganda and Kenya to conduct home visits and mobilize communities to take up immunization services. **We have also designed demand-creation interventions for these pilot branches**, including having CHWs distribute educational materials about immunizations during home visits, at community events, and on immunization days. In addition, we plan to work with a consultancy firm to design innovative demand-generation interventions and incentive structures that will be tested in two branches to generate learnings for the wider field. GAVI is also supporting the integration of CHW data into DHIS2 in Uganda.

CHWs will be responsible for determining the immunization status of every child they visit and referring those who have missed scheduled vaccines to immunization sites. CHWs will follow up with these families regularly until the immunization has been completed. Following the pilot phase, we expect to roll out immunization interventions to all CHWs in our network starting in July 2019, to reach a total of 5,000 across Kenya and Uganda by the year's end.

Working alongside Uganda's Ministry of Health, we developed an immunization training module and are finalizing something similar in Kenya. We've successfully conducted a training-of-trainers session on immunization for 22 Living Goods Uganda staff, and have already hired project managers in both countries, as well as other key staff. We've also begun refining the immunization workflow in the Smart Health app to optimize support to CHWs.

DEEPENING OUR INTERNAL TECHNICAL CAPACITY

Our partnership developing the Smart Health app with Medic Mobile was transformative. It enabled us to power scalable, high-impact community health programs that ensure a consistent quality of care and effective performance management of geographically dispersed CHW networks. We will continue working closely with Medic Mobile to scale our direct operations and are grateful for their support in teaching us to develop on their platform. However, knowing there's no one-size-fits-all solution for every country, **we spent considerable time in 2018 working to deepen our internal technical capacity to become more versatile with the technologies we can use.** To reduce our reliance on third-party vendors, in 2018, we brought on a Chief Technology Officer and a team of 10 technologists who will develop on the Medic Mobile platform and explore new technologies.

As we continue our geographic expansion, **we're working to guide governments and implementing partners through the process of gathering technical requirements and selecting a platform that meets their needs.** Consequently, we have been evaluating how we can customize, deploy and leverage other key technology systems in the community health domain, including OpenSRP and CommCare by Dimagi. In Q4, we rolled out a GPS tool developed in-house to help validate the activities of CHWs, optimize health workers' daily routines through the App's workflow, contribute insights into the technology needed for our results-based financing plan, and introduce a new exam module for CHWs.



Pictured: CHWs work with their phones during an in-service refresher training.

ENSURING A CONTINUUM OF CARE

The Bill & Melinda Gates Foundation is supporting Living Goods to lead the Community Health Innovation Network. Its goal is to expand the pipeline of groundbreaking ideas that extend high-quality diagnostic technologies to effectively reach families at the community level. The network is testing innovations through our Bomachoge Chache sub-county branch office, located in Kisii, Kenya. It is being driven by a group of about 170 CHWs and the nearly 140,000 patients they serve.

We completed developing and testing a methodology for “closed-loop” patient referrals in August 2018. By digitizing the paper-based referral system, we are working to ensure a continuum of care between CHWs and health facilities for malaria, diarrhea, pneumonia, undernutrition, ANC and PNC. **We are working to ensure that 100% of referrals are confirmed via verifiable digital data, 85% of referred patients are seen at facilities, and 85% of CHWs conduct appropriate follow-ups.**

The 21 CHWs involved in the pilot made 234 digital referrals by the end of 2018, and registered 178 follow-up confirmations that clients actually made it to facilities. While the innovation appears to be working well with CHWs, we want to strengthen its effectiveness within health facilities, including by extending the time before referral tasks expire in the app, as only 31 referrals were electronically confirmed by facility staff.

