QUARTERLY REPORT

Q2 | April – June 2026

EXECUTIVE SUMMARY

Performance saves lives. That conviction drives everything Living Goods does.

For us, performance is the ability to deliver reliable, measurable results at scale—turning policy, financing, and delivery into care people can depend on, so that when families need health care, it's there.

This is built through continuous learning: understanding what drives results, what doesn't, how systems break down under pressure, and how to make them stronger.

That commitment to learning—and to acting on what we learn—is a discipline that has shaped how we approach this bridge year toward our new strategy. Halfway through 2026, we are making progress testing, refining our approach, and building the evidence base that will continue to shape implementation.

Importantly, as governments across Kenya, Uganda, and Burkina Faso deepen their commitments to community health, **Living Goods is working alongside them as a performance partner—helping build affordable, intelligent, high-impact community health systems that deliver responsive and durable care to more families.**

This quarter, our impact showed up in concrete ways.

- **Expanding our reach:** We now support nearly 13,000 community health workers (CHWs) serving 6.2 million people in three countries.
- **Implementation Support (IS) 2.0:** Evidence from two optimized implementation support sites offer promising early signs that IS 2.0 is the right path to government-led performance at scale. With technical support from Living Goods, government teams in Bungoma, Kenya, and Zorgho, Burkina Faso are leading supervision and digital systems management, and CHWs are exceeding early targets.
- **Improving outbreak readiness:** In Uganda, Living Goods provided technical assistance to the government to integrate Community Event-Based Surveillance (CEBS) into its electronic Community Health Information System (eCHIS). By enabling CHWs to report unusual health, climate, and environmental events, CEBS gives decision makers an earlier view of what is happening in communities, strengthening the health system's ability to detect and respond to emerging health threats, including the recent Ebola outbreak.
- **Building government capacity for digital health governance:** In Kenya, government teams are building skills to manage digital health systems independently. Over the past six months, they resolved 2,650 digital issues without escalation, accounting for 61% of all reported cases. These lessons are now being adapted for Burkina Faso and Uganda.
- **Shaping practices and financing for community health:** We led discussions on the responsible use of artificial intelligence (AI) in community health and drove advocacy that secured domestic funding commitments for CHWs and essential health services in Burkina Faso, Kenya, and Uganda.

Each of these efforts shows the same underlying commitment to learn, improve, and deliver. What follows is a closer look at our progress and the work still ahead. ■

Cover: *CHP Carolyne Nanjala with her client, Jescah and her two-months-old baby, Angelina at their home in Webuye West Sub-County, Bungoma.*

"In the month of April, Webuye West recorded one case of unskilled delivery compared to 17 in the neighboring sub-county. With close supervision of community health promoters (CHPs)–CHWs–by the community health assistants (supervisors), our target is to ensure that Webuye West does not experience any maternal or newborn deaths," said Humphrey Nyongesa, the Community Health Coordinator for Webuye West Sub-County, Bungoma. Barely six months into Living Goods' partnership with Bungoma County, Nyongesa said the Sub-County was already showing improvements in maternal and child indicators ranging from antenatal and postnatal care facility visits, skilled deliveries, reduced maternal and child mortalities, and a generally motivated workforce. ■

IMPACT OVERVIEW

Living Goods' Q2 2026 Accomplishments

325,707
sick child treatments

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

43,088
pregnancies supported

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

86%
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.

54,526*
couple years of protection

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

**Family planning KPIs are undereported given e-CHIS CHW application workflow gaps in Kenya.*

$1.24
cost per capita

We operate at a price governments can sustain, ensuring vital services reach millions who might otherwise go without care.

Q2 2026

OUR IMPACT

12,959

COMMUNITY HEALTH WORKERS SUPPORTED

6.2 million

PEOPLE REACHED WITH LIFESAVING HEALTHCARE

IMPLEMENTATION SUPPORT SITES

Government in the Lead: Early Results from IS 2.0

Implementation support 2.0 builds on eight years of co-implementing and co-financing community health programs with Kenyan county governments. It addresses the challenges that most often limit performance at scale: supervision quality, supervisor capacity, data use for monitoring and improving performance, co-financing mechanisms that support sustainable CHW remuneration, and government management of digital tools.

