PharmAccess Foundation

Annual Accounts 2019

24 June 2020

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Amsterdam, the Netherlands

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MANAGEMENT BOARD'S REPORT

Our shared Mission

In 2019, through collaboration with (local) governments, the private sector and communities across sub-Saharan Africa, new policies and legislation have been implemented and our interventions have evolved and been scaled—increasing the potential for delivering better healthcare to 50 million people in Ghana, the Lagos and Kwara States of Nigeria, Tanzania and Kenya.

All four of these countries have adopted universal health coverage (UHC), where national and state governments, despite budget constraints, are increasingly expressing their commitment to partly subsidize health insurance for low-income people. In Tanzania, for the first time, the National Health Insurance Fund (NHIF) has been able to extend insurance to about 640,000 poor people through a collaboration with PharmAccess in the iCHF program. In Ghana, advances in data analytics are helping provide insights for improving the financing and delivery of insurance to 40 percent of the population. In Nigeria, as the result of advocacy efforts, 30 of 36 states have adopted laws to provide subsidized health insurance, with the potential to cover 20 million people. And in Kenya, the digital registration of two million households in three counties for UHC has been completed. These commitments, based on lessons learned from initiatives that we are implementing in each country, marks a transformational shift in the way that healthcare is financed for millions of underserved people.

Yet the progress only underscores that we must continue to work together with our partners to capitalize on digital innovations and sustainable approaches. For our shared mission depends upon finding innovative, efficient ways to provide more people with access to higher quality healthcare — no matter where they live or how they earn a living.

In the nearly twenty years since Professor Joep Lange founded PharmAccess Group, certain tactics have evolved or been discarded, but the essential mission remains unchanged: we want to make inclusive health markets work in Africa.

The continent has never been more connected. Over the last decade a surge in information and communication technologies has given nearly 70 percent of those in sub-Saharan Africa (SSA) access to a mobile phone. In 2019, after long advocating for mobile payments to improve financial inclusion for about 60 million Nigerians — primarily women who do not have a bank account — we were pleased when authorities in Nigeria amended regulations to allow mobile providers to engage in mobile payments. By the end of 2019, the Central Bank of Nigeria had issued licenses to 15 mobile money operators as part of its drive to increase financial inclusion. This is an important development, given that seven percent of GDP transactions in SSA take place through mobile payments compared to just two percent in Europe and the U.S.

In terms of Quality Improvement, we made important strides in 2019 by investing in a SafeCare digital quality platform that better connects providers and stakeholders with data for informed decision making while complementing the work traditional SafeCare assessors perform on the ground. In Ghana, the cooperation between the Health Facility Regulatory Agency and National Health Insurance Authority (NHIA) means that there

is now an incentive — in the form of income derived from insurance — for healthcare providers to adopt quality standards on a long-term, sustained basis.

Our loan program has financed more clinics with more loans than in any year before, with a total disbursement of over USD 20 million in 2019. This success is partly driven by Medical Credit Fund's digital loan product in Kenya, the Cash Advance. Clinics can access small, fast loans from their mobile phone without the collateral requirements and burdensome administrative procedures. With more than 70 percent repeat customers, the product is clearly valued by customers.

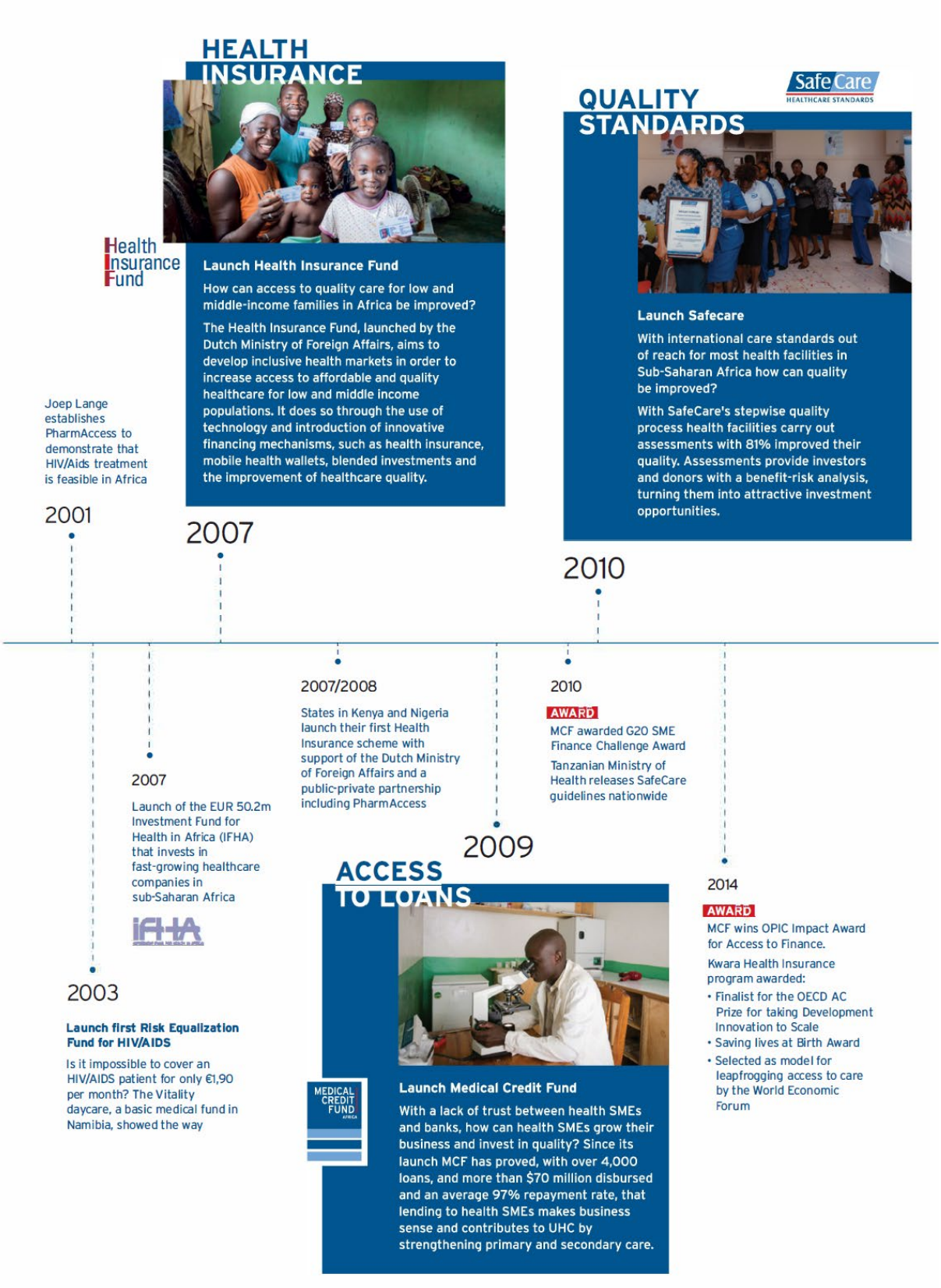
To address a fragmented supply chain that often delivers substandard and fake medications in Ghana, we worked closely with partners to pilot a digital platform for procuring pharmaceuticals — so that people in Ghana can trust the medicines they buy, and at a lower cost.

Our work with smart contracts for maternity and non-communicable diseases (NCDs) reflect a shift toward value-based care that uses mobile technology to better connect stakeholders and put patients where they belong—with more control, at the center of their own healthcare journeys.

Of course, no single intervention or organization can solve the healthcare problems facing our world. If anything, the coronavirus pandemic has reminded every one of us that health systems can be fragile, and that we must continue to work together, with fearlessness, to ensure that every individual has access to dependable care.

Tackling the complex problems of health systems requires collaboration and activism, and a certain pragmatic realism about realities on the ground. The road to UHC twists and bends, but our mission drives us onward.

TIMELINE OF HIGHLIGHTS



PRAGMATISM, SCIENCE AND ACTIVISM

JOEP LANGE INSTITUTE

Launch Joep Lange Institute

The Joep Lange Institute combines science, activism, and pragmatism to make health markets work for the poor in countries where the system fails the people.

SMART CONTRACTING

MOMCARE

MomCare

How can care be organized around the patients needs?

With MomCare, mobile data is leveraged to offer evidence and value based care, which puts patients and their health outcomes at the center of the decisions about allocating scarce resources.

CarePay a company that digitally connects health payers such as insurers, beneficiaries and health providers on to one mobile platform is founded

2015

2015

MOBILE HEALTH FINANCING INNOVATIONS

m-tiba

Launch M-TIBA

How can mobile reshape healthcare?

Over 4 million patients can now access healthcare from 1,400 + facilities direct on their mobile thanks to a mobile health exchange. M-TIBA facilitates access to care for low-income groups whilst distributing funds in the healthcare system in smarter and equitable (or something that refers to equity/social redistribution) ways, demonstrating that UHC can be achieved at low marginal cost."