In August 2018, we also began testing digital facility referrals in tandem with a small pilot around the distribution of free government HIV self-testing kits by CHWs. **Our goal is to see a 20% increase in clients tested for HIV and a 90% increase in HIV-positive clients receiving ongoing treatment and care by the end of Q2 2019.**

PREDICTING WHO NEEDS TARGETED CARE

In October 2018, we began a pilot with 65 CHWs who are using the data and analytics we gather around neonatal mortality, facility delivery, early danger sign detection in the first 28 days of life, and disease risks for U5 children to **predict targeted support and mitigate negative health outcomes for those most at risk.** So far, our Predictive Algorithm (PA) application tagged more than 650 U5 children as being at risk of getting sick and not being diagnosed within 72 hours of symptom onset, identified 13 out of 72 pregnant mothers as being at risk of not delivering at a health facility, and flagged 70 newborns as at risk of developing danger signs. CHWs are responsible for following up on the numerous targeted tasks generated by the app’s algorithm.



Meet Justine

Justine has been working as a CHW in our Bwaise, Uganda branch for the last several years, and was among the first 60 CHWs to pilot family planning services with Living Goods. Based in a peri-urban area outside the capital of Kampala, she regularly introduced herself and her services to new residents, while following up with longstanding clients. Family planning services are in high demand, with many women opting for the long-lasting Sayana Press injection. CHWs like Justine play an important role in sharing accurate information and fielding questions about the side effects of various contraceptive methods. We are now expanding family planning across Uganda and will expand to Kenya later in 2019.

Spreading Community Health

In 2018, we worked to catalyze global momentum for scalable, effective community health programs by deepening our support to the Kenyan and Ugandan governments as they develop policies and budget allocations at local and national levels.

ACCELERATING KENYA'S INVESTMENT IN COMMUNITY HEALTH

The study showed that investments in community health have a 9.4-fold return on investment—coming from increased productivity and reduced disease burden.

The Kenyan Ministry of Health's Community Health Technical Working Group has now ratified the findings of an investment case for community health that Living Goods played a fundamental role in helping to develop. **Using the Living Goods approach as their model, the study showed that investments in community health have a 9.4-fold return on investment**—coming from the increased productivity and reduced disease burden that these investments enable. The study looked at costing across all levels of the community health system—not only at CHW and facility-based levels.

We carried out targeted advocacy activities for both local- and national-level policymakers and donors in the second half of 2018 and presented the study's findings at the 2nd Africa Maternal and Child Health Conference, which drew participants from more than 21 African countries. Advocacy around the findings in the counties in which we operate has contributed to the development of a community health bill in Kisii County, a community health policy



in Kakamega County, and a request from Kiambu County to support the development of their community health bill. We are also assisting Busia County to craft the structure for Ojaamong Care, a healthcare initiative led by the governor, with specific input around community health.

Our new role as a **member of the Kenya Ministry of Health's Technical Committee on the National Health Insurance Fund** will also play an important role in ensuring we continue to serve as a thought leader with the government, especially regarding the role CHWs can play in increasing insurance coverage.

Above: Our staff in Busia County participate in a campaign for World Health Worker Week.

GLOBAL CONFERENCE ON PRIMARY HEALTH CARE

ASTANA, KAZAKHSTAN 25-26 OCTOBER 2018



PARTNERING FOR SUPPORTIVE POLICIES IN UGANDA

The Ugandan Government has committed approximately \$800,000 for the first year of incentives for an estimated \$93 million, four-year CHEW program that will train 15,000 CHEWs, expected to start in 2019. **Living Goods has been supporting the Ministry of Health (MOH) to develop the National CHEW Policy and Strategy since 2016** with direct technical assistance and facilitation support. We're also working in lockstep with a range of officials at the MOH to support the development of a new National Community Health Strategy and driving advocacy efforts for UHC.

We've also partnered with the World Health Organization and PATH to support the MOH in engaging Parliamentarians on the importance of advocating for UHC as well as equipping them with effective advocacy tools. Parliamentarians have committed to presenting a motion on the floor in support of UHC and continuing to provide oversight, budget appropriations, representation, and accountability, with a focus on health for all. In addition, they committed to continuing to advocate for national health insurance.

A GLOBAL RALLYING CRY FOR UNIVERSAL HEALTH COVERAGE

Living Goods was invited to join the WHO's CHW Hub in early 2018, which enabled us to influence the development, dissemination, and implementation of the WHO's long-awaited CHW Guidelines. Leveraging that momentum, we sent our first delegation to the annual World Health Assembly (WHA) in May.

