LivingGoods

Delivering Data-Driven Health Care, Door to Door

QUARTERLY REPORT

Q1 | Jan. – March 2026

EXECUTIVE SUMMARY

In Q1 2026, Living Goods entered the bridge year for our new strategy, working with governments to sustain delivery of essential, lifesaving services for families. Our highlights include:

- **Reaching more mothers and children:** We supported 9,803 community health workers (CHWs) serving 4.7 million people across three countries, ensuring families could access essential health services no matter where they lived.
- **Strengthening national health workforces:** In Kenya and Uganda, we supported the governments to develop performance management frameworks that will ensure greater effectiveness of CHWs and their supervisors nationwide to strengthen service delivery at scale.
- **Redefining our innovations work:** We are redesigning our innovation operating system to better address the biggest bottlenecks in community health. Our priorities include designing for scale and cost from the start, taking a user-centered approach, and integrating AI and emerging technology.
- **Launching our co-implementation approach in Burkina Faso—and optimizing it in Kenya:** We launched our first co-financing partnership in Zorgho, Burkina Faso, building the foundation for government-led impact. After years of learning, we are also testing an optimized co-implementation approach in Kenya to address core operational challenges and strengthen supervision, digital capacity, and government ownership to improve the performance of CHWs.
- **Embedding intelligence in community health:** We are working with African governments to move from fragmented digital and AI pilots to affordable, scalable, intelligent health systems built on strong foundations that improve performance and deliver better health outcomes.
- **Embarking on a new strategic plan:** 2026 is our bridge year. We are sharpening our approach to reach our North Star by 2030: **Support 3+ African governments to build and sustain high-performing community health systems — enabling at least 50,000 CHWs to reach 25 million people and reducing under-five and maternal mortality by at least 10%.** ■

Living Goods is a government performance partner building **affordable, intelligent, high-impact** community health systems.

Because **when health systems perform, people live. When they don't, people die.**

Cover: *Deborah Atieno and her six weeks old baby at their home in Busia, Kenya.*

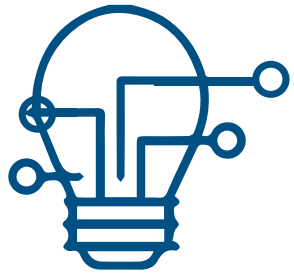
BUILDING SYSTEMS GOVERNMENTS CAN AFFORD, SUSTAIN, AND SCALE

DESIGN FOR PERFORMANCE

Co-create the foundations — policies, frameworks, digital infrastructure — that enable performance at scale

MAKE DELIVERY WORK AT SCALE

Embed performance-driven tools, routines, and capabilities into frontline delivery



CREATE SMARTER SOLUTIONS

Use data, AI, and evidence to fuel innovations that continuously improve performance

IMPACT OVERVIEW

Living Goods' Q1 2026 Accomplishments

255,736
sick child treatments

CHWs battle the deadliest childhood killers – malaria, pneumonia, and diarrhea – preventing needless deaths from treatable diseases.

29,261
pregnancies supported

By monitoring expectant mothers and educating them on pregnancy's hidden dangers, CHWs help guarantee a safe journey to motherhood.

89%
of children fully immunized

CHWs work to link every child to the vaccinations they need, shielding them against deadly diseases and strengthening community immunity.

95%
of babies delivered at a facility

CHWs guide pregnant women to deliver at the health facility, where the dangers of childbirth can be most effectively managed.

150,897
couple years of protection

CHWs empower couples to determine their reproductive futures, preventing unintended pregnancies and saving women's lives.

$1.21
cost per capita

Our model operates at a price governments can sustain, ensuring these vital services reach millions who might otherwise go without.

The Visit That Changed Saodate's Destiny

Burkina Faso: Saodata and her daughter, after CHW Mariam's visit.

In the village of Siglogin, near the Nagréongo health center in Burkina Faso, Tapsoba Mariam, a community-based health worker supported by Living Goods, was carrying out her routine home visits when she met Ouedraogo Saodate, a 33-year-old pregnant woman who was seven months along.