IS 2.0 is a key example of government performance partnership in action. Through this approach, we equip CHWs and supervisors with the capabilities and tools they need to deliver consistent care to families, strengthen how data is used so that information drives action, and build capabilities within government to effectively own and maintain digital tools. The result: CHWs have the routines, tools, and support to perform reliably; supervisors use live data to coach and drive improvement; and government is managing the digital systems that support frontline workers—all within a budget the government can sustain.

This approach is already paying off. **The IS 2.0 site in Kenya, Bungoma County, has consistently been one of the country's top-performing counties. CHPs exceeded early implementation targets across several indicators,** including pregnancy registration and completed referrals for children under five. Notably, we have seen steady improvement across all tracked areas, a stronger trajectory than we typically see at this stage of implementation.

CHP Carolyne Nanjala accompanied by her supervisor Jackline to attend to a pregnant client, Harriet, at her home in Webuye West Sub-County, Bungoma.

While it is still early, these results suggest that government-led implementation can achieve and maintain strong performance. We're codifying these lessons into a practical playbook for future partnerships, including opportunities for in-country scale-up.

Performance in other Kenyan Counties

In May, we completed the transition of the Busia learning site to implementation support, fully consolidating our work in Kenya under the government-led approach. We are applying lessons from Bungoma IS 2.0 in Vihiga, Kisumu, and Busia to further strengthen performance.

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Teso-North Sub-County Community Focal Person Alfayo Ogecha (left) supervises CHP Winnie Juma as she attends to her client, Cynthia Atyang' and her 17-months-old baby at their home in Kocholya, Busia, County.

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More CHAs (supervisors) were equipped with digital tools this quarter, contributing to a 16% increase in CHP mentorship and supervision compared to Q1. We also saw improvements in prenatal care, driven by the use of estimated delivery date (EDD) data to identify and follow up with pregnant women, stronger facility-community linkages, and the integration of traditional birth attendants as birth companions.

In counties where under-five positive diagnoses per CHP exceeded targets, performance was driven by refresher training on integrated community case management (iCCM) case detection, stronger test-and-refer messaging, expanded under-5 coverage, and targeted advocacy to improve commodity availability.

Our advocacy efforts also helped address workflow gaps in immunization referrals and postnatal care within the eCHIS application, improving access to reliable data for program monitoring and decision-making. ■

Burkina Faso

Building on lessons from Bungoma County, Kenya, **we are testing a version of the optimized Implementation Support 2.0 approach tailored to the Burkina Faso context in Zorgho, where we trained 516 CHWs and 89 government supervisors.**

Early results are encouraging. Within the first month of implementation, supervision and service delivery improved significantly, with pregnancy registrations, malnutrition screening, and maternal indicators increasing more than six-fold. CHWs in stock of essential commodities hit 71%, exceeding the 67% target. These gains were driven by strong government leadership, with MoH supervisors, regional health officials, and district health teams leading supervision and performance monitoring during rollout.

By funding more than three-quarters of program costs, the government is demonstrating real ownership and building a solid foundation for long-term sustainability. As the Zorgho District Medical Chief put it, ***"IS 2.0 is not a Living Goods project. It is a government program that Living Goods supports."*** ■

Cross-country learning on IS 2.0 in Ouagadougou, bringing together teams from Burkina Faso, Kenya, and Global Functions.

LEARNING SITES

Burkina Faso's learning sites surpassed expectations in pregnancy registration, reaching 3.8 per CHW per month, more than 50% above the 2.5 target. This result was driven by teamwork among midwives, CHWs, and local associations to identify and register pregnancies early, catching women before they slip through the cracks.

Family planning (FP) also followed an upward trajectory. Couple-years of protection per CHW rose from 1.6 in Q1 to 2.6 in Q2, approaching the target of 3.0. The improvement came from some concrete changes—ambassadors, maternity staff, and CHWs actively sought out contraceptive users and brought them into awareness sessions, rather than waiting for them to come in. FP was also reinforced during routine supervision, keeping it visible and actionable for CHWs. Equally important was **the shift toward a continuum of care approach—integrating FP counseling into the broader care journey that includes antenatal visits, delivery, newborn care, and postpartum follow-up so that women received comprehensive guidance and support across multiple touchpoints.**

Decline in under-five positive diagnoses and treatment were driven by amoxicillin stockouts and seasonal changes that reduced malaria and pneumonia prevalence.

