LEARNING & ANALYSIS BRIEF

PharmAccess FOUNDATION

LESSONS LEARNED FROM SAVING ON A DIGITAL PLATFORM

TAKING HEALTHCARE TO SLUM SCHOOLS IN NIGERIA THROUGH A MOBILE MONEY SCHOOL HEALTH FUND

Makoko, the world's largest floating slum, faces many challenges including; poor water and drainage systems, poor quality of education and limited access to proper healthcare. Despite the poor conditions, hundreds of new private schools are opening in Nigeria, many of them charging less than one dollar a week. In Makoko, Ken-Ade Private School is one of the institutions trying to provide quality education for the less privileged in society. Other than providing education for the poor, Ken-Ade school has gone a step further in trying to provide quality healthcare for its students.

KEY COUNTRY FACTS

182.2 M
population

USD 118
health expenditure per capita (2014)

71.7%
out-of-pocket expenditure (2014)

Data according to World Bank (2016)

PROGRAM FACTS

85,840
population of Makoko

Target participants
parents and guardians of pupils of Ken-Ade Private School

3 facilities and 1 pharmacy
participated in test

In September 2016, the PharmAccess Mobile Health Research Lab in Nigeria commenced the testing of a school health contributory fund using a mobile money wallet for the students of the Ken-Ade Private School, located in Lagos. The main objective of the mHealth Research Lab is to study how mobile phone and digital payment technologies can be used to improve access to affordable and quality healthcare services in resource-limited settings The mHealth Lab uses social learning and behavioral theories to rapidly test and observe participants' behavior in response to successive health experiments. More specifically, using operational research towards making evidence based decisions on product development and implementation.

Approach

The test was designed to (1) introduce and organize a platform for contributions to the health of the school pupils; (2) to assess the willingness of parents to contribute; (3) to observe any change in healthcare utilization in the participating health facilities and the target participants' health-seeking behavior and (4) if successful, to eventually scale the solution to other schools.

This test was set to run for the first term of the 2016/2017 school year (Oct. – Dec. 2016), and would be open to all students of the Ken-Ade Private School (Nursery & Primary). Parents and guardians of the pupils would be invited to contribute N300 (~$1) per term for each of their wards in the school. The school administration would also contribute a fixed amount ranging from N5,000 – N10,000 (~$15 - $30). The donor would match 50% of the total amount to further seed the fund.

The fund would be lodged in a mobile money account which would be locked for payments to only three health facilities in Makoko and one pharmacy.

A school health team was established – constituting the school proprietor, one senior teacher, two parents, and a member of the implementation agency – to manage the contributions and disbursements of the fund. Other key duties would include:

- Sensitizing, mobilizing, and encouraging parents to contribute into the school health fund;
- Monitoring fund use for incidental healthcare needs of the students;
- Liaising with the selected health facilities to receive the best quality healthcare at the optimum price;
- Deciding on school-wide health projects to be funded
- Conducting regular meetings to plan the direction and growth of the fund

Prior to the commencement of the test, the school administration, parents, and implementation agency had a meeting to discuss the objectives, and structure of the fund; including the covered health services (primary care), selected health facilities (three private health facilities in Makoko), and the period of coverage (per school term).

The following table shows an analysis of contributions by parents and guardians approached for the test.

Table 1: Household Recruitment Statistics

Parents approached	107
Parents that indicated interest by picking up the enrolment form	85
Parents who contributed	51
Total Number of Pupils	350
Pupils covered under the Fund	**87**

All students covered were given identification cards. Other planned incentives include stickers, badges, and buttons (similar to the 'I Voted' campaign). Finally, a health talk – to be given by one of the health proprietors to all students, and followed by a health screening only for covered students – is also being planned as a positive reinforcement to contributions.

Findings

Smaller Family Size

Just under half of the parents contributed, implying that 25% (See Fig. 1) of the total student population were covered. These contributions came from smaller-sized households. The average student to parent ratio of the school is 3.3, but the average for parents who contributed was 1.6.

'Wait-and-See' Approach

Most households adopted a 'wait-and-see' approach to contributions. The concept of the fund is new to most parents, and they would rather wait to see the practical operation of the fund. This is the why early positive reinforcements are important.

Female Preference?

There was a slight preference for contributing for female children. Of the total number of female dependents, 92% attended the school, and 84% were covered by the Fund; compared to male children where 88% of them attended the school, and only 78% were covered by the Fund (See Fig. 2).

Figure 1 **Students Covered by School Health Fund**

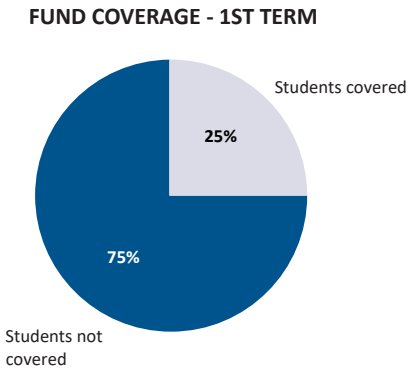
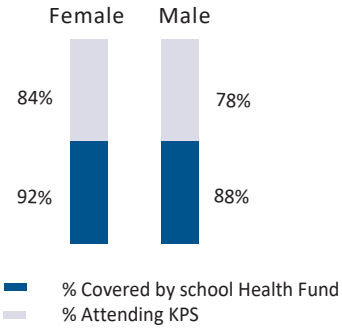


Figure 2 **Gender Distribution of Covered Students**



Ten students utilized the Fund for health services for the first school term. Some of the health facility bills were disputed by the School Health team, and the bills were reduced by 25%.

54% of the Fund was utilized by 11% of the cov-ered student population. To make the School Health Fund more sustainable, about 80% of the school population should be covered. We are expecting an increase in the percentage coverage for the next term as the benefits become more obvious.

No school-wide projects were undertaken this term, as the School Health team had decided to leave a buffer of funds for episodic health provision for the students; so there were no extras for projects. It is expected, though that as the Fund grows with contributions during the school year, school-wide projects may become feasible.

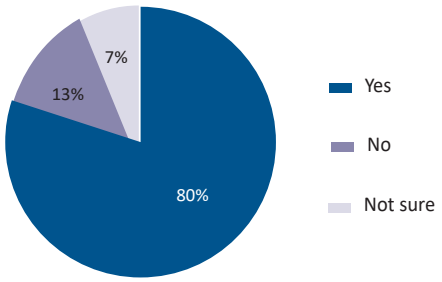
Conclusion

We will be expanding the Fund to cover these schools, and will test both centralized and de-centralized funding system to ascertain which is more efficient.

Next steps

The test is also considering utilizing the school health fund as an entry point to provide health access for other members of the contributing households. Household members would be asked to moderately increase their contributions to get the same level of coverage as their wards. The households would be surveyed to determine their willingness to join this expanded Fund. Parents overwhelmingly requested that the Fund should be extended to cover other members of their households (See Fig. 3). We hope that this will shed more light on using pre-existing platforms as an entry point to increased health access, as well as the sustainability of small-scale contributions for health finance.

Figure 3 **Expansion of the health fund cover to other household members**



Lessons learned

- **The enrolment and contribution figures show that a sizeable number of parents and guardians are interested in contributing into a fund for the health of their children, especially those with smaller family sizes.**
- **Small projects to provide positive reinforcements for contributions are being planned for inclusion into the test. The creation and distribution of stickers, buttons, and badges would show positive reinforcement, while the screening of covered pupils will provide functional aspects of the benefits of the Fund.**
- **Other schools in the Makoko area requested a similar school health fund.**

ARTICLE TITLE & AUTHORS

Taking healthcare to slum schools in Nigeria through a Mobile Money School Health Fund

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