Saodate had no idea that this ordinary visit would change her life. She did not yet know that she had just met the person who would become, in a way, her guardian angel.

This is her story.

"I still remember the day Mariam came to visit me at home. I was seven months pregnant … and I had never attended any prenatal visit. To me, the pregnancy was simply progressing, despite the pains I sometimes felt after meals, and the bleeding I could not really bring myself to explain.

When Mariam asked questions and examined me, I realized something was wrong. She told me gently but firmly: 'You need to go to the health center immediately.' I listened to her.

At the Nagréongo health center, the health workers examined me and referred me to Ziniaré District Medical Centre. There, after an ultrasound scan, I received difficult news: I was carrying twins. But one of them had already died… and the other was in danger. Everything happened very quickly. I was taken into the operating room for an emergency caesarean section.

I woke up with immense pain… and even deeper pain in my heart. My baby had not survived. But I was alive. With time, I came to realize that without Mariam, I would probably not be here today to tell this story.

A few months later, I became pregnant again. This time, I did not hesitate. I chose to be supported by Mariam. She followed me, advised me, and accompanied me at every stage. She took the time to listen, to check that everything was going well, and to reassure me.

This second pregnancy was nothing like the first. I felt safe. And this time, everything went well.

I gave birth to a healthy baby girl. Today, she is one and a half years old, and every time I look at her, I think of the journey we have been through.

I know one thing for sure: Without Mariam, I would not be here. And neither would my daughter." ■

FROM DIGITIZATION TO INTELLIGENCE: MAKING AI WORK FOR COMMUNITY HEALTH WORKERS

What Emerging Technology Needs to Succeed in Community-Based Primary Health Care—Not Just Through Pilots, but at National Scale

By Kanishka Katara, Living Goods Chief Digital Health Officer

Emerging technologies like AI can expand healthcare's reach, reduce costs, and improve health outcomes—but only if we design interventions with scalability and affordability in mind from the start. That means building foundations that enable systems to perform at the national level, not just in pilots.

In partnership with governments in Africa, Living Goods is driving the evolution from digital to intelligent health systems powered by AI that perform for people at scale, so that every family gets the care they need to live longer, healthier lives.

THE CHALLENGE

AI is the new buzzword in global health. I see it on conference agendas, in strategy decks—I'm almost seeing it in my dreams. But the future of global health will not be defined by how boldly we imagine AI. It will be defined by how responsibly and effectively we implement it.

Too many AI pilots in the health ecosystem sound exciting but are disconnected from reality. They are not designed with affordability, scalability, or integration within existing health systems in mind. Some are AI in name only. As a computer science engineer who in an alternative life would have been a medical doctor, I see both the opportunity and risk: we are underestimating the complexity of building technology that actually works to drive impact in health programs.

We must consider AI-interventions with the deepest sense of responsibility. Therefore, we need a more disciplined approach that prioritizes real problems, accounts for system constraints, and designs for scale and affordability from the outset. Otherwise, we will continue investing in pilots that never translate into impact at scale.

Finally, African governments have made huge strides in digitizing their health systems. But a hard question remains: are these just digital versions of old processes, or do they truly use intelligence—data, analytics, and smart workflows—to drive better health outcomes?

THE OPPORTUNITY

We now have a chance to build health systems, and the technology that powers them, differently designed for scale, grounded in real-world constraints, and focused on solving the hardest frontline problems.

We must build the foundations for AI to work and invest in the infrastructure and people that allow it to endure. In primary health care, that means a well-supported community health workforce – fairly compensated, equipped with the tools and