In Uganda, as malaria cases rose across the country, CHWs were increasingly called upon to diagnose and treat sick children. More than 90% maintained stocks of essential commodities, with nearly two-thirds supplied through government health facilities, ensuring uninterrupted care.

Burkina Faso: CHW Tapsoba Mariam sensitizes women about family planning options.

Under-five treatments averaged 25.8 per CHW per month, far exceeding the target of 16.

These results were driven by close collaboration with the MoH, including targeted CHW supervision, ongoing capacity building, and improvements to eCHIS workflows. While responding to immediate health needs, the MoH also continued to invest in its digital health systems, integrating surveillance workflows with public health emergency management systems and piloting new tools to improve data quality.

Looking ahead, we have developed a performance improvement plan to address gaps in pregnancy registration and antenatal care coverage. Running from August through December, the plan will focus on identifying and registering pregnancies earlier and encouraging women to begin antenatal care visits during the first trimester.

"I Could Have Lost My Baby" - Harriet

CHW Susan wraps a MUAC tape around little Jibu's arm as his mother, Harriet, watches closely. It is a routine follow-up visit in Namataba Village, Wakiso District, Uganda, one of many Susan makes each week. Just a few months earlier, Harriet faced a frightening situation. At around three o'clock in the morning, Jibu would not stop crying. Assuming he was simply being fussy and sensitive to heat, Harriet tried to comfort him. Nearby, CHW Susan heard the baby's persistent cries and decided to check on the family.

As she examined Jibu, Susan noticed something Harriet had missed: his chest was drawing in as he struggled to breathe, a danger sign requiring urgent medical attention. Susan immediately referred him to the health facility, where he received life-saving care for pneumonia.

Looking back, Harriet believes the outcome could have been very different.

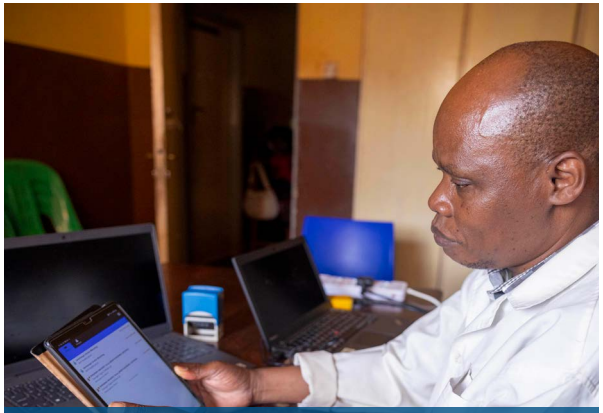
"If Susan hadn't come to check on us that night, I don't know what would have happened. I think I could have lost my baby."

Recognizing such danger signs early is part of Susan's everyday work, but it also requires continuous learning and close community engagement. Through regular household visits, she checks on pregnant women, assesses children under five for common childhood illnesses such as malaria, diarrhea, and pneumonia, treats uncomplicated cases, and refers patients who need care beyond what she can provide.

"I follow up to make sure every child I refer receives care," she says. ■

CHW Susan during a routine follow-up visit at her neighbors', Harriet and son Jibu.

Innovation in Action: Building Stronger Outbreak Readiness



Uganda: Kasiko Willy, Facility In-charge and Focal Person at Bweyogerere Health Centre III, reviews information on a tablet used to support patient follow-up and coordination with CHWs.

In outbreak response, speed matters. But the ability to respond quickly is built long before an emergency begins. Communities need a simple way to raise alerts, while health workers need a clear process to investigate them, and decision-makers need timely information to act. A surveillance system works best when everyone can see what happens next, from the first report to response and feedback.

In Uganda, Living Goods provided technical assistance to the government to integrate Community Event-Based Surveillance (CEBS) workflows into the national eCHIS. These workflows have given CHWs a structured way to identify and report unusual health, climate, and environmental threats. Verified reports move

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through district surveillance teams into national dashboards and emergency coordination structures.