We also formally **launched the Communities at the Heart of Universal Health Coverage campaign** in October, at the invitation-only 40th Anniversary of the Alma Ata Conference on Primary Health Care in Kazakhstan, hosted by the WHO and UNICEF. Living Goods is leading the campaign in partnership with Amref Health Africa, Aspen Management for Health, Financing Alliance for Health, the International Rescue Committee, and Last Mile Health.

Through targeted advocacy efforts, this global campaign aims to generate political will and commitment to **ensure that government-owned, high-quality, financially sustainable, and well-integrated community health programs are included in national UHC strategies**. The campaign aims to support and encourage national governments to include community-based primary health care updates in the country reports they will deliver at the 2019 UN High-Level Meeting on UHC. We're working with countries to highlight visions for community health that tie into broader health systems, frameworks that measure access to life-saving care for women and children, and plans for equity to ensure that community health is affordable and accessible to all.

Pictured: Dr. Diana Nsubuga, Living Goods Uganda Deputy Country Director for Community Health Partnerships; Her Excellency Dr. Jane Aceng, Uganda's Minister of Health; Liz Jarman, Living Goods' CEO; and Dr. Sarah Byakika, Assistant Commissioner of Health Services Quality Assurance at Uganda's Ministry of Health at the Alma Ata Conference on Primary Health Care in Kazakhstan.

Supporting the Living Goods Plan

DIGITIZING OUR INTERNAL OPERATIONS

We began a massive effort to digitally transform Living Goods' internal operations in 2018, rolling out a new enterprise resource planning (ERP) system that will improve our reporting, operational efficiency, and create the foundation for dramatically scaling our programs. As part of this effort, **we launched our mobile Point-of-Sale (POS) system across Kenya and Uganda in Q4** to support a much broader radius of CHW coverage and conduct transactions in the field, which is providing real-time inventory updates and greater visibility into stock management and forecasting.

We learned many important lessons in the process, including the **importance of focusing on behavior change, and engaging staff broadly in system design** and development. Moving from a group of disjointed processes to an interconnected system also taught us how often we had workarounds and system breaks. For instance, we used to be able to easily sell an item through a basic point-of-sale system. While that transaction may have been a simple one, it failed to provide adequate end-to-end insights and updates throughout the supply chain.

Now, **every element of the product supply chain must be properly registered in the system**—purchase order to a vendor, receipt of product, transfer to the right branch, and receipt of product at the branch into inventory—for a sale to happen. While this makes sense intellectually, it's hard to shift the behaviors of every department to ensure they're properly processing each step. **Change entails the ongoing training of many departments**, a system administrator who is constantly looking for blockages, and regular meetings to ensure that everyone is aligned and working towards the same goal.

***Pictured:** The Living Goods Board of Directors and Global Executive Team*

STRENGTHENING OUR LEADERSHIP & BENCH STRENGTH



Following the departure of Shaun Church, **we were thrilled to welcome Nairobi-based Liz Jarman as our new CEO**. Liz joined Living Goods five years ago as our Director of Product Strategy, was later promoted to Kenya Country Director, and was named our Chief Strategy Officer in 2017. Born in Zambia, Liz spent a long portion of her career at the \$30 billion UK grocery giant Sainsbury, where she rose to head of Product Development, leading their Fairtrade strategy. She ultimately decided to cross over to the social sector, moving to Kenya to work with Fairtrade Africa before joining Living Goods.

We were **delighted to continue strengthening our board and organizational oversight in 2018**, adding Pat Naidoo, Executive Director, ELMA Philanthropies Services (East Africa) Limited, and Dr. Mphu Keneiloe Ramatlapeng, the executive vice president

of the Clinton Health Access Initiative, who served as Lesotho's Minister of Health and Social Welfare from 2007-2012.