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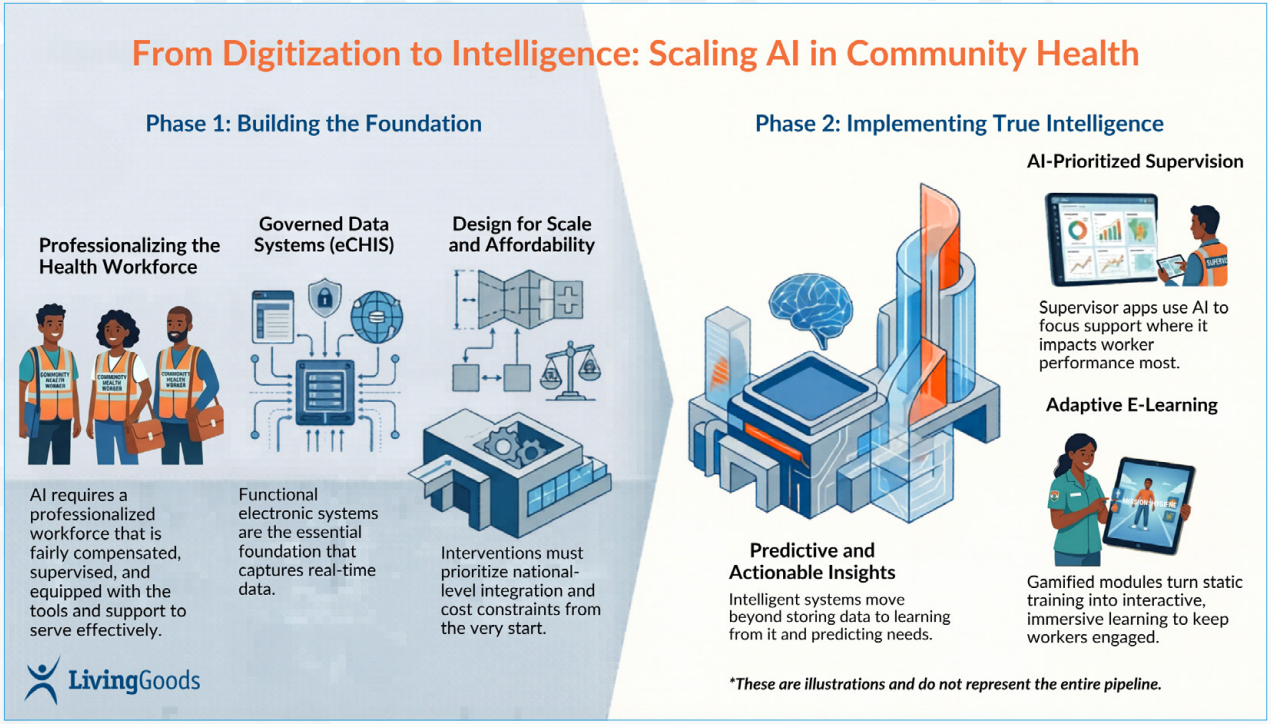
CHW Fatuma and her client Jalia share a light moment, marveling at how the digital tool works.



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knowledge to serve, guided by supervisors who use data to continuously improve performance, and enabled by effective digital solutions. Also critical is a functional, well-governed electronic community health information system (eCHIS) – one that consistently captures the data and insights needed to guide decisions, improve performance, and respond to patient needs in real time.

You wouldn't install a fancy hot tub on a crumbling building. In the same way, **AI cannot succeed without strong underlying systems. This unglamorous "behind-the-scenes" work is often invisible and underfunded, but it's what will allow AI to have the most meaningful impact.**

The move from digitization to true intelligence is what will transform outcomes—technology that goes beyond storing data to learning from data. Intelligent systems can spot problems early, flag unusual patterns, predict what patients might need, and suggest what to do next. And intelligence should solve the problems that drive impact—reducing health worker workload, increasing efficiency, speeding up care, and lowering costs—so systems can deliver better outcomes with greater affordability.

LIVING GOODS' APPROACH

In partnership with governments in Africa, Living Goods leverages emerging technologies, including AI, to strengthen the foundational systems for it to perform at scale and at a cost governments can afford.

With nearly two decades of experience in community health and ten years in digital health, **Living Goods is partnering with governments to build intelligent systems that turn data into actionable insights. These systems help predict behaviors, flag inequities in near real time, support better supervision, and equip frontline workers with adaptive decision-making tools to enhance performance.** The result is care that is more targeted to where it is needed most, better aligned with patient needs, and delivered in a timely manner – ultimately saving more lives and building healthier communities.