By embedding CEBS into routine health systems, surveillance becomes part of everyday public health practice rather than a stand-alone reporting channel. This approach proved especially helpful during the recent response to an Ebola outbreak that began in the Democratic Republic of Congo and spread into Uganda. Working with the MoH, we accelerated training for CHWs and supervisors to strengthen local detection and reporting. **CEBS workflows helped frontline workers connect potential threats to the national response system at a time when every hour mattered.**

Implementation of CEBS in Uganda builds on lessons from a six-month pilot in Kenya in 2025, in which 286 reported signals by CHWs were confirmed as public health events and 225 were verified by supervisors. The pilot highlighted some critical lessons around how to manage delays between verification and response, the barriers of network connectivity on timely reporting, and the importance of clearly defining disease outbreak signals.

Drawing on lessons from both countries, Uganda is now scaling CEBS to nearly 50 digitized districts, strengthening every step from detection and verification to response, closure, and feedback, in line with national frameworks. The goal is to make community-level disease surveillance routine, resilient, and firmly integrated into the country's epidemic and pandemic preparedness system. ■

What it Means to Feel Supported

Iboudo Mariam, 30, lives in Tanghin Yorgo, a village in the commune of Nagréongo in Burkina Faso's Oubritenga Province. In this village, like many others, conversations about health, especially family planning, are often difficult. Many women have limited access to information and services.

That began to change when CHWs, including Tapsoba Mariam, started holding discussions in the village. They spoke with women about family planning, pregnancy follow-up, and infant care, creating a space where questions could be asked openly and without judgment.

"I truly understood, for the first time, that there were several contraceptive methods," says Mariam.

The CHWs took time to explain the different options and referred women to the Nagréongo health center when additional services were needed. Later, some family planning services became available directly within the community, making access easier and more convenient.

"We no longer had to travel to the health center. It was as if healthcare itself was coming closer to our lives," Mariam recalls.

After learning about her options, Mariam chose a three-month contraceptive method. The impact was immediate. Accessing services became easier and more discreet, as the CHW lived just a short distance from her home.

"What used to be a long and sometimes uncomfortable process has become simple, almost natural," she says.

ILBOUDO Mariam (3rd from left), with other women from her community after a health education session by CHW Mariam.

Beyond convenience, Mariam values the ongoing support she receives.

"I am not left on my own. When the date approaches, she reminds me. She follows my journey and looks out for me."

Today, Mariam speaks openly about her healthcare choices and the support that helped her make them. She credits the MoH for bringing services closer to communities through CHWs and Living Goods.

"In my village, healthcare is no longer far away. It has gently entered our lives, and it is here to stay." ■

ENABLING ENVIRONMENT

Lessons in Governing Digital Health Systems

Governments are rapidly digitizing health systems, creating new opportunities to improve service delivery, support health workers, and strengthen data-driven decision-making. But technology alone does not determine success. Many digital health challenges are ultimately governance challenges, making institutional capacity and financing just as important as the technology itself.

Building resilient digital health governance requires shared responsibility and real-world experience to take root. **In Kenya, rather than creating parallel structures, we've invested in Digital Delivery Teams (DDTs)—formerly PMUs—establishing a partnership framework that brings government and partner staff at the national level to work side by side.** Through daily collaboration, coaching, and problem-solving, teams have improved their ability to manage digital tools and address challenges. Unlike traditional support models, the goal here is not to build a team that runs the system on government's behalf, but to build a government team to run, own, and continuously improve the system.

We've also learned that support works best when it's close to the people using the technology every day. Together with Kenya's MoH, we've trained community health supervisors to serve as Digital Champions, making them the first point of contact for CHWs when they need technical support. Resolving common issues closer to where care is delivered reduces downtime and helps health workers continue serving families without interruption.

A Living Goods Digital Health staff (second right) supervises a training for Digital Champions and CHAs for Chakol North Ward during their monthly meeting at Alupe Sub-County Hospital, Busia.

To support this approach, we implemented Afya Desk, an issue tracking platform that enables government teams to log, prioritize, and track technical issues until they are resolved. The value of a tool like Afya Desk is in creating a feedback loop: problems are identified, resolved, and teams can use those insights to improve the system. Over the last 6 months,

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Over the last 6 months, the Digital Champions and community health supervisors have resolved at least 2,650 issues without escalation across Busia, Kisumu, Vihiga, and Bungoma counties, accounting for about 61% of all issues reported during this period.