Our teams continue to grow, and we are pleased to have **onboarded new leaders in 2018 who will help us achieve our aggressive goals** for transforming community health, including our Chief Technology Officer Asif Akram, Kenya Country Director Thomas Onyango, Communications Director Jennifer Hyman, Uganda Deputy Country Director for Community Health Partnerships Dr. Diana Nsubuga, and Chief People and Culture Officer Maria Shapiri. We also promoted Dr. Ruth Ngechu to Deputy Kenya Country Director, Community Health Partnerships; and Rita Bulusu to Deputy Director, Community Health Strengthening Team. In total, we hired 177 new employees in 2018 and about 2,000 new CHWs.

Living Goods 2018 Key Metrics*

	Living Goods-Uganda			BRAC-Uganda***			Living Goods-Kenya		
	2018 Target	2018 Actual	2017	2018 Target	2018 Actual	2017	2018 Target	2018 Actual	2017
Impact Metrics**									
Pregnancies Registered / CHW per month	3	2.3	3.4	3	2	2.8	2	1.2	1.4
Under-1 Assessments / CHW per month	4	3.7	4.3	4	3.1	NA	3.8	3.6	4.2 / 3.3
Under-1 Treatments / CHW per month	2	1.6	2.4	2	3.1	4	1.7	1.4	1.9 / 0.8
Under-5 Assessments / CHW per month	18	17.3	18.6	18	15.4	17.7	16.5	16.4	17.1 / 9.7
Under-5 Treatments / CHW per month	14	7.7	10.9	14	12.6	13.9	12.6	7.7	9.9 / 3.9
Active CHWs****	3,200	3,244	2,288	4,065	3,800	4,042	1,960	1,890	1,250
Total Pregnancies Registered	94,809	69,946	72,778	131,706	86,479	123,398	39,528	21,582	16,123
Total Under-1 Assessments	126,412	109,991	91,675	175,608	133,609	NA	73,166	63,046	48,667
Total Under-1 Treatments	63,206	28,614	51,968	87,804	134,328	175,134	35,634	24,125	22,656
Total Under-5 Assessments	568,853	510,446	398,384	790,236	668,966	760,503	320,410	289,011	198,234
Total Under-5 Treatments	442,441	231,264	232,975	614,628	546,436	608,201	253,232	134,144	114,139
% On-Time Referral Follow-Up*****	80%	79%	80%	80%	80%	89%	80%	82%	81%
% Postnatal Care Visit in first 48 hours	85%	49%	51%	85%	NA	73%	85%	57%	61%
% of 'High Impact' Items in stock	100%	96%	100%	100%	98%	98%	100%	100%	100%
Sustainability Metrics									
Wholesale Sales (USD)	\$1,008,432	\$748,030	\$686,612	\$975,600	\$551,129	\$474,105	\$403,200	\$372,983	\$243,251
Sales / CHW per month (USD)	\$30.00	\$22.32	\$28.19	\$20.00	\$13.96	\$10.81	\$20.00	\$18.36	\$19.10
Sales / CHW per month (local)	111,000	83,286	100,683	74,000	51,152	38,696	2,040	1,859	1,944
Initial Wholesale Margin	18%	16.1%	14.7%	13%	16.2%	15%	18%	19.5%	20.3%
Final Wholesale Margin	17.2%	12.4%	13.7%	12%	16.2%	15%	15.9%	19.5%	19.7%
Population Served****	2,560,000	2,595,200	1,830,400	3,252,000	3,040,000	3,233,600	1,568,000	1,512,000	1,000,000
Net Cost per Capita Served (annualized)	\$1.54	\$1.88	\$2.02	\$1.14	\$1.58	\$1.53	\$2.74	\$3.69	\$3.88

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

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

*** Note 3: A small amount of data from BRAC-Uganda's December results is still being calculated, this data is estimated in these results.

**** Note 4: Targets for CHWs and Population Served were recalibrated (lowered) during 2018 to account for an increased focus on strengthening the Living Goods platform.

***** Note 5: Living Goods is in the process of re-analyzing our data for this metric, and expect that the % of visits completed ontime will be revised upwards. Due to ongoing data issues this metric is not available for BRAC. BRAC is working to resolve for 2019.