2015

AWARD

SafeCare finalist for OECD DAC Prize for taking Development Innovation to Scale

2016

NATIONALE POSTCODE LOTERIJ

Winner, with AMREF, of Dutch Postcode Lottery's EUR 10m Dream Fund

2016

Ministry of Foreign Affairs of the Netherlands

Dutch Ministry of Foreign Affairs refinances the HIF for 7 years

2016

2017

AWARD

M-TIBA wins Financial Times/IFC Transformational Business award

Partnership with National Health Insurance Fund Kenya

HealthConnect launched to enable direct and fully transparent peer-to-peer funding through mobile.

2018

Diabetes and hypertension care pilots launched in Kenya with special partners

Kwara state, Nigeria, launches mandatory health insurance for all using mobile to enroll the population

2019

2019

Med4All

Medicine supply chain program, Med4All, launches in Ghana

Financial Times Future of Healthcare conference

Introduction

At the United Nations General Assembly on UHC, David Malpass, the President of the World Bank, spoke about the effectiveness of the mobile health platform M-TIBA in delivering digital health insurance. In addition to recognizing our work with partner CarePay as thought leaders in digitalizing health financing and delivery, his words speak to how digital and mobile technology has revolutionized healthcare, especially in Africa.

These advances provide enormous opportunities to address the challenges that have thwarted the efforts of governments and the private sector to deliver health for millions of underserved populations. Using available funds more effectively and building sustainable health systems are critical to our work, as well as harnessing data to strengthen these systems, and in ways that send the benefits back to society.

To promote a strategic dialogue on these issues, PharmAccess organized the Financial Times Future of Health Coverage Conference in May of 2019, along with the Dutch Ministry of Foreign Affairs, the Joep Lange Institute (JLI), and the private sector in both Africa and Europe. The conference was opened by Her Majesty, Queen Maxima, UN Secretary-General's Special Advocate for Inclusive Finance for Development. Sigrid Kaag, the Dutch Minister for Foreign Trade and Development Co-operation and Yaw Osafo-Maafo, the Senior Minister of Ghana, attended.

As a direct result of the conference — and the underlying advocacy — the Global Fund signed a partnership agreement with PharmAccess to support African countries in accelerating progress toward UHC by harnessing digital technology. Relying on a solid base of local and international public-private partnerships, and with the support of international stakeholders including the Dutch Ministry of Foreign Affairs, we will embrace the challenge.

PharmAccess is dedicated to strengthening health markets with digital technology so that people can access better services, lead healthier lives, and reach their full potential. Our work echoes the global call for universal health coverage, and we do this by mobilizing private and public resources, to reach those in even the most remote areas with affordable healthcare they can trust.

Seventy percent of our staff operates in local country offices, driving advocacy, scaling innovations, and implementing proven solutions.

Establishing PharmAccess

At one point, in challenging the healthcare status quo, Joep Lange declared, "if we can get cold Coca Cola and beer to every remote corner of Africa, it should not be impossible to do the same with drugs."

In 2001, his first objective after founding PharmAccess was to push groundbreaking scientific research into action by bringing HIV/AIDS treatment to regions where it had previously been unavailable. As an initial step, PharmAccess partnered with Heineken to design workplace healthcare programs for their employees and dependents who were based in Africa — a practice to be followed by many other companies. These programs laid the foundation for international action by proving that treatment in Africa was viable and that the delay in delivering care was a political choice.

The work also highlighted the financing challenge in Africa: the need for affordable, social health insurance that would include coverage for communicable disease like HIV. As a result, several multinational companies, the Dutch Ministry of Foreign Affairs and PharmAccess decided that more needed to be done to provide people in Africa with access to better healthcare. A working group was formed to discuss possibilities for including the private sector, which led to the creation of the Health Insurance Fund in 2006 and the signing of a long-term partnership with the Dutch Ministry of Foreign Affairs. Consequently, the Health Insurance Fund contracted PharmAccess as its implementing partner.

After a positive evaluation of the first funding term by the Boston Consulting Group in 2015, the Ministry renewed the partnership for another seven years.

Five Strategic Objectives were developed to guide our efforts in making inclusive markets work. In interventions spanning this period we will continue to:

1. Develop private pre-payment mechanisms, risk pooling structures, and mobilize resources for organized demand (Accelerating Health Financing)
2. Strengthen, benchmark, and certify clinical and business performance for healthcare providers (Strengthening the Quality of Health Services)
3. Improve efficiency, effectiveness and transparency to better match demand and supply of healthcare transactions.
4. Mobilize capital into the health sector.
5. Conduct research on interventions and advocate those that are successful.

Envisioning a virtuous cycle

Several longstanding propositions guide our work. We believe that providing healthcare is a semi-public good where governments can meet the health needs of society. The reality remains, though, that only about half the world's population can access essential health services — which is why the private sector must play a role in delivering healthcare. In Africa, the private sector delivers approximately 50 percent of health services.

At the same time, governments play a critical part as well — as only they can intervene at the required scale to enforce financial synergies, risk pooling and regulation. However, in SSA, governments may lack the capacity to finance, regulate, and enforce health policies. As a result, a large segment of the population — especially those at the bottom of the pyramid — are on their own. The low quality and uncertain availability of health services discourage people from pre-paying for health. Pre-payment is also a relatively new concept for the region, and many families face competing priorities for their limited resources. Because of this, most pay out-of-pocket when they need care.

The high proportion of out-of-pocket expenditure combined with little trust in the health sector has led to low and unpredictable revenues for providers, which in turn prevents them from investing in the quality, scope, and scale of their services. Almost everything is post-paid. The resulting limited exchange and high transaction costs mean that banks and investors are generally unwilling to invest, especially at the lower end of the market. This leaves the healthcare sector with limited or no access to the capital required for inclusive growth. Therefore, the market remains stuck in a vicious cycle of low demand and poor supply.

PharmAccess and our partners (both public and private) aim to break this pattern by moving toward a **virtuous cycle** of trusted, inclusive markets that leverage private sector development to benefit low- and middle-income groups.

Thanks to the unprecedented opportunity of mobile technology, an outline of that virtuous cycle is beginning to take shape. The costs and time involved with administrating healthcare programs has been significantly reduced, and recent pilots have shown that fragmented sources of health financing can be unified through mobile health platforms. On the individual level, families and households can now be supported directly through their devices and smartphones —and can be reached at low marginal costs.

Starting private, growing public

Strong partnerships are essential: for intensifying impacts and making programs efficient and sustainable. PharmAccess partners with the private sector to develop scientifically evaluated proofs of concept that deliver data and can later be adopted by the public sector. And we work with the public sector to provide insights and data for more informed decision making.

In terms of the **private sector**, in 2019 PharmAccess launched the SafeCare Quality Improvement Program with the Christian Health Association of Ghana (CHAG).
In Nigeria, the CarePay digital platform has been chosen by Lagos state to run its mandatory health insurance scheme. The platform has also been featured prominently in the international and Kenyan news media.

In terms of collaborating with the **public sector**, in Tanzania we worked with the NHIF and regional authorities to integrate iCFH into the national health insurance program. In Nigeria, we partnered with the Global Fund and CarePay to scale digital innovations for UHC and quality improvement models within the Lagos State health insurance scheme. And, in every country we support, PharmAccess has actively participated in national policy dialogue, debates and expert meetings organized by policy makers.

Our partnership with Ghana's NHIA is a particularly important example. Ghana has adopted a "Beyond Aid" economic policy for relying on its own resources, technology, and the private sector to deliver prosperity to more Ghanaians. Recognizing this as an opportunity to contribute, PharmAccess offered to serve as a technical advisor to help the NHIA analyze all membership and claims data, with the aim of developing data-based insights and reducing costs. PharmAccess began analyzing NHIA data in 2019, with key insights expected in 2020.

Objective 1: Accelerating Health Financing

Sub-Saharan Africa struggles with a health system that has very low health expenditure per capita and limited risk pooling. The problem has multiple sources — insufficient funding, highly fragmented and limited funds, and poor access to quality healthcare services. PharmAccess is partnering with local governments and the private sector to roll out insurance plans that address health financing — and support the momentum for UHC. The potential for digital technology and mobile health financing platforms are central to this approach.

As we increasingly work with local governments, political challenges in the countries we support can affect the implementation of health financing initiatives. Elections were held in Nigeria which ushered in new State Governments — including both Lagos and Kwara — requiring that we intensify our advocacy efforts to ensure the continuity and consolidation of governmental policy on health financing.

In Lagos State, PharmAccess has assisted the Lagos State Health Management Agency (LASHMA) with the design and operational set up of the Lagos State health Scheme (LSHS). During 2019, PharmAccess supported the enrollment and registration of formal and informal households in the scheme. LASHMA employs CarePay's mobile health financing platform for registration, member management and claims submission purposes. PharmAccess has supported LASHMA and the CarePay collaboration with technical support (setting scheme rules and parameters, user acceptance testing, marketing planning and agent training). The aim is to ensure that LSHS is prepared for a rollout to the citizens of Lagos in 2020. In Kwara State, preparations have been ongoing to launch the Kwara State Health Insurance Scheme (KwSHIS). With the Kwara State Health insurance Agency (KwSHIA) established, healthcare providers recruited across the State and indigent households identified

and registered for activation, the first phase of the program is set to commence during the first half of 2020. This will be followed by a rollout to formal and informal households across the State.