Felix Duya, a CHA of Gem Rae and Lisana CHUs in Nyakach Sub-County, Kisumu.

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the Digital Champions and community health supervisors have resolved at least 2,650 issues without escalation across Busia, Kisumu, Vihiga, and Bungoma counties, accounting for about 61% of all issues reported during this period.

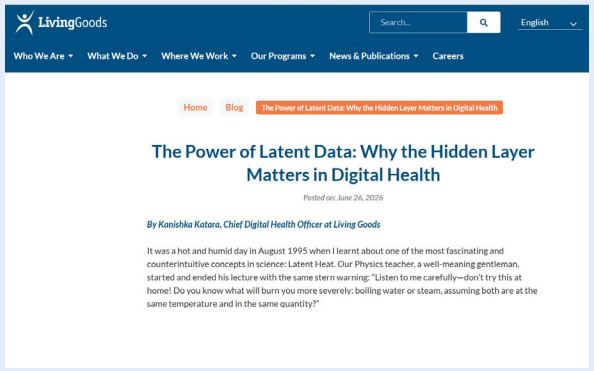
"It's a welcome strategy for accountability of cases solved at the Community Health Unit (CHU) level. It aids in tracking the cases raised, thereby making it a centralized system for real-time solutions," says Felix Duya, a CHA of Gem Rae and Lisana CHUs in Nyakach Sub-County, Kisumu.

After piloting the platform in Kenya, we're now adapting it for Burkina Faso and Uganda to support government teams to find a more consistent issue management approach. As we continue to test and refine these solutions, we have learned that capability is built through doing. Joint planning, mentoring, troubleshooting, and shared decision-making strengthen government ownership far more effectively than standalone training. ■

Media Corner

The Power of Latent Data: Why the Hidden Layer Matters in Digital Health

By Kanishka Katara, Chief Digital Health Officer at Living Goods



Governance, scale, and integration: building community health worker systems ready for artificial intelligence

THE LANCET Primary Care

How an AI-powered app is helping Busia track missed visits, flag underperforming CHPs and keep mothers on care

By Angeline Ochieng, Daily Nation

Driving Smarter Investments in Community Health Systems

Emilie Chambert, CEO of Living Goods, at the CHIC convening during WHA79, held at the Warwick Hotel in Geneva. © Sigfredo Haro

Living Goods is helping to define how AI can transform community health systems at scale. CEO Emilie Chambert and Chief Digital Health Officer Kanishka Katara co-authored a commentary in THE LANCET Primary Care with partners from the Community Health Impact Coalition, drawing on evidence from AI use in CHW programs across 18+ countries. The publication called for AI tools that governments can own, manage, and integrate into national health systems. It emphasized that AI should support CHWs, not replace them, helping health workers deliver better care and reach more families.

In Burkina Faso, our continued collaboration with the MoH contributed to securing more than one-third of the funding needed to support the entire community health workforce and maintain regular government payments for their compensation.

Building on this evidence, Living Goods convened and contributed to high-level discussions with governments, funders, technology partners, and other health implementing organizations at the Skoll World Forum and the World Health Assembly. Through these discussions, **Living Goods encouraged decision-makers to move beyond AI pilots and invest in sustainable, government-led intelligent health systems. The conversations helped inform approaches to AI governance, digital health investments, and the responsible use of AI in community health programs.**

At the same time, we are working alongside health ministries, parliamentarians, and multi-stakeholder platforms to ensure that community health systems are backed by sustainable financing.

In Kenya, our advocacy contributed to securing national budget allocations for CHP compensation and social health insurance premiums. We also worked with county governments to increase investments in supervision and digital tools that help CHPs deliver quality care.

In Uganda, our ongoing engagement with parliamentary committees and government leaders contributed to securing more than 6% of the national budget for health. The FY2026/27 budget prioritizes maternal and child health, nutrition, and immunization, increasing investment in essential services that CHWs provide.

In Burkina Faso, our continued collaboration with the MoH contributed to securing more than one-third of the funding needed to support the entire community health workforce and maintain regular government payments for their compensation.