Our supervisor app will be the first in the field to use AI to prioritize tasks, enabling supervisors to focus their support to CHWs where it can have the greatest effect on performance – and as a result health outcomes. And the e-learning platform we designed integrates AI-powered modules including gamification that turns static training into adaptive, interactive learning with immersive learning options to keep CHWs engaged and interested in pursuing learning.

OUR VISION

We partnered with African governments to make the transition from paper-based to digitised health systems. Now, we are working to make those systems intelligent. But intelligence alone is not enough. Systems must be owned by governments, designed for sustainability and real-world cost constraints, and solve the everyday challenges of CHWs.

That's the future we're building—a future where AI is not just a buzzword, but a powerful tool that helps health workers work smarter, act faster, and save more lives. ■

LEARNING SITES

Burkina Faso

Our Burkina Faso learning sites continued their strong performance in Q1. A highlight was pregnancy registration, with each CHW supporting an average of 3.5 pregnant women per month against a target of 2.5. This was driven mainly by strengthened supervision, which supported CHWs to more proactively identify pregnant women. We learned that closer collaboration between midwives and CHWs improves credibility, leading to expanded access to family planning and strengthened referral data collection across the continuum of care.

Kenya

Q1 2026 marked the transitioning of commodity supply, in-service refresher training, and CHW compensation fully to government in our Busia learning site. The site demonstrated notable resilience, with high household coverage, structured and accountable supervision, and improved data syncing rates. Meanwhile, workflow challenges limited reporting of family planning services, and low commodity availability especially for mRDTs affected CHWs' ability to test children with malaria. To improve the identification of sick children overall, we are strengthening messaging on disease assessment, diagnosis, and referral.

Uganda

The Uganda learning sites delivered strong results, driven by sustained supervision (95% against a 75% target) and strengthened data use from eCHIS, with weekly active users standing at 78%. Commodity availability remained robust at 92%, well above the 60% target, supporting consistent service delivery.

A highlight of the quarter was family planning. Couple years of protection per CHW was 6.9 in Q1, 117% of the target. This indicator captures the lasting protection women receive through CHW services—calculated based on the contraceptives distributed in a one-year period—demonstrating both the reach and quality of community-based family planning. This was driven by the scaleup of family planning services in Wakiso District as well as active partner integration with Marie Stopes, TIKO, RHU, and Empower, which expanded family planning coverage and CHW engagement.

IMPLEMENTATION SUPPORT SITES

Burkina Faso

We partnered with government for the first time to codesign, cofinance, and coimplement community health services, embedding performance-driven tools, routines, and capabilities in government systems. This is an exciting milestone as we extend this approach to a second country after several years deploying it in Kenya. Operational activities are now underway in Zorgho District, including staff training, orientation for regional and district management teams, Training of Trainers (ToT), and equipment distribution. About 500 CHWs in the site will be actively providing health services in the coming months.

Kenya

In Q1, highlights included:

- **Rolling out our optimized implementation support approach as a test in Bungoma County and Kisumu County:** This adjusted approach entails supporting county governments to take the lead in implementation while Living Goods provides embedded support. For instance, we support the capacity building of county-level training of trainers (ToTs) who in return cascade the training down to CHWs. This knowledge cascade model is scalable but vulnerable to content dilution and variable delivery, so quality assurance mechanisms such as standardized materials, competency assessments, mentorship systems, periodic refreshers, and feedback loops must be embedded at every level. For a deep dive on this new approach, see page 10.

CHW Carolyne attends to her client Harriet in Webuye West Sub-County, Bungoma.

- **Scaling Bungoma County operations:** March marked the first month of service delivery for the 1,242 CHWs in Bungoma. They recorded good results, although it takes time to sensitize new CHWs to their activities, so impact will improve in the months ahead. We plan to scale to a total of 3,590 CHWs in the county by the end of the year.