In Ghana, by supporting the rollout of the Claim-it app — a digital system within the provider panel of the NHIA — we hope to assist in digitizing more claims, support an efficient, transparent process, and help shape a blueprint for what UHC can look like in the context of sub-Saharan Africa. NHIA is a mandatory scheme, and the outcome of our collaboration has the potential of extending access to care for 30 million people in Ghana. NHIA now covers about 11 million people.

In Tanzania, the NiCHF currently covers more than 650,000 people. PharmAccess continues to support the scheme, both operationally and in refining the design. One critical element is the inclusion of the private sector, especially faith-based clinics — as in Tanzania, more dialogue is required to ensure the active participation of both private sector health facilities and insurance companies — for pushing towards UHC.

In Kenya, UHC remains a major objective of the 'Big Four' development agenda announced by President Kenyatta in 2017. To support this push, PharmAccess and its technology partner CarePay were contracted to organize and register 2.6 million people for healthcare in three of four pilot counties. Collecting health visit data in approximately 45 county facilities was essential. Based on the data, relevant insights will be given back to local and national stakeholders concerning patients' facility selection, medicine prescription practices and overall disease patterns.
While realizing UHC in Kenya depends on political and policymaking decisions yet to come, PharmAccess has rekindled an agreement with Kisumu County to provide UHC support there, beginning with the indigent population, and using the mobile health financing platform M-TIBA.

M-TIBA was developed in partnership with CarePay and the telecommunications company Safaricom and powers a digital 'health wallet' on mobile phones that allows for the mobilization and earmarking of private and public resources, including insurance benefits. This can ensure that individuals access healthcare at a lower cost and help protect them against health expenses. M-TIBA connects patients to outpatient clinics, hospitals, payers, insurers and donors. M-TIBA can also receive and store subsidies to help people cover future healthcare expenses. Put simply, through this mobile health platform we can put the individual at the center and enable two-way, real time interactions which can include the exchange of information with providers.

When a person uses the wallet in a clinic, the patient's claims data is uploaded to the platform (compliant with GDPR policies). This information offers key insights to funders and payers (both public and private) about how specific target populations have been reached, but also on problems and inefficiencies that may have occurred. It also generates valuable data for healthcare providers, data that better informs them on their financing and patient caseloads. Ultimately M-TIBA will help promote efficient health financing and service delivery with greater transparency.

Alongside our work in the pilot counties, PharmAccess also digitally enrolled nearly 36,000 pregnant women, women with young children and their households for health insurance with the NHIF. This program, the Innovative Partnership for Universal Sustainable Healthcare (i-PUSH), was developed with Amref Flying Doctors and funded by The Dutch Postalcode Lottery — to create a pathway to better healthcare for key populations and develop insights for reaching UHC.

Objective 2: Strengthening the Quality of Health Services

"We are committed to ensuring that people everywhere can obtain health services when and where they need them," says WHO Director-General Tedros Adhanom Ghebreyesus. "We are equally committed to ensuring that those services are good quality. Quite honestly, there can be no universal health coverage without quality care."

Ensuring the right to health is impossible without providing quality healthcare services, and sub-Saharan African governments have a responsibility for providing equitable, affordable and high-quality services for all citizens. But the challenges of enforcing quality standards in facilities on the ground are daunting. Medication stock-outs, lack of sterilization equipment, no proper waste management, shortage of skilled midwives and other professionals; the shortcomings in hospitals and clinics in SSA are plentiful and do not compare easily with quality problems in high-income countries. In these emerging countries, 10% of hospitalized patients will come down with an infection while they are being treated, a figure three percent higher than in higher-income countries. Therefore, access to healthcare alone cannot guarantee the effectiveness of care.

SafeCare is an initiative that empowers providers by helping them measure, monitor and improve their services using innovative solutions. Accredited by the International Society for Quality in Healthcare (ISQua), SafeCare evaluates clinics by conducting an assessment against a set of standards that provides a clear, objective view of the facility's performance, identifying the gaps in service and challenges that must be addressed.
Based on the assessment report, providers are given a tailor-made quality improvement plan with transparent and achievable goals, and tools that guide them down a motivating and manageable road to improvement. Typically, facilities work on infection prevention measures, waste management, the development and implementation of guidelines and standard operations but also financial topics such as audit and procurement processes. The aim is to have a medically and financially healthy organization, which translates into patient and staff safety, better health outcomes and more investments and (insurance) contracting.

In 2019, SafeCare made progress by investing in the **Quality Platform**, an online model developed to support the quality improvement processes of facilities. Features on the platform include weekly QI challenges, connection to best practice examples, chatbots, benchmarking, and others. Human Centered Design workshops with healthcare facilities were used to develop a minimal viable product in 2019, which will be rolled out to scale in 2020. The platform will also be made accessible to governments, NGOs, provider networks, medical associations, insurance companies and other organizations in the health sector.
To expand locally and internationally — and ensure the institutionalization of the methodology with public and private partners — SafeCare has also introduced a licensing model. The model allows partner organizations to use the SafeCare methodology and brand under a licensing contract, making it possible for more providers, payers and patients to benefit from SafeCare. The licensing contract is also available under a white label for public institutions.

Strengthening regulatory systems

The first step for improving a health system is establishing a strong regulatory backbone. Lagos State has the highest number of private facilities in Nigeria. PharmAccess conducted a GIS mapping of 2,800 facilities, jointly developed a quality inspection tool with State representatives, facilitated the development of the State Quality Policy for the Health Sector and conducted an organizational capacity assessment of the Lagos State Health

Facility Accreditation Agency (HEFAMAA) to identify gaps in the system. The licensing inspection tool sets the minimum requirements for a facility to operate.
As a result, PharmAccess supported the development of a website and portal for registration to help improve the Agency's operational efficiency with licensure processes.
Registering new health facilities and annual renewals have been done electronically since the launch of the portal in July 2019.

Strengthening health services

To be empaneled under the scheme, healthcare providers must first apply to LASHMA. After being contracted and assigned individual patients, the provider then must participate in a mandatory quality improvement program that draws upon the SafeCare Standards. The SafeCare standards guide the facilities toward excellence, building on the minimum standards set by the inspection tool.
The facility undergoes a baseline quality assessment that uses the SafeCare Tool. A Quality Improvement Plan is put in place for 18 months, during which LASHMA supports the provider on their quality improvement journey with periodic audits, a yearly renewal of empanelment for high performing providers and follow-up quality assessments every 18 months.
Institutionalizing the program in Lagos has required training state officials and agencies on the Standards, so they can serve as assessors and conduct provider appraisals.
Lagos State now has a Quality Team of 20 assessors who lead the assessments and 45 Quality facilitators who mentor the teams in implementing the improvement plans. This marks the first time Lagos State has implemented such a team.

As a result of the partnership, health providers in Lagos will be trained to understand and comply with the treatment protocols and quality standards that can help fight infection and deliver better health outcomes.

Partnering with the Private Sector

Quality assurance (QA) and improvement (QI) programs in LMICs are often fragmented and linked to vertical programs that treat specific diseases and conditions, such as HIV/AIDS or maternity. Benchmarking across programs and facilities is not possible, and institutionalizing is complex, especially as countries move toward UHC. A strong healthcare system is one that has an institutionalized quality assurance policy and embeds QA into the contracting approaches of (national) insurance bodies, lending and investment institutes. This would send the information back to patients, so that they can make informed choices when selecting a provider. In line with UHC, the focus must be on primary and secondary providers.

The SafeCare licensing approach empowers local organizations to own and institutionalize a quality assurance program that measures quality healthcare comprehensively, with the ability to deep-dive into specific conditions or disease profiles.
As part of an initiative to support employees worldwide, the Heineken Corporation currently funds 70 healthcare clinics in LMICs. At these facilities, free healthcare is available to Heineken employees as well as their spouses and children.
In 2001, Joep Lange persuaded Heineken to commit to offering workplace healthcare and treatment for those living with HIV/AIDS in Africa. This marked the first of many public-private partnerships that have enabled PharmAccess to contribute to improving health systems in Africa.
Now, Heineken is the first multinational corporation to adopt the SafeCare standards.

By contracting to use SafeCare, Heineken has committed to providing transparency and quality improvement at their health facilities.
For SafeCare, the partnership with Heineken expands our reach outside the African continent and gives us an opportunity to connect with clinics in regions such as Papua New Guinea and Asia—with scalable, affordable packages that deliver real impact on Quality of Care.

Improving the availability, affordability, and quality of pharmaceuticals
Throughout SSA, the problem of fake and substandard medication presents an enormous challenge for both providers and patients. The combination of a fragmented, poorly regulated market with insufficient quality control measures, inefficient procurement and inventory management means that providers cannot always purchase quality supplies and patients cannot be sure that those medications are safe and effective.

In Ghana in 2019, PharmAccess, funded by Achmea, Helmsley and Pfizer, has developed a pooled procurement platform solution — in partnership with the Christian Health Association of CHAG and the NHIA — that will add value to all stakeholders. The CHAG facilities provide about 30 percent of the care to the mostly rural Ghanaian population. Through the new Med4all platform, clinics, hospitals and pharmacies will be able to order much-needed medicines in bulk, against reduced, pre-negotiated prices with pre-selected distributors. This will ensure the required availability of medicines and guarantee that prices will be much lower than what the providers currently experience.