Collectively, these efforts are helping governments build stronger, domestically financed community health systems. ■

Q2 2026 KPIs	LEARNING SITES				IMPLEMENTATION SUPPORT SITES										Total
	Burkina Faso		Uganda		Busia		Kisumu		Vihiga		Bungoma[1]		Zorgho		
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	
Monthly Per-CHW Impact Metrics															
New Pregnancies Registered	2.5	3.8	1.3	1.4	0.8	0.8	0.8	0.6	0.8	0.6	0.8	1.2	2.5	4.2	1.2
% of 4+ ANC visits	N/A	N/A	64%	66%	64%	75%	64%	78%	64%	80%	64%	65%	N/A	N/A	72%
% Facility Delivery	N/A	N/A	85%	92%	85%	94%	85%	98%	85%	97%	85%	95%	N/A	N/A	95%
% On-Time Postnatal Care Visit	N/A	N/A	64%	95%	64%	78%	64%	80%	64%	81%	64%	48%	64%	N/A	72%
Couple Years Protection	2.0	2.6	4	8.1	6	0.5	5	0.5	4	0.4	2.5	0.5	0.5	0.8	1.5
% Children 9-23 Months Fully Immunized	N/A	N/A	85%	85%	85%	93%	85%	72%	85%	97%	85%	89%	N/A	N/A	86%
Under-5 Treatments or Referrals	18.0	13.4	16	32.5	11	7.3	8	4.8	8	9.1	5	3.0	7	1.0	8.9
Under-1 Treatments or Referrals	N/A	N/A	4	2.8	2.6	0.6	2	0.3	2	0.6	1	0.2	N/A	N/A	72%
% Sick Child Facility Referrals Completed	N/A	N/A	68%	61%	68%	98%	68%	98%	68%	99%	68%	96%	68%	N/A	93%
Program Quality Metrics															
% CHWs in Stock w/ Essential Commodities	60%	21%	60%	90%	50%	60%	50%	64%	50%	50%	50%	42%	50%	71%	42%
% CHWs w/ Supervision in Last 1 Month	75%	91%	75%	97%	60%	68%	60%	67%	60%	80%	60%	43%	60%	89%	53%
CHW Income per Month[2]	$30	$30	$20	$17	$38	$38	$38	$38	$38	$38	$38	$38	$30	$30	26
Impact Total Metrics															
Active CHWs (3-Month Active)	820	815	1,580	1,538	2,200	2,177	3,000	2,944	1,450	1,446	3,590	3,584	526	456	12,959
Population Served	677,108	672,908	948,000	922,800	990,000	979,650	1,140,000	1,118,720	594,500	592,860	1,651,400	1,648,640	315,600	273,600	6,209,178
Total New Pregnancies Registered	6,207	9,026	5,333	6,417	5,280	5,193	6,750	5,126	3,263	2,762	8,616	12,667	1,315	1,897	43,088
Total Under-5 Treatments or Referrals	22,716	19,071	74,655	146,672	72,600	47,045	67,500	41,567	35,888	39,061	53,850	32,062	1,841	229	325, 707
Total Under-1 Treatments or Referrals	N/A	N/A	16,709	12,859	17,160	4,033	16,875	2,855	8,156	2,675	10,770	2,472	N/A	N/A	24,894
Total Couple Years Protection[3]	7,380	6,009	17,775	34,620	28,170	2,917	47,250	4,127	19,575	1,807	26,925	4,858	263	188	54,526
Total Unintended Pregnancies Averted	1,784	1,452	4,296	8,368	6,809	729	11,420	1,032	4,731	452	6,508	1,214	64	45	13,293
Net Cost per Capita (Annualized)	$3.60	$3.63	$2.00	$2.18	$1.20	$1.80	$0.80	$0.76	$1.00	$1.01	$0.50	$0.45	$0.90	$0.94	$1.24

NOTES:

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

[2] 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 Q2.

[3] Kenya family planning KPIs are undereported given e-CHIS CHW application workflow gaps.

THANK YOU

For families, a health system is not an institution. It's a promise. Care will be there when a child falls ill, when a pregnancy becomes dangerous, when help is needed most.

Living Goods is a government performance partner working alongside African governments to help their community health systems perform at scale, within real-world constraints, so that when families need healthcare, it's there.

Your partnership makes this work possible.

Join us, and together we can ensure systems perform reliably enough for families to count on them.

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