- **Launching an impact optimization plan with marked improvement:** We rolled out a structured performance improvement plan with improvements across some KPIs seen by March. This entails weekly reviews with a focus on optimized household coverage and prioritization of integrated core services. CHW mentorship and refreshers through quality supportive supervision will also help address their capacity issues, especially on entry points for iCCM services—the care for children sick with malaria, pneumonia, and diarrhea. Commodity availability and advocacy are further being prioritized to reduce on-and-off stockouts. ■

Revamped Implementation Support: Optimizing Government-Led Community Health at Scale

Since 2019, Living Goods has co-implemented community health alongside county governments in Kenya as a key strategy for building community health systems that perform, and will keep performing long after our partnership has ended. We've learned a great deal since then about what works and what's needed to drive deeper, more sustainable impact at scale. In Bungoma, Kenya, we're now testing an optimized implementation support model that will do just that.

What's staying the same?

The heart of co-financed implementation support is not changing: we are working hand-in-hand with government partners to manage and fund high-performing community health programs. Our focus remains ensuring every family can access high-quality, affordable healthcare no matter where they live. We are strengthening public community health systems so governments can lead and maintain them in the long-term.

What's changing?

What's changing is how we deliver support to governments. In particular, we're focused on evolving our government partnerships and improving supervision and digital system management. This means:

- Clearer roles and responsibilities for Living Goods and governments that are established from the start and evolve year over year, with defined impact milestones and exit plans attached.

CHW Carolyne Nanjala attends to a client, Jescah and her two-months-old baby in Muteremko 'A' Village, Bungoma County.

- Upskilling Living Goods staff to ensure key capabilities are embedded at the right level of government, enabling best practices to cascade throughout the system.
- Ministry of Health trainers will lead all CHW training, with Living Goods focused on enhancing curricula, with an emphasis on performance management.
- A greater focus on equipping sub-national Ministry of Health teams to effectively lead and manage digital systems.
- Integration of new digital and data tools, including a Next-Generation Supervisor App and intelligent dashboards, to help supervisors and county leaders understand and act on the data that drives health impact.

Why Bungoma?

Bungoma was selected based on our scoping criteria – high levels of child and maternal mortality, strong government co-financing commitment, and readiness for partnership. Learnings will shape how the revamped model rolls out across all our implementation support sites, including Burkina Faso later this year and potentially in new countries.

Why now?

Implementation support is a key driver of scale in Living Goods' new strategic plan, which marks our evolution from proving that government-led community health works to helping governments scale and sustain it. As governments across Africa are making historic commitments to community health, and as global health funding declines, the stakes for translating these commitments into results for families have never been higher. ■

CHWs are Bridging the Gap in Kenya's Malaria Response

The sun was beginning to set over the rolling hills of Boyani A Village in Vihiga County, Kenya, when four-year-old Ryvine went down with fever. It started as a dull lethargy, but by nightfall, the boy was burning to the touch; his appetite gone. He started shivering.

Everywhere, fever in a child is a stressful inconvenience. In rural Kenya, it is a race against time. Ryvine's caregiver sat in the dim light of their home, caught in the agonizing "wait and see" cycle that often precedes tragedy. But then, she remembered a neighbor, Lidia Mmbone, who lives in the village and protects it.

Lidia is a CHW supported by Living Goods and the Vihiga County Government. She is the lifeline of many families in Boyani A Village. When she arrived at Ryvine's bedside, her kit beside her, she started by conducting a rapid diagnostic test. The two red lines were unmistakable: **Malaria.** Given her many years in this role, Lidia has gained the trust of her community.

"Lidia came at the right time," Ryvine's caregiver recalls. **"I didn't know how serious it was, but she acted quickly. She didn't just treat the boy but she stayed with us through the process."**

Because Lidia arrived within the critical 24-hour window, she administered antimalarials, so the family did not have to endure the expensive journey to the health facility. Ryvine's recovery is part of a larger, hopeful story. Across Kenya, the fight against malaria is being won not just in hospitals, but in villages like Boyani.