The condition of the drugs will also be tested to improve quality control. Selected distributors will be able to stock the required medicines as a result of buyers pre-paying for their orders — supported through loans by the Medical Credit Fund, as needed.
End-users of the medicines will benefit too, by gaining access to better-priced, quality drugs when they need them.

Objective 3: Matching Demand and Supply

Improving a health market that is deeply fragmented depends on doing more than just increasing the availability of funds and enhancing the quality of medical services. In LMICs, vulnerable groups — such as expectant mothers — may experience something like chaos during their pregnancies because available services are not organized around patient needs. We believe that the availability of data and mobile exchange platforms has the potential to completely change healthcare financing and delivery and facilitate better, more patient-centered services. By leveraging real-time mobile data, PharmAccess is working to offer evidence- and value-based care, which puts patients and their health outcomes at the center of decisions about allocating scarce resources.

Together with several strategic partners, PharmAccess is now using mobile technology to address the full patient journey and its outcomes.
After joining forces with Sanofi and CarePay, we have begun working to break access and awareness barriers for diabetes and hypertension treatment in Kenya.
The result of this collaboration is Ngao Ya Afya ('Shield for Health' in Kiswahili): a digital service model for NCD-care that combined direct financial support and access to care for low-income patients while stimulating quality of care and generating real-time medical and financial data insights for doctors and healthcare payers.
This digital tool was designed with a view to developing a scalable service model that optimizes cost of care and efficiency, while leveraging available funds from patients and payers in one wallet.

The costs of a pregnancy journey

Every year, roughly 300,000 women die as a result of a preventable complications during a pregnancy. This statistic is 14 times higher than in high-income countries, and sub-Saharan Africa accounts for 66 percent of these deaths.

For pregnant women in LMICs, navigating the health system comes with specific barriers. Home births may be the standard. Prenatal care could involve additional costs that are impossible for the household. Even if an expectant mother has 'free' healthcare, getting a clear picture of the treatments, and the costs, can still seem murky.
By enrolling expectant mothers on a digital payment platform, it becomes possible to contractually offer these women a better 'deal'. For example, the MomCare package in Kenya and Tanzania covers the full journey of care and includes all providers whose services could be needed during that journey. Because the contract is digital, it can be transparent about the specific care and treatments expectant mothers are entitled to receive. SMS surveys following doctor visits empower these women to evaluate medical services and the mobile platform makes it possible for them to have smart contracts that create an accountable care journey that they can *trust*.

The product draws upon well-documented interventions such as timely antenatal care visits and assisted birth deliveries and enforces the clinical guidelines that are essential to keeping mothers and babies healthy.

First piloted in Kenya, MomCare uses a trusted platform and begins by better connecting mothers and providers. Before the first consultation, both agree to a path of maternal care at a predetermined cost and quality.
For the mother, knowing the specific treatments she is entitled to can help her manage the risks in her pregnancy, and save for her portion of premium costs, if any.
Mobile technology also allows for better communication between mother and doctor. The technology sends triggers to both doctor and patient to enhance their interactions and ensure that every step in the nine-month journey is addressed according to clinical guidelines.
MomCare benefits providers in other ways. The predetermined costs offer reliable income, which the provider can then use to invest in his or her business.

Objective 4: Mobilize Capital into the Health Sector

Small and medium size health clinics in Africa have received more than 4,000 loans amounting to USD 71 million from the Medical Credit Fund since 2009. In 2019 alone, more than USD 20 million in loans were disbursed. These funds have helped clinics purchase better equipment, grow their businesses and improve the overall quality of their healthcare services. Loan repayment stands at 96 percent. The clinics have around 450,000 patient visits per month across the six countries.

In sub-Saharan Africa, the public sector faces major financial and management challenges in delivering quality services to everyone who needs healthcare. This applies to the treatment of major diseases such as HIV/AIDS, and non-communicable illnesses like diabetes or hypertension, as well as the essential primary care services that provide the foundation for health systems everywhere.
Consequently, most Africans rely on private healthcare facilities.

Meanwhile, the private small and medium size health enterprises (health SMEs) that provide primary and secondary care services to the lower income groups in Africa are struggling. They often lack the financing to invest in their infrastructure or purchase the equipment they need to provide quality services. Compounding the problem, commercial banks tend to shy away from lending to SMEs in general, and health SMEs in particular — as they perceive these facilities to be high-risk.

MCF is the first and only impact investing initiative dedicated to providing loans combined with technical assistance to health SMEs in sub-Saharan Africa — to enable them to strengthen their business and improve

health care quality. The Fund works both directly and with a wide network of financial partners to serve clinics with the loans and technical assistance they need to offer more people better healthcare services.

Supporting health SMEs directly

From the start, MCF has had a mandate to co-lend with local financial institutions. Despite a solid track record—we had 19 financial partners and USD 22.6 million in loans outstanding with them in 2019 —MCF has also encountered challenges in getting banks to disburse funds. Collateral requirements remain an obstacle that SMEs must overcome to qualify for bank loans. In Kenya, which holds the largest share of the portfolio, a continued interest rate cap has reduced the banks' appetite to lend to SMEs.

Recognizing this challenge as well as the unmet demand for loans, MCF decided in 2019 to start lending directly to health SMEs — to better serve its customers. While most of the portfolio remains held with financial partners, 10 percent of disbursements were made through direct lending in 2019.

Delivering fast, effective digital loans for Primary Care

Small loans can make a tremendous difference to clinics in the countries we support, but these loans also face a high bar for approval. While collateral is a major barrier for SMEs, small loans present a challenge for banks—in that issuing small loans can be costly and time-consuming. To perform due diligence, a loan officer must understand a customer's needs, circumstances, and liabilities. The earnings on these loans are limited, but the administrative burden remains the same regardless of loan size. As a result, most banks prioritize larger loans to corporate clients or investments in capital markets.

To address this challenge, MCF, has leveraged mobile technology to develop a digital loan product: **Cash Advance**. A short-term loan facility, the product uses the mobile money revenues of healthcare providers to secure and repay loans. Through Cash Advance, MCF can offer loans as small as USD 100 sustainably because of the streamlined process. Moreover, Cash Advance loans are convenient for the smaller healthcare providers, typically the providers of primary care, as no collateral is required, and administrative procedures are limited.

Borrowers apply for Cash Advance loans with a mobile phone. The healthcare providers often need short-term loans to cover expenses like rent, salaries, and medicines. These smaller loans are critical to bridging the gap for providers between buying necessities like pharmaceuticals and being paid for their services — especially given the frequent and lengthy delays of health insurance payments.

Repayments are automatic, drawn in daily installments as a percentage of income from the mobile revenues of digital tills. If a clinic's earnings increase or decrease, repayment adjusts proportionately, based on what the healthcare provider can pay.

Ultimately, once a healthcare provider has repaid a digital loan, they can easily take out a new Cash Advance to close another gap between expenses and reimbursements; and grow their business as a result.

MCF launched the product in 2016, processing 11 digital loans in that year. Now, in 2020, 844 Cash Advance loans have been disbursed with an average amount of KES 760,000 (USD 7,500). Total Cash Advance disbursements stand at USD 9 million. Around 70 percent of clients enter into repeat loans, indicating high customer satisfaction.

Digital lending products like **Cash Advance** have the potential to accelerate the lending process and offer capital to more providers. We have partnered with Philips Foundation and other donors to aggressively develop similar products in other countries, starting in Tanzania and Uganda.

Strengthening management skills

Most health SMEs are managed by healthcare professionals who have been trained to provide healthcare to patients and are fully engaged with the daily operations of their clinic. They often lack the management skills and financial knowledge that are necessary to plan for the future and take their facility to the next level. In 2017, MCF launched the first executive business development training in investments and management for health SMEs in sub-Saharan Africa.

In 2019, more than 100 health SME managers participated in comprehensive healthcare management courses at the Strathmore Business School in Kenya and the Enterprise Development Center in Nigeria. MCF helped coordinate these programs, along with other training programs for healthcare professionals in Ghana that are accredited by the Medical and Dental Council.

Objective 5: Measuring impact with Research and Advocacy

At PharmAccess, research is integral to strengthening successful interventions by disseminating findings across a wider network. Beyond reach, research is also crucial to developing new product offerings and improving existing ones.

In Cameroon, an estimated 200,000 people are infected with Hepatitis C Virus (HCV), a chronic infection which can lead to life-threatening liver disease. In collaboration with our partners — and funded through the Joep Lange Institute (JLI) and the Achmea Foundation — we are seeking to facilitate a sustainable HCV treatment model using phased demonstration projects which will increasingly be financed by an innovative, pay-for-performance impact investment instrument. This effort capitalizes on recent advances in HCV treatment and utilizes antivirals with proven cure rates at about 95 percent in high-income countries. So far, we have completed an HCV

treatment project for 161 patients — with a cure rate of 96 percent — demonstrating that decentralized treatment is feasible in Cameroon.

Another research priority in 2019 included a focus on connected diagnostics: a process where we can link diagnostic test through the cloud to digital payment mechanisms that fund only accurate medical treatments. Put simply, the process ensures that doctors only get paid for services or drugs they prescribe when a patient has actually tested positive for a certain condition, which can be verified through a simple test that has been uploaded to the cloud.

As part of a pilot in Kisumu, seven private clinics were analyzed using connected diagnostics. Nearly 12,000 people were tested for malaria, with the results uploaded to the cloud. Initial results show that the process demonstrates significant potential for decreasing the over-prescription of malaria drugs by verifying the tests, and also lowering administration costs by decreasing paperwork. Valuable, real-time data on malaria hotspots can be fed into national information systems (such as DHIS-2) to help governments allocate resources; and connected diagnostics also has the potential to empower patients, who can actively choose facilities that have a proven track record of testing accurately for disease.

Evaluating SafeCare and MCF in Tanzania

Over the past four years, we have collaborated with the London School of Hygiene and Tropical Medicine and the Ifakara Health Institute to conduct a randomized control trial in Tanzania. The focus of the study was to evaluate SafeCare's impact and assessment scores in relation to clinical quality of care. The analysis marks a first effort to evaluate the link between quality and business performance for private healthcare providers in sub-Saharan Africa.

Initial results from the study show that healthcare facilities with higher quality ratings perform better with standardized patients — in terms of providers prescribing (or not prescribing) inhalers, blood tests for malaria, microscopies, or antibiotics.

The insights derived from the study have helped drive the development of the Quality Platform, which was designed to spur quality improvement through benchmarking, reinforcement exercises and regular mobile communications between SafeCare, providers and their peers.

Advocacy

2019 was an important year for the advocacy that PharmAccess does with Queen Maxima of the Netherlands, the United Secretary General Special Advocate for Financial Inclusion. Queen Maxima celebrated the tenth anniversary of her work on financial inclusion which has contributed to, among other things, the Central Bank of Nigeria's decision to license mobile operators for mobile payments for the benefit of 60 million Nigerians without a bank account. Sigrid Kaag, the Netherlands Minister for Foreign Trade and International Development, visited a PharmAccess initiative in Nairobi with the goal of learning about how the Dutch government's funding has helped deliver digital interventions to increase lending to health SMEs as well as better access to healthcare for people in the informal sector.

In 2019, MoFA collaborated with PharmAccess in many areas such as 'initiating policy discussions with the World Bank's Health in Africa initiative on digitalizing and financing healthcare for the informal sector' and 'arranging for the Director of Sustainable Economic Development to speak at the FMO-AfricInvest/PharmAccess Conference on Investments in Health Care'.

The Health in Africa (HiA) initiative was also instrumental in implementing activities across the countries we support. In Nigeria, HiA supported PharmAccess in engaging the new political leadership in Kwara and Lagos States to launch health insurance schemes, and in Kenya, HiA engaged counties and the Ministry of Health to ensure the integration of digital interventions in UHC-focused activities.

The Joep Lange Institute (JLI) applies research, innovation, pragmatism, and action to improve access to quality healthcare by building efficient and effective health systems. JLI's events, research, and network of leading researchers in Africa, the Netherlands and elsewhere were essential for advocating for PharmAccess. Last year's highlight: in cooperation with JLI PharmAccess organized the Financial Times Future of Health Coverage Conference in May of 2019, along with the Dutch Ministry of Foreign Affairs and the private sector in both Africa and Europe.

Financial

As in 2018 total income in 2019 amounts to EUR 24.3 million and the operating result is EUR 82,083 (2018: EUR 111,342). Together with financial result, PharmAccess Foundation's records show a surplus of EUR 63,759 for the year 2019 (2018: EUR 187,203).
Based on a board decision the result can (partially) be allocated to a special purpose reserve. The size of the reserve will differentiate within the following computation guidelines:

- Until a maximum of 10% of the total equity.
- Until a maximum of EUR 200,000.

The reserve can be used for employees who, in person, are confronted with a catastrophic event and insuperable cost. Since the maximum of EUR 200,000 was reached in 2018 the full result for the year 2019 (EUR 63,759) has been added to the continuity reserve.

After appropriation of the result the total equity amounts to EUR 2,483,956 (2018: EUR 2,420,197). To secure the continuity of PharmAccess Foundation, management continuously is looking for additional funding possibilities and is seeking to further improve the capital structure.

The financial statements reflect all the activities of the PharmAccess Foundation. All activities are supervised by 'head office' based in Amsterdam. Apart from general management, resource mobilization, financial management, HR, ICT and communications the 'head office' is staffed with Demand-, SafeCare-, data- and tech-, research- and advocacy-teams managing and/or supervising the respective programs. The actual implementation of the programs takes place in the African countries for which PharmAccess has offices in Tanzania, Kenya, Nigeria and Ghana. These offices are established according local regulations and governed and managed by (staff from) 'head office' in Amsterdam. The financial statements have been prepared in accordance with the Guideline for annual reporting 640 "Not-for-profit organizations" of the Dutch Accounting Standards Board. Contrary to the Guideline for annual reporting 640 the budget on overall level has not been included. Control is performed on project level. Financial risks are limited since PharmAccess holds cash on dedicated

interest-bearing bank accounts. PharmAccess does not work with 'embedded derivatives' and 'hedge accounting' and all larger programs are prefunded. Currency risks are shifted to the programs.

The foundation has been incorporated for the sole purpose of running the activities along the lines of the objectives as mentioned in the introduction paragraph of the management board report. The foundation has no objective to gain reserves, the activities are funded by multi-year grants.

Given the nature of the organization risk assessment is addressed on regular basis. The monitoring and managing of risks take place on the level of the Foundation and its implementing partners. Risks have been categorized and prioritized on possibility and impact. The most significant risks which have been identified are:

- Financial risks - continuity of funding; (successfully) mitigated by business development and submitting proposals for new funding.
- Personnel risks - health and safety of staff; mitigated by establishing a travel policy.
- Personnel risks - fraud; mitigated by establishing a code of conduct and by sound financial management (segregation of duties, dual level authorization).
- Performance risks - management capacity of the implementing partners and their local project partners; mitigated by capacity building activities.
- Legal / Privacy - mitigated by implementing a data policy and involving specialist monitoring.
- Reputational risks - mitigated by attention for external communication and advocacy.

Outlook 2020 and beyond

In April 2020, African and European political leaders called for the urgent transformation of an international collaboration on economic and global health — to fight Covid-19 in Africa.
The virus is a communicable disease that reminds us that we are all vulnerable: within months, a disease originating in China spread around the globe and destroyed trillions in wealth. Covid-19 can strike anyone, anywhere. Wealth and power do not matter; and as such, Covid-19 works as a profound 'equalizer' - at a global and country level. We have all learned that the world will only be safe when we can collectively stop the impact of the pandemic everywhere.

In this interconnected world, the Covid-19 crisis confronts us all with daunting challenges. In this regard it is important to realize that most of the recent communicable disease crises originated in resource-poor countries. While this pandemic threatens health security and economic prospects globally, it will hit the African region even harder and will risk excluding the African continent from aspects of the global economy if the continent cannot manage to control Covid-19. The travel bans - which have ruled out medical tourism - contribute massively to the political will of the elites' and citizens' support at country-level to realize UHC and the much-needed transformation of health financing and delivery.
A unique opportunity has emerged to dramatically strengthen systems for health and at the same time build systems that are resilient and can be sustained beyond this crisis to the benefit of millions. However, given the low average health expenditures in the countries we support, this kind of genuine transformation is achievable only if we fully employ the potential of innovation. Such a system needs to reach and include all people interactively, through their mobile phones and networks of outpatient clinics, referral systems and connected diagnostics.

Therefore, PharmAccess and CarePay aim to support efforts to combat Covid-19 using the mobile health financing platforms, quality systems and investment instruments that we have helped build and test over the past ten years.

The Covid-19 crisis has revealed an urgent need for remote care. M-TIBA helps in this area by allowing individuals to communicate on their own terms, regardless of where they live.
In terms of specifically fighting Covid-19, an app is currently being developed to allow for the remote tracking of symptoms. Through the app, individuals can be counseled from remote care centers, thus reducing the infection risk at healthcare facilities.
As healthcare clinics begin responding to Covid-19 by upgrading their infection control protocols and services, the SafeCare digital program supports providers in helping them identify what equipment they need.
Timely credit is also needed for facilities as they purchase protective gear and supplies. Accordingly, MCF has begun providing faster emergency loans to healthcare providers, and with more flexible conditions.
For PharmAccess the Covid-19 crisis does bring challenges because of delays (staff is working from home in all countries) in implementing the programs, but moreover, it offers opportunities as described above. Continuity of PharmAccess is not at risk.

Our strategy will evolve in 2020 and beyond, while our mission remains the same. PharmAccess will stay focused on using public-private partnerships and innovation to strengthen health markets with digital technologies — so that people can access better services, lead healthier lives, and reach their full potential.

Institutional development

Since January 2017, in line with a request of The Ministry of Foreign Affairs, the governance structure of PharmAccess has been revised. The statutory responsibility for Stichting PharmAccess International and all PharmAccess group entities (i.e. Stichting Health Insurance Fund, Stichting Medical Credit Fund, Stichting SafeCare and Stichting HealthConnect) is vested with PharmAccess Group Foundation (PGF), represented by its executive board (statutair bestuur) under the supervision of one Supervisory Board, the PGF Supervisory Board.

During 2019 the composition of the PGF Supervisory Board as well as the Executive Board has not changed. Pauline Meurs who, at the end of 2018, took over from Max Coppoolse on temporary basis, still chairs the Supervisory Board. A search for a new chair is ongoing. Willem van Duin, Ben Christiaanse, Ruud Hopstaken, Peter van Rooijen and Lidwin van Velden stayed in their position as member of the Supervisory Board during 2019. As per January 1, 2020 Christiaan Rebergen (Treasurer-General of the Dutch Ministry of Finance) and Mirjam van Praag (President of the Vrije Universiteit, Amsterdam) joined the Supervisory Board.
Monique Dolfing-Vogelenzang and Jan Willem Marees stayed in their role of resp. CEO and CFO of the Executive Board.

In 2019, the number of staff increased to a total of 205,8 FTE per year-end (2018: 177.1 FTE per year-end). Out of the 205.8 FTE, 141 FTE are employed in Africa. The average number of full-time equivalents during the financial year 2019 was 210.0 (2018: 184.7). This increase can be largely explained by the start of a PharmAccess payroll in Nigeria whereas previously a payroller service was used until the end of 2018.

Signing of the Management Board's report

Amsterdam, 24 June 2020

J.W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang

J.W. Marees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IMPORTANT

CONSOLIDATED FINANCIAL STATEMENTS

- Consolidated Balance sheet
- Consolidated Statement of income and expenditure
- Consolidated Cash flow statement
- Notes to the consolidated financial statements

Consolidated balance sheet as at 31 December 2019

(After appropriation of the result)

	Note		31.12.2019		31.12.2018
			EUR		EUR
Assets					
Fixed assets					
Intangible fixed assets	1	29,688		60,253	
Tangible fixed assets	2	383,444	413,132	447,303	507,556
Current assets					
Receivables:					
Debtors	3	1,391,147		1,211,936	
Other receivables	4	834,327	2,225,474	1,786,372	2,998,308
Cash	5		9,819,723		11,107,302
			12,458,329		**14,613,166**

	Note		31.12.2019		31.12.2018
			EUR		EUR
Equity and liabilities					
Equity					
Continuity reserve	6	2,283,956		2,220,197	
Special purpose reserve	7	200,000	2,483,956	200,000	2,420,197
Current liabilities					
Creditors	8	1,044,979		811,924	
Taxes and social security contributions	9	255,912		179,303	
Deferred income	10	6,175,950		8,835,518	
Other liabilities and accrued expenses	11	2,497,532	9,974,373	2,366,224	12,192,969
			12,458,329		**14,613,166**

Consolidated statement of income and expenditure for the year 2019

	Note		2019		2018
			EUR		EUR
Income	12		24,267,142		24,330,888
Operating expenses:					
Direct project costs	13	12,840,260		12,815,827	
Personnel expenses	14	9,968,033		10,287,986	
Amortization and depreciation		154,037		162,030	
Other operating expenses		1,222,729	24,185,059	953,703	24,219,546
Operating result			***82,083***		***111,342***
Financial income and expenses:					
Financial expenses	15	(22,057)		(15,636)	
Financial income	16	3,733	(18,324)	91,497	75,861
Result			***63,759***		***187,203***
Appropriation of the result:					
Continuity reserve			63,759		97,336
Special purpose reserve			-		89,867
			63,759		**187,203**

Consolidated cash flow statement for the year 2019

(Based on the indirect method)

		2019		2018
		EUR		EUR
Operating result		***82,083***		***111,342***
Adjustments for:				
Depreciation (and other changes in value)		154,037		160,785
Changes in working capital:				
• movements operating accounts receivable	772,834		(333,617)	
• movement deferred income	(2,659,568)		(1,166,072)	
• movements other current liabilities	440,972	(1,445,762)	(572,019)	(2,071,708)
Cash flow from business activities		(1,209,642)		(1,799,581)
Interest received/paid		(14,085)		(6,130)
Cash flow from operating activities		*(1,223,727)*		*(1,805,711)*
Investments in (in)tangible fixed assets		(59,613)		(53,084)
Disposals of (in)tangible fixed assets		-		1,319
Cash flow from investment activities		*(59,613)*		*(51,766)*
Net cash flow		***(1,283,340)***		***(1,857,477)***
Exchange gains/(losses) on cash at banks and in hand		(4,239)		81,991
Movements in cash		**(1,287,579)**		**(1,775,486)**

The movement in cash at banks and in hand can be broken down as follows:

Cash as at 1 January	11,107,302	12,882,788
Movements in cash	(1,287,579)	(1,775,486)
Cash as per 31 December	**9,819,723**	11,107,302

Notes to the consolidated financial statements

General

Foundation

"Stichting PharmAccess International", hereinafter "PharmAccess Foundation", was founded on 19 January 2001 in accordance with Dutch law. PharmAccess Foundation's head office is based in Amsterdam, the Netherlands and has branch offices in Tanzania, Kenya, Nigeria and Ghana. PharmAccess Foundation is registered with the Trade Register at the Chamber of Commerce under number 34151082.

The financial statements have been prepared in euro's.

Objectives

Stichting PharmAccess International (PharmAccess Foundation) is a Dutch not-for-profit organization, founded in 2001, aiming to improve access to better basic healthcare including HIV/AIDS treatment and care in low income countries by stimulating public private partnerships (PPPs). Its vision is that in the absence of a fully functional state one has to revert to local private sector capacity and stimulate PPPs as a bridge to the establishment of regional and national programs. These programs are aimed at enlarging the available amount of money in the healthcare system, at increasing trust in institutions and at lowering risk for investments and prepayments and so stimulating the demand side of the healthcare sector and strengthening the supply side. PharmAccess Foundation works mainly in sub-Saharan Africa and has offices in the Netherlands, Nigeria, Tanzania, Kenya and Ghana.

Group structure

Stichting PharmAccess International in Amsterdam is the head of a group of legal entities.
A summary of the information required under articles 2:379 and 2:414 of the Netherlands Civil Code is given below:

Consolidated entities:	Registered office
- Stichting PharmAccess International	Netherlands
- Stichting PharmAccess International	Tanzania
- PharmAccess Foundation	Kenya
- PharmAccess Foundation	Nigeria
- P.A.I. Ghana	Ghana

Consolidation principles

Financial information relating to group companies and other legal entities controlled by Stichting PharmAccess International or where central management is conducted, has been consolidated in the financial statements of Stichting PharmAccess International. The consolidated financial statements have been prepared in accordance with the Dutch-Generally Accepted Accounting Principles (NL-GAAP).

The financial information relating to Stichting PharmAccess International is presented in the consolidated financial statements.

In accordance with article 2:10 of the Netherlands Civil Code, the foundation-only financial statements have been prepared separately and are not separately presented in these consolidated annual accounts.

Financial information relating to the group entities and the other legal entities included in the consolidation is fully included in the consolidated financial statements, eliminating the intercompany relationships and transactions.

Accounting principles

General

The consolidated financial statements have been prepared in accordance with the Guideline for annual reporting 640 “Not-for-profit organizations” of the Dutch Accounting Standards Board (‘Raad voor de Jaarverslaggeving’).

These consolidated financial statements represent the activities of PharmAccess Netherlands and the branch offices in Tanzania, Kenya, Nigeria, Ghana and Namibia.

The consolidated financial statements have been prepared using the historical cost convention and are based on going concern. Income and expenses are accounted for on accrual basis. Profit is only included when realized on balance sheet date. Liabilities and any losses originating before the end of the financial year are taken into account if they have become known before preparation of the financial statements.

If not indicated otherwise, the amounts of the accounts are stated at face value.

Consolidated Balance sheet

Intangible fixed assets

Intangible fixed assets are presented at cost less accumulated amortization and, if applicable, less impairments. Amortization is charged as a fixed percentage of 20% of cost. The useful life and the amortization method are reassessed at the end of each financial year.

Tangible fixed assets

Tangible fixed assets are presented at cost less accumulated depreciation and, if applicable, less impairments. Depreciation is based on the expected future useful life and calculated as a fixed percentage of cost, taking into account any residual value. Depreciation is provided from the date an asset comes into use.

Costs for periodical major maintenance are charged to the result at the moment they arise.

Receivables

Upon initial recognition the receivables are valued at fair value and then valued at amortized cost. The fair value and amortized cost equal the face value. Provisions deemed necessary for possible bad debt losses are deducted. These provisions are determined by individual assessment of the receivables.

Cash

The cash is valued at face value. If cash equivalents are not freely disposable, then this has been taken into account upon valuation.

Provisions

Provisions for employee benefits

The PharmAccess Foundation pension scheme for staff based in the Netherlands concerns a defined contribution scheme which is accommodated at the insurance company Delta Lloyd. The contribution to be paid is recognized in the 'Statement of income and expenditure'.

In countries where local branch offices are operational, pension contributions for local staff are recognized in the 'Statement income and expenditure' based on local legislation.

Current liabilities

Deferred income

Deferred income consists of payments from donors related to projects to be carried out decreased by the realized revenue of these projects, taking into account foreseeable losses on projects.

Other current liabilities

Upon initial recognition, liabilities recorded are stated at fair value and then valued at amortized cost.

Principles for the determination of the result

Consolidated Statement of income and expenditure

Income and expenditure are recognized as they are earned or incurred and are recorded in the consolidated financial statements of the period to which they relate.

Income

Income from 'Realized income related to projects' is recognized in proportion to the completed project activities rendered on active projects, based on the cost incurred up to balance sheet date. The costs of these project activities are allocated to the same period.

Other income relates to other non-project related items.

Direct project costs

Direct project costs consist of expenses directly related to projects (out-of-pocket costs) excluding staff costs.

Recognition of transactions in foreign currency

Transactions in foreign currencies are recorded at the exchange rate prevailing at the transaction date. At year-end, the assets and liabilities reading in foreign currencies are translated into euros at the rates of exchange as per that date.

Financial instruments

Financial instruments include both primary financial instruments, such as receivables and liabilities, and financial derivatives. Reference is made to the treatment per balance sheet item for the principles of primary financial instruments. The group does not use derivatives and there are also no embedded derivatives.
The group does not apply hedge accounting.

Principles for preparation of the consolidated cash flow statement

The consolidated cash flow statement is prepared according to the indirect method. The funds in the consolidated cash flow statement consist of cash and cash equivalents. Cash equivalents can be considered to be highly liquid deposits.

Cash flows in foreign currencies are translated at an estimated average rate. Exchange rate differences concerning finances are shown separately in the cash flow statement. Comparative figures have been adjusted for this cause.

Notes to the specific items of the consolidated balance sheet

1. Intangible fixed assets

	2019	2018
	EUR	EUR
Book value as at 1 January	60,253	90,818
Amortization during the year	(30,565)	(30,565)
Book value as at 31 December	**29,688**	**60,253**
Purchase value as at 31 December	167,361	167,361
Accumulated amortization	(137,673)	(107,108)
Book value as at 31 December	**29,688**	**60,253**

Intangible fixed assets concern software licenses of Microsoft and Exact. The amortization percentage of the intangible fixed assets is 20%.

2. Tangible fixed assets

	2019	2018
	EUR	EUR
Book value as at 1 January	447,303	525,757
Additions during the year	59,613	53,084
Depreciation during the year	(123,472)	(130,220)
Disposal of assets	-	(1,319)
Book value as at 31 December	**383,444**	**447,303**
Purchase value as at 31 December	970,640	911,027
Accumulated depreciation	(587,196)	(463,724)
Book value as at 31 December	**383,444**	**447,303**

The depreciation of the tangible fixed assets is calculated according to the straight-line method. The depreciation percentages are based on the economic life span. For computer equipment a depreciation of 33.3%, for refurbishment a depreciation of 10% and for office furniture and other assets a depreciation of 20% is used.

3. Debtors

	31.12.2019	31.12.2018
	EUR	EUR
Debtors	1,315,566	1,205,089
Related foundation: Health Insurance Fund (HIF) - accounts receivable	53,196	123
Related foundation: Medical Credit Fund (MCF) - accounts receivable	22,385	6,724
Provision for doubtful debts	0	0
Balance as at 31 December	**1,391,147**	**1,211,936**

4. Other receivables

	31.12.2019	31.12.2018
	EUR	EUR
Other	455,564	1,191,099
Revenues to be invoiced	310,576	314,645
Advances partners related to projects	60,780	263,681
Related foundation: Stichting PharmAccess Group Foundation (PGF)	-	9,620
Pension and other personnel insurances	7,407	7,327
Balance as at 31 December	**834,327**	**1,786,372**

5. Cash

	31.12.2019	31.12.2018
	EUR	EUR
ABN-AMRO-AMRO accounts Netherlands - EUR	4,818,827	6,597,486
ABN-AMRO-AMRO accounts Netherlands - USD	2,930,929	2,720,263
Bank accounts Tanzania - TZS	148,857	175,563
Bank accounts Tanzania - EUR	36,690	33,074
Bank accounts Tanzania - USD	57,289	70,647
Bank accounts Tanzania - GBP	10,661	10,781
Bank accounts Kenya - KES	572,016	324,528
Bank accounts Kenya - EUR	13,262	306,716
Bank accounts Kenya - USD	145,817	15,588
Bank accounts Nigeria - NGN	665,010	706,523
Bank accounts Nigeria - EUR	29,790	3,101
Bank accounts Nigeria - USD	257,707	910
Bank accounts Nigeria - GBP	7,168	7,500
Bank accounts Ghana - GHC	23,525	33,606

Bank accounts Ghana - EUR	99,151	97,410
Cash in hand	3,024	3,605
Balance as at 31 December	**9,819,723**	**11,107,302**

Funds are available in line with the different program and foundation objectives.

6. Continuity reserve

	2019	2018
	EUR	EUR
Balance as at 1 January	2,220,197	2,122,861
Result current year	63,759	97,336
Balance as at 31 December	**2,283,956**	**2,220,197**

Result appropriation for the year

Due to the appropriation of the result, an amount of EUR 63,759 has been added to the continuity reserve.

The continuity reserve is available to use in line with the described objectives of the foundation as stated in article 2 of the Articles of Association.

7. Special purpose reserve

	2019	2018
	EUR	EUR
Balance as at 1 January	200,000	110,133
Result current year	-	89,867
Balance as at 31 December	**200,000**	**200,000**

Result appropriation for the year

There has been no movement on the special purpose reserve as the maximum has been reached and no use was made during 2019.

Based on a board decision the result can be appropriated to the special purpose reserve. The size of the reserve will differentiate within the following computation guidelines:

- Until a maximum of 10% of the total equity;
- Until a maximum of EUR 200,000.

The reserve can be used for employees who, in person, are confronted with a catastrophic event and insuperable cost.

8. Creditors

	2019	2018
	EUR	EUR
Creditors	989,659	811,924
Related foundation: Health Insurance Fund (HIF) - accounts payable	53,390	-
Related foundation: Medical Credit Fund (MCF) - accounts payable	1.930	1,002
Balance as at 31 December	**1,044,979**	**811,924**

9. Taxes and social security contributions

	31.12.2019	31.12.2018
	EUR	EUR
Value added tax	76,908	35,407
Wage tax	179,596	143,914
Social security contributions	(592)	(18)
Balance as at 31 December	**255,912**	**179,303**

10. Deferred income

	31.12.2019	31.12.2018
	EUR	EUR
Received from donors related to projects	85,885,417	96,677,907
Realized revenue on projects	(79,709,467)	(87,842,389)
Balance as at 31 December	**6,175,950**	**8,835,518**

Below an alternative disclosure of the movement in the deferred income throughout the financial year:

	2019	2018
	EUR	EUR
Balance as at 1 January	8,835,518	10,001,590
Received from donors related to *active* projects	(10,792,490)	19,669,924
Realized revenue on *active* projects	8,132,922	(20,835,996)
Balance as at 31 December	**6,175,950**	**8,835,518**

The deferred income reflects the balance of the 'work in progress' per year-end. The 'work in progress' (contract portfolio) contains an amount of EUR 7,167,137 (2018: EUR 9,496,795) for by donors pre-financed projects (credit) and an amount of EUR 991,187 (2018: EUR 661,277) for reimbursement projects (debit).

11. Other liabilities and accrued expenses

	31.12.2019	31.12.2018
	EUR	EUR
Holiday allowance	179,619	177,028
Liabilities projects	435,569	320,702
Salaries	-	2,189
Accrued expenses	1,290,105	1,313,411
Liability Health Insurance Fund / MoFA	15,504	14,843
Other liabilities	576,735	538,051
Balance as at 31 December	**2,497,532**	**2,366,224**

The liability projects include an amount of EUR 431,636 (2018: 310,048) as liability to a 'related foundation', Medical Credit Fund (MCF).

Contingent assets and liabilities

Regarding the current project portfolio PharmAccess Foundation received from donors' commitments for grants for an amount of about EUR 108 million (2018: EUR 104 million). Of this amount EUR 86 million (2018: 97 million) has been received. PharmAccess Foundation has the obligation to use these funds in accordance with the contractual donor requirements.

Financial instruments

For the notes to financial instruments reference is made to the specific item by item note. The main financial risks the foundation is exposed to are the currency risk, the liquidity risk and the credit risk. The foundation financial policy is aimed at mitigating these risks by:

Currency risk

The currency risk is mitigated by holding the received foreign currency pre-payments on ongoing foreign currency contracts as long as possible in the contracted foreign currency and only convert into the functional currency (EUR) based on commitments.

Liquidity risk

The liquidity risk is mitigated by monthly monitoring the work in progress portfolio and closely monitor and steer the deferred income position per contract.

Credit risk

The credit risk is limited as most of PharmAccess' programs are prefunded. For the local branch offices, the credit risk is mitigated by providing only two months rolling advances.

Non-recognised assets and liabilities and contingent assets and liabilities

Although it is not a contractually agreed commitment, PharmAccess has the intention to yearly allocate up to EUR 2 million of the HIF-funding (Ministry of Foreign Affairs) to the Medical Credit Fund (MCF).

The exact yearly budgets are to be determined during the yearly activity planning and budgeting process within the PharmAccess Group, and finalized before November 1st, prior to the budget year.

In December 2016 a ten-year operational lease agreement was signed for the premises - AHTC buiding, 4th floor, Tower C and D - located at the Paasheuvelweg 25 in Amsterdam, the Netherlands. The yearly operational lease amount amounts to EUR 211,185. The first two years are free of charge, year 3: 60%, year 4: 73,3%, year 5: 86,6% and year 6 -10: 100% of the yearly operational lease amount.

Notes to the specific items of the consolidated statement of income and expenditure

12. Income

	2019	2018
	EUR	EUR
Realized income related to projects	24,328,120	24,271,602
Other income	(60,978)	59,286
	24.267,142	**24,330,888**

The main 'Realized income related to projects' consist of:

Ministry of Foreign Affairs - HIF	10,750,391	10,096,980
Nationale Postcode Loterij - Amref: I-Push	1,490,729	1,563,196
Children's Investment Fund Foundation (CIFF)	1,353,859	-
National Hospital Insurance Fund (NHIF), Kenya	1,144,168	-
PEPFAR	1,103,338	4,224,156
Nationale Postcode Loterij	900,000	900,000
Medical Credit Fund (MCF)	860,681	748,539
Boehringer Ingelheim	701,033	-
Sint Antonius Stichting	500,597	-
Merck for Mothers	455,087	527,956
Ministry of Foreign Affairs - JLI: FT-conference	400,000	-
USAID - Palladium International LLC	394,425	-
FDOV MoH - Healthy Business	362,905	187,943
M-Pesa Foundation - Samburu	346,071	101,260
John C. Martin Foundation	324,553	161,274
Sanofi	316,654	285,930
Marie Stopes International (MSI): AHME	312,230	478,647
The Henry M. Jackson Foundation (HJF)	271,108	256,271
Society for Family Health (SFH)	219,331	90,579
Global Fund - ICI-Santé	218,846	-
Joep Lange Institute (JLI): HCV Treatment	172,901	180,957
Human Development Innovation fund (HDIF)	167,549	830,723
USAID - Saving Lives at Birth: Kwara	163,122	347,954
Pfizer Foundation - Health Wallet & Chamas	102,774	180,316
Embassy Kingdom of the Netherlands in Accra, Ghana	74,150	63,471
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH	61,091	-
Achmea	51,306	-
AmsterdamDiner Foundation - Aidsfonds: Mozambique	36,967	89,991
KNCV - DGIS Nigeria	19,486	186,404
Gilead Sciences, Inc.	10,818	410,266

Elma Foundation	-	305,373
AmsterdamDiner Foundation - Aidsfonds: 2017	-	555,000
Other	1,041,950	1,498,416
	24,328,120	**24,271,602**

*) The 'Ministry of Foreign Affairs' funding has been received via the Health Insurance Fund.

PAI attracts external funding for specific activities/programs in order to reach its strategic objectives. These activities are carried out within the timetable as set in the different funding contracts. The duration of those funding contracts differs from several months to several years. At the end of a subsidy period, depending on the (financial) progress of the program, PAI could request for a budget neutral extension to complete the planned activities within the available budget.

13. Direct project costs

	2019	2018
	EUR	EUR
PAI - Netherlands	5,824,680	5,030,789
PAI - Tanzania	1,979,594	4,479,471
PAI - Kenya	3,814,921	2,490,413
PAI - Nigeria	765,109	500,937
PAI - Ghana	455,956	314,217
	12,840,260	**12,815,827**

14. Personnel expenses

	2019	2018
	EUR	EUR
Salaries	7,765,692	7,882,607
Social security contributions	1,020,550	1,079,792
Pension costs	520,490	499,954
Other personnel expenses	661,301	825,633
	9,968,033	**10,287,986**

15. Financial expenses

	2019	2018
	EUR	EUR
Exchange rate differences	2,838	0
Bank interest and charges	17,818	13,987
Other	1,401	1,650
	22,057	**15,637**

16. Financial income

	2019	2018
	EUR	EUR
Bank interest	3,733	9,506
Exchange rate differences	-	81,991
Other		0
	3,733	**91,497**

Other notes

Number of employees

The average number of full-time equivalents during the financial year 2019 was 210.0 (2018: 184.7). This increase can be largely explained by the start of a PharmAccess payroll in Nigeria whereas previously a payroller service was used until the end of 2018.

Remuneration Directors and Supervisory Board

The remuneration of Directors during the financial year 2019 amounted to EUR 323,762 (2018: EUR 381,816). This remuneration consists of gross salary and a defined pension contribution:

	2019	2018
	EUR	EUR
Gross salary	294,888	347,701
Pension contribution	28,874	34,115
	323,762	**381,816**

The average number of full-time equivalents for the Board of Directors in 2019 was 2 (2018: 2.4).

2019

	M.D. Dolfing-Vogelenzang CEO	J.W. Marees CFO	Total
	EUR	EUR	EUR
Gross	136,092	134,684	270,776
Holiday allowance	10,887	9,775	20,662
Total remuneration DG-standard	146,979	144,459	291,438
Health insurance contribution	2,070	1,380	3,450
Total gross salary	149,049	145,839	294,888
Costs allowance	-	-	-
Pension contribution	14,466	14,408	28,874
Total remuneration WNT	163,515	160,247	323,762
Period of engagement:			
Engaged from	01.01.2019	01.01.2019	
Engaged to	31.12.2019	31.12.2019	
FTE%	100%	100%	

Although PharmAccess Foundation is not obligated to comply with the WNT-norm, management has chosen to voluntarily comply and therefore disclose the above presented table. The remuneration costs for individual Directors meet the WNT-norm and the standard DG-norm as set by the Ministry of Foreign Affairs. Both norms

set an upper boundary for Board Member remuneration. The Supervisory Board does not receive any remuneration.

2018

	O.P. Schellekens CEO	M.D. Dolfing-Vogelenzang COO	J.W. Marees CFO	Total
	EUR	EUR	EUR	EUR
Gross	55,354	132,120	131,120	318,594
Holiday allowance	4,428	10,570	9,490	24,488
Total remuneration DG-standard	59,782	142,690	140,610	343,081
Health insurance contribution	1,320	1,980	1,320	4,620
Total gross salary	61,102	144,670	141,930	347,701
Costs allowance	0	0	0	0
Pension contribution	6,093	14,038	13,984	34,115
Total remuneration WNT	67,195	158,707	155,914	381,816
Period of engagement:				
Engaged from	01.01.2018	01.01.2018	01.01.2018	
Engaged to	31.08.2018	31.12.2018	31.12.2018	
FTE%	60%	100%	100%	

Subsequent events

The outbreak of Covid-19 developed rapidly in 2020. To mitigate the risk of this outbreak, we have taken a number of measures to monitor and prevent the effects of the Covid-19 virus, such as safety and health measures for our employees (e.g. limiting social contacts and working from home). At this stage, the impact on our operations and our results is limited. We will continue to follow the policies and advice of the various national institutions. Given the future developments of Covid-19 pandemic is uncertain we can not predict if there will be more severe impact from Covid-19 in the future. Based on our current analysis the Covid-19 pandemic does not lead to material uncertainties on the going concern of the organization.

Signing of the consolidated financial statements

Amsterdam, 24 June 2020

J.W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang

J.W. Marees

OTHER INFORMATION

Independent auditor's report

The independent auditor's report is recorded on the next page.

Independent auditor's report

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Independent auditor's report

To the Management Board of Stichting PharmAccess International

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS 2019 INCLUDED IN THE ANNUAL ACCOUNTS

Our opinion

We have audited the accompanying financial statements 2019 of Stichting PharmAccess International, based in Amsterdam.

In our opinion the accompanying consolidated financial statements give a true and fair view of the financial position of Stichting PharmAccess International as at December 31, 2019, and of its result in accordance with Dutch Accounting Standard 640 "Not-for-profit organizations".

The financial statements comprise:

1. The balance sheet as at December 31, 2019.
2. The statement of income and expenditure for 2019.
3. The notes comprising a summary of the accounting policies and other explanatory information.

Basis for our opinion

We conducted our audit in accordance with Dutch law, including the Dutch Standards on Auditing. Our responsibilities under those standards are further described in the "Our responsibilities for the audit of the financial statements" section of our report.

We are independent of Stichting PharmAccess International in accordance with the Wet toezicht accountantsorganisaties (Wta, Audit firms supervision act), the Verordening inzake de onafhankelijkheid van accountants bij assurance-opdrachten (ViO, Code of Ethics for Professional Accountants, a regulation with respect to independence) and other relevant independence regulations in The Netherlands. Furthermore, we have complied with the Verordening gedrags- en beroepsregels accountants (VGBA, Dutