REDWOOD POLYCARE

Pitch Deck for an innovative Solution to Healthcare Financing in Rural AFRICA

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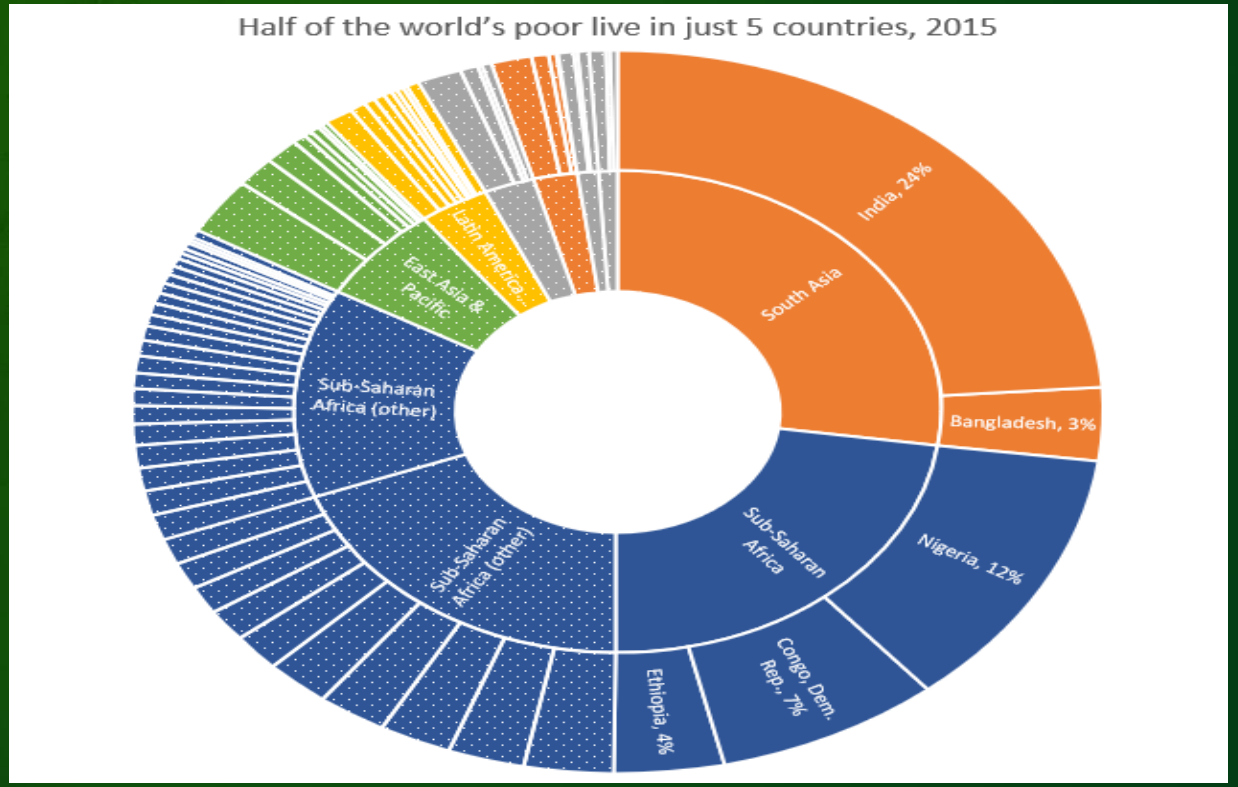
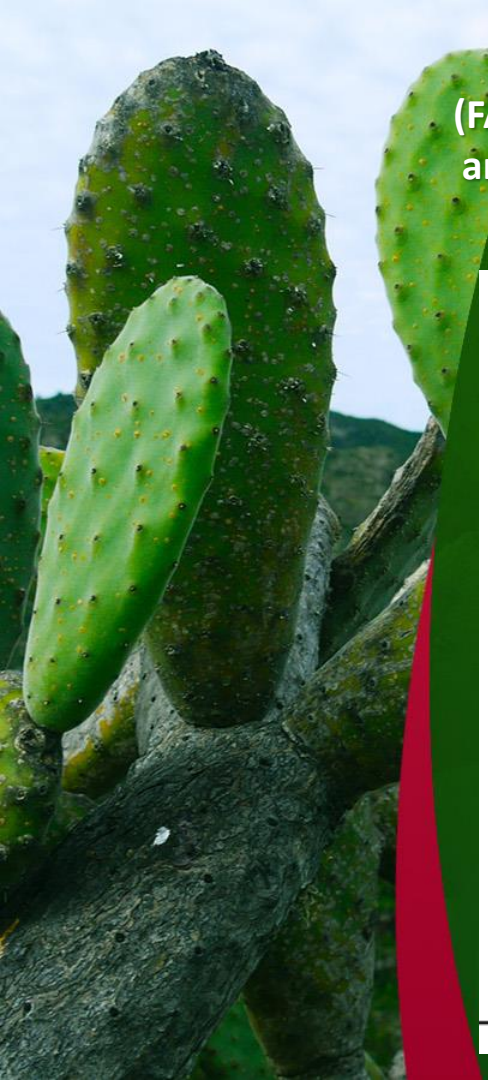
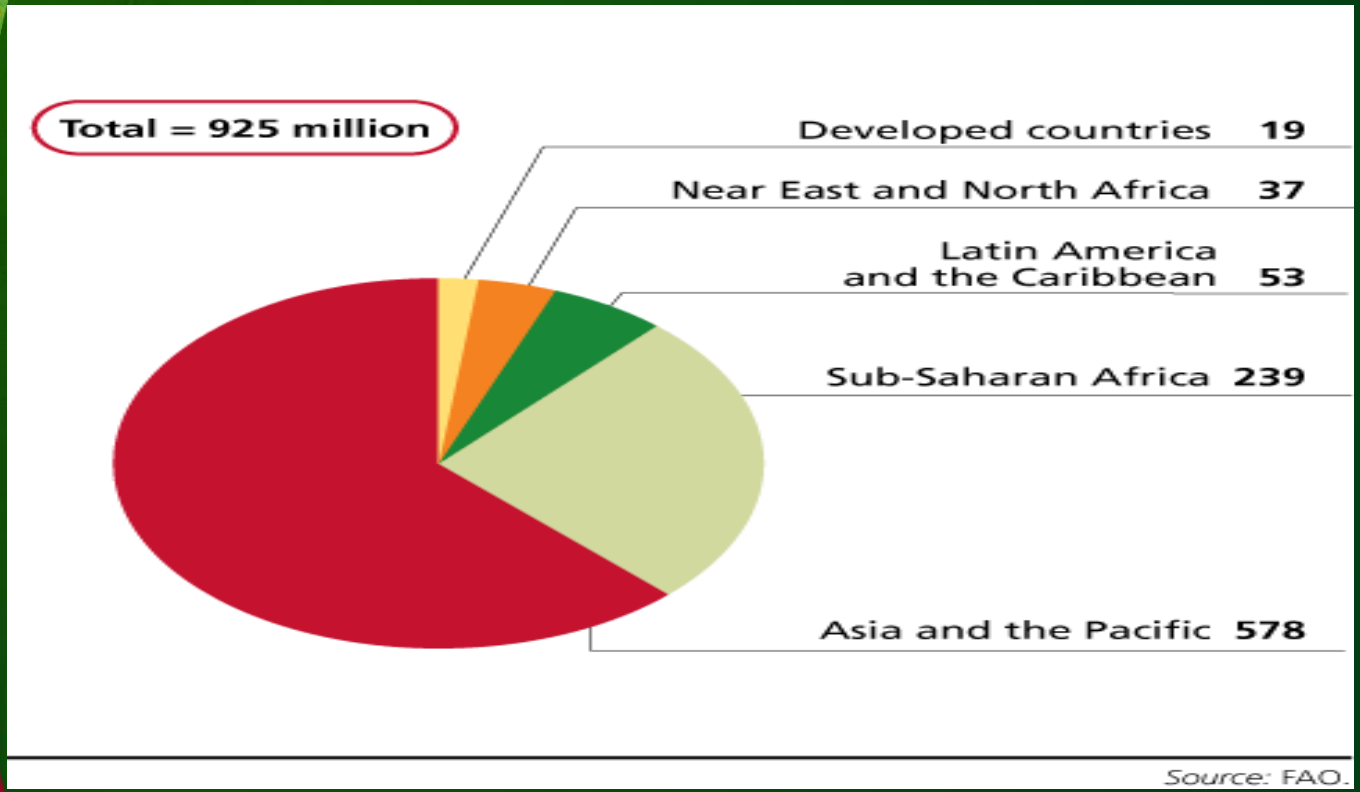
The Tragedy of Poverty- a child dies every 15 seconds around the world (WHO , 2019). because poverty promotes needless deaths.

HALF of the World's poor live on just 3 Continents…. with 41% of the world's poor located in Sub Saharan Africa alone. The poor in Africa often have little or no access to affordable health services





However…1 in 3 persons in Sub Saharan Africa are undernourished (FAO,2018),while 925 Million people suffer from HUNGER. ‘45% of Deaths among children under 5 years of age are linked to undernutrition’ (WHO, 2018), and a ¼ of the world’s HUNGRY live in AFRICA.



Re-inventing community based health insurance programs in Africa

- In CONTRAST to traditional health focused community programs, in West AFRICA, our unique community based health insurance model AGRICARE is designed to Combat the ROOT causes of preventable deaths and diseases among women and children in Africa.
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- POVERTY, HUNGER AND LOW EDUCATIONAL parameters are DIRECTLY responsible for preventable deaths and diseases in Sub Saharan Africa.
- Therefore, our innovative services do not focus solely on PRIMARY HEALTHCARE
- Besides improving access to health services and medicines at village health posts, we offer, Family FOOD BENEFITS, poverty alleviation initiatives, such as ASSET financing, and mobile education programs for out of school Girls.
- Lastly our health technology -ICAREHub invented by our Co-Founder, can establish effective connectivity between health workers all over the region, interface with mobile devices, and aggregate data for disease monitoring and health planning purposes

THE MARKET

Our target customers are low-income populations who reside in rural areas of East and West Africa

West Africa Population estimates

www.worldometers.info/world-population/western-africa-population

Year	**2018**
Population	**381,980,688**

EAST Africa Population estimates Year, 2018

Tanzania (59,091,392)
Kenya (50,950,879)
Uganda (44,270,563)
South Sudan (12,919,053)

According to WHO, 40-50% of low income African populations live in rural Areas. This refers to approximately 274 million people. This population is expected to grow by 37% by the year 2050 (IFAD)

Revenue Model

Contributions for healthcare, food benefits, mobile education, asset financing and interests on financing make up our revenue model.

We also receive a fixed food subsidy from partnering NGO on a monthly basis.

We expect a revenue of $251,980 by December 2021.

Competition

- In rural South-West Nigeria, the ***National Health insurance scheme*** (NHIS) offers benefits mainly to public servants, through payroll deductions and currently has the largest market share in the health insurance industry in Nigeria (about 60% of industry clients) .
- **Strengths**- NHIS also claims to provide benefits to rural communities, and low income individuals. The NHIS covers expensive surgeries and this is a plus for NHIS enrollees, since our community health program is not yet able to cover surgical procedures.
- There are also a few state governments offering services to rural communities, but these are operating in South-South Nigeria and South-East Nigeria. Such schemes are mainly funded by the state

- **Our competitive advantage is linked to our level of differentiation in the area of social benefits.**
- **None of the existing schemes offer any benefits besides access to healthcare and this is responsible for low participation, slow growth and declining coverage.**
- The NHIS in Nigeria was launched in 2005, and became operational in 2007. Only 5% of the population (mainly public servants and college students) are currently benefitting from the program.

- The Cost of participation is steep. Each family member will be required to pay $44 per annum , and the typical African family with 4 or more children would then need to pay $268.00 or more per year.
- In comparison, with our lean structure , and focus on village health services and home care, our family contributions do not exceed $84 / year
- **BARRIERS to entry** include the lack of accessibility to rural populations due to poor road structures, and the cost of manpower. Our model has minimized such challenges.

Marketing Strategy

Community Brand ambassadors

Empowering community members rather than hiring marketing staff has improved our reach and effectiveness in terms of market Penetration. No competitor has achieved this

- **We utilize a unique marketing strategy that can be described as a modified multi-level marketing structure.**
- Community leaders who are registered members receive commissions Gifts, and honorarium based on the number of villagers they introduce and retain. Community leaders are trained as Brand Ambassadors and are usually resident in the village. They use their influence and position in the community to drive participation and acceptance.
- Our organization then supports their efforts by providing marketing materials, such as branded gifts, flyers, and training materials. Brand ambassadors are encouraged to sign up other villagers as ambassadors and this constitutes the network from which they earn commissions. We also reach out to potential brand ambassadors through community groups and associations

Our Teams

The Board of Directors

- **Dr Olasimbo Davidson (MBBS, MPH,CQP), ROLE- CEO/Founder** of Redwood Polycare Ltd . **Key skills & experiences :**
- Dr Olasimbo Davidson is an entrepreneur with over 10 years' experience in Health Systems Management, health financing, and community health insurance program development. Dr Davidson has piloted numerous community health models to date

- Dr Gil A. Adorno (PHD pharmacy). **ROLE-** CEO, inventor of the ICAREHub, LLC software and a co-Founder of Redwood Polycare. **Key skills & experiences-** Dr Adorno received his doctorate degree in pharmacy from the *University of Puerto Rico, School of Medicine*, pharmacy school, with a minor in computer Sciences. Over 30 + in the healthcare industry.

- **Dr Charles Cudjoe ROLE-** Non executive Chairman. **Key skills & experiences :** Dr Cudjoe acts in an Advisory capacity, and is graduate of the *Athens University Medical School. Dr Charles Cudjoe h*olds a Masters in Public Health (MPH) from Boston University

- **Our operational Team is made up of**
- **National Leader -Mr Ogunbayo is a member and part time media professional who supports us by engaging deaf communities and other minorities across our target regions.**
- **We have members who are State leaders. Ambassador Charles Abioro is a community teacher who oversees expansion into Ondo and Osun states, while Amb Charles Murorun is responsible for Lagos rural and Oyo states. Ambassador Adenuga a community teacher, and her deputy Titilayo a community trader are overseeing mobile education and community engagement for health and food benefits in core rural areas**
- **We also have advisors and experts in agriculture Mr Ibrahim who oversees all our farm land activities including planting and harvesting**

Action Plan

My PLAN FOR 2020 ;

- To BOOST Agricare's food program, by establishing a sustainable source of **fresh farm produce** over the next five years (through the lease and or purchase of up to 36-40 acres of farm land in established communities by December 2020). We aim to lease 3 acres per month

- To reach a minimum of 20,000 multi-dimensionally poor subscribers in rural areas of target regions by the end of 2020 and 100,000 by 2025. We plan to achieve this by offering our attractive mix of health and social-benefit packages for maximum impact on POVERTY, Hunger, Poor population Health, and LOW literacy.

- To support a modified franchising system that empowers eligible community leaders and groups to run the program in a minimum of 25 communities comprising 100 rural villages by January 2021.

- To establish village health posts with telemedicine facilities in remote target rural regions by JUNE 2021, in order to increase access to obstetric physicians in such areas by 60%.
- To partner with governments and government hospitals in one other target West African nation by 2021, for the purpose of collaborating to promote universal health coverage (UHC) through our community based health insurance program.

Revenue Projections

REVENUE	YEAR 1 (2020)	Y1 Assumptions	YEAR 2 (2021)	Y2 Assumptions	YEAR 3 (2022)	Y3 Assumptions
Net Sales	$100,800	24 communities with 50 families each paying $84.00 / yr	$251,980	48 communities with 50 familieseach at $84/yr nigeria & 10communities Sierraleone plus250 girls with school contributions $335/yr	$1,121,500	10,600families/106 communities/3 countries x$90/yr & 500school girls $335/yr
Cost of Goods Sold (COGS)	$25,200	direct cost estimate 25% of revenue	$62,207	direct costs health 25% of revenue, direct cost school-15%	$224,300	direct costs health 25% of revenue, direct cost school-15%
Gross Profit	$75,600		$189,773		$897,200	

Our average Medical loss ratio or MLR (which represents the percentage of premiums spent on health services) on our pilot program in 2019 was 60%.

We therefore had a Net profit margin of approximately 40%

Funding Needs- $16,449

- **We aim to fully implement our telemedicine service in 2020 as this is critical to promoting safe motherhood in remote villages that lack health centers or skilled health workers.**
- The equipment is the **mobile virtual care for telemedicine** manufactured by Trividia which has multiple capabilities including devices for remote monitoring of heart parameters, respiratory assessments, and other body functions**. COST -- $12,407.86**
- **We also plan to boost food security programs through mechanized farming**
- **Farm machinery cost- $4042.8**

THANK YOU FOR LISTENING