This progress is fueled by a "digital-first" approach where CHWs like Lidia use digital tools to monitor seasonal outbreaks and focus on prevention approaches by ensuring families use insecticide-treated bed nets. At Ryvine's family, she spent the following days teaching the family how to clear mosquito breeding sites and proper bed net use.

"She is a blessing," the family says. ■

CHW Lidia attends to four-year-old Ryvine who had malaria.

Ryvine's recovery is part of a larger, hopeful story. Across Kenya, the fight against malaria is being won not just in hospitals, but in villages like Boyani.

We're Reengineering Our Innovation Operating System to Improve Care

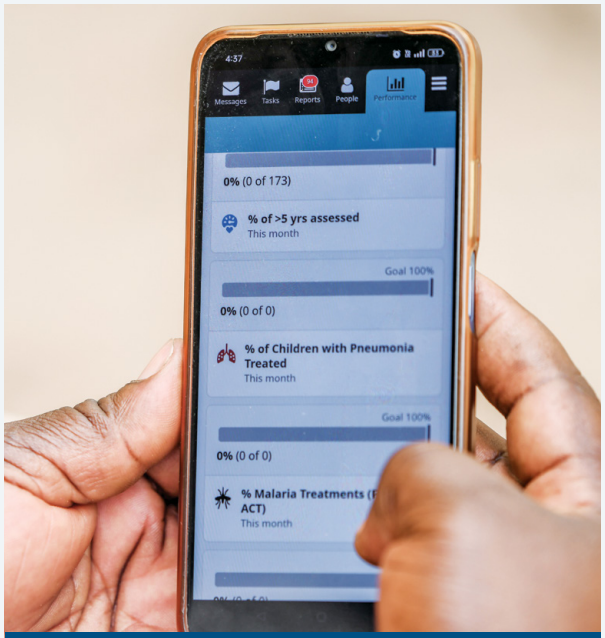
With global health funding tightening, innovation is essential to making lifesaving care smarter, faster, and more affordable at national scale. We have elevated innovation in our new strategy–focused on building smarter solutions that continuously improve performance through data, AI, and evidence.

Partnering with governments, our vision is to move from digitization to intelligence as we embed high impact, tech enabled solutions directly into government community health systems. We treat data, digital tools, and responsible AI as core system enablers to improve outcomes for mothers and children.

We will implement innovations focused on three persistent bottlenecks that constrain impact. First, CHWs are overloaded and inconsistently supported, limiting quality and consistency of care. Second, risks are detected too late, when care is more costly and potentially less effective. Third, care breaks down across the household-to-facility continuum, undermining results.

Implementing innovations to address these bottlenecks will require a shift to an agile innovation operating system where we prioritize evidence-based problems, apply clear stop-go decision points, and embed continuous learning. This approach will allow us to move faster and more strategically to accelerate the transition from ideas to system-wide implementation.

Along the way, we are strengthening our technology and AI capabilities by building on a decade of digital experience while integrating new tools that support scale, accountability, and government adoption. ■



A close-up image of the summarized workflow on a digital device.

2026 Priorities: The Bridge Year from Experimentation to Scale Readiness

Build the engine

Implement the new operating model, launch quarterly learning cycles and organize delivery around clearer authorities.

Prove priority projects

Run disciplined pilots across E-learning, the next generation supervisor app, and Community Event-Based Surveillance.

Prepare adoption

Generate evidence and knowledge products so projects move toward institutionalization and financing.

What this means: Innovation is no longer a side portfolio. The 2026 question is which projects are strong enough to justify deeper investment, explicit government pathways and scale-readiness work.

ENABLING ENVIRONMENT

Institutionalizing Performance Management to Improve Health Outcomes

Uganda and Kenya are taking deliberate steps to institutionalize performance management within their community health systems, recognizing it as a prerequisite for improving service quality and health outcomes at scale. Both countries are moving away from fragmented approaches toward standardized, government led systems that set clear expectations for performance, supervision, and data use.

In Uganda, this shift coincides with the introduction of Community Health Extension Workers (CHEWs), a professionalized cadre designed to strengthen service delivery and supervision at the community level. Drawing on our deep practical experience in strengthening workforce performance, Living Goods contributed significantly to the development of the recently adopted national CHEW Performance Management Framework, which embeds clear standards and accountability across the full workforce lifecycle—from recruitment and ongoing training to supportive supervision and performance-linked compensation. The framework shows how digital tools connect CHEWs to supervisors and decision-makers in near real time, enabling fast course correction and consistent quality of health services. By formalizing standards and incentives, Uganda aims to stabilize the workforce, reduce attrition, and maintain full household coverage nationwide.

Living Goods engaging with Bungoma County health and finance leaders to align budget priorities and strengthen data-driven health financing.

Kenya's approach builds on an already extensive community health infrastructure. Rather than restructuring the workforce, Kenya is strengthening the supervisory backbone that drives performance. Its supervision framework—under development—standardizes how supervisors are trained, how supervision occurs, and how data from eCHIS informs decisions. Digital checklists, dashboards, and clear targets shift supervision from ad hoc inspection to structured coaching and mentorship, improving accountability and equity across more than 11,000 community health units supporting 107,000 CHWs. ■

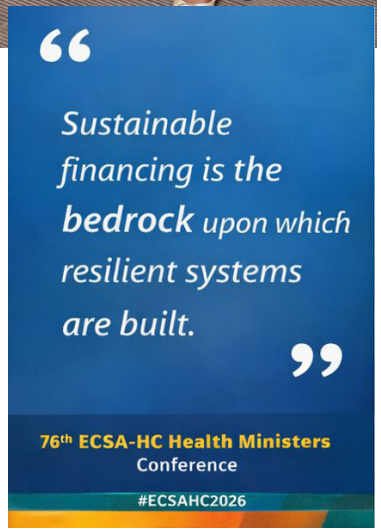
Both countries are moving away from fragmented approaches toward standardized, government led systems that set clear expectations for performance, supervision, and data use.

Driving Policy and Systems Change in Community Health

Living Goods works across the community health ecosystem to translate global and regional convenings into policy and implementation.

- At the 76th ECSA Health Ministers Conference, we contributed to the discussions around shifting from donor-dependent community health systems to government-led, domestically financed models. Co-presenting with Africa Frontline First, Living Goods supported a ministerial communiqué that positions community health as a results-driven investment for Ministries of Finance. Countries committed to output-based financing, annual performance scorecards, and fully costed primary healthcare plans.
- At the India AI Impact Summit, Living Goods facilitated targeted South–South learning by supporting government delegations from Kenya and Burkina Faso to engage directly with India's experience. The exchanges gave delegations firsthand exposure to what effective scale looks like in a professionalized, digitally enabled health workforce that's grounded in national digital public infrastructure. By connecting policymakers with practitioners operating at scale, we reinforced our role as a government strategic partner in digital health transformation.
- In February, Living Goods hosted a stakeholder event in Nairobi, attended by national and county government leaders, implementing partners, our board members and staff, and long-time champions of community health. **Mary Muthoni, CBS, HSC.**, Principal Secretary for Public Health and Professional Standards at Kenya's Ministry of Health acknowledged the role Living Goods has played in strengthening Kenya's health system. ■

> **"Long before national scale-up, you partnered with county governments in Kisumu, Isiolo, and beyond to show that a digitally enabled, trained, supervised, and compensated workforce can lead to measurable impact. These practical lessons are now shaping national policy."**



Q1 2026 KPIs

	LEARNING SITES						IMPLEMENTATION SUPPORT								Total
	Burkina Faso		Kenya: Busia County		Uganda		Busia, Kenya		Kenya: Kisumu County		Kenya: Vihiga County		Kenya: Bungoma County[1]		
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	
Monthly Per-CHW Impact Metrics															
New Pregnancies Registered	2.5	3.6	0.8	0.7	1.3	1.3	0.8	0.5	0.8	0.5	0.8	0.5	0.8	0.5	0.9
% of 4+ ANC visits	N/A	N/A	64%	79%	64%	55%	64%	70%	64%	71%	64%	81%	64%	57%	69%
% Facility Delivery	N/A	N/A	85%	98%	85%	91%	85%	92%	85%	97%	85%	97%	85%	96%	95%
% On-Time Postnatal Care Visit	N/A	N/A	64%	78%	64%	94%	64%	48%	64%	61%	64%	58%	64%	19%	61%
Couple Years Protection	2.0	1.6	6	5.9	4	6.9	6	4.9	5	6.3	4	6.6	2.5	3.2	5.5
% Children 9-23 Months Fully Immunized[2]	N/A	N/A	85%	TBD	85%	89%	85%	TBD	85%	TBD	85%	TBD	85%	TBD	89%
Under-5 Treatments or Referrals	18.0	15.4	14	15.9	16	29.9	11	1.9	8	3.5	8	6.8	5	0.8	9.4
Under-1 Treatments or Referrals	N/A	N/A	5	1.4	4	2.6	2.6	0.2	2	0.2	2	0.5	1	0.1	0.7
% Sick Child Facility Referrals Completed	N/A	N/A	68%	69%	68%	62%	68%	50%	68%	70%	68%	96%	68%	55%	68%
Program Quality Metrics															
% Weekly Active Users [NEW]	50%	N/A	50%	N/A	50%	74%	50%	N/A	50%	N/A	50%	N/A	50%	N/A	N/A
% CHWs in Stock w/ Essential Commodities[3]	60%	47%	60%	61%	60%	91%	50%	29%	50%	29%	50%	10%	50%	40%	40%
% CHWs w/ Supervision in Last 1 Month	75%	85%	75%	59%	75%	94%	60%	60%	60%	28%	60%	58%	60%	TBD	52%
CHW Income	$30	$30	$38	$38	$20	$17	$38	$38	$38	$38	$38	$38	$38	$38	$34.02
Impact Total Metrics[4]															
Active CHWs (3-Month Active)	820	818	635	617	1,580	1,531	1,565	1,543	3,000	2,941	1,450	1,443	910	910	9,803
Population Served	677,108	675,708	285,750	277,650	948,000	918,600	704,250	694,350	1,140,000	1,117,580	594,500	591,630	418,600	418,600	4,694,118
Total New Pregnancies Registered	6,207	8,448	1,572	1,223	5,333	5,489	3,521	2,384	6,750	4,488	3,263	2,291	2,048	4,938	29,261
Total Under-5 Treatments or Referrals	22,716	22,116	27,146	29,016	74,655	127,893	49,298	8,632	67,500	30,378	35,888	29,444	13,309	8,257	255,736
Total Under-1 Treatments or Referrals	N/A	N/A	8,573	2,589	16,709	11,548	12,324	833	16,875	2,055	8,156	2,011	2,457	595	19,631
Total Couple Years Protection	7,380	1,955	11,430	10,201	17,775	27,650	28,170	19,567	47,250	45,055	19,575	26,903	7,166	19,566	150,897
Total Unintended Pregnancies Averted	1,784	472	2,763	2,550	4,296	6,683	6,809	4,892	11,420	11,264	4,731	6,726	1,732	4,892	37,478
Net Cost per Capita (Annualized)	$3.63	$3.63	$2.77	$2.08	$2.18	$2.18	$1.07	$1.80	$0.76	$0.76	$1.01	$1.01	$0.45	$0.45	$1.21

NOTES:

[1] Bungoma has progressive targets as CHWs onboard throughout the year; per-month targets increase in future quarters.

[2] Kenya immunization data computation was affected by workflow gaps during the quarter.

[3] All Kenya sites are paid by both national and county government. The income indicated is the standard government rate; however, their payments were delayed during Q1.

[4] Kenya family planning KPIs have been computed with complementary Ministry of Health data given workflow gaps.

THANK YOU

Since 2008, Living Goods has brought essential healthcare to millions of people outside the reach of the health system.

Your partnership makes this work possible.

But still more families await care, and investment in global health is waning.

Now's the time to resource CHWs. Join us, and together we can ensure no family is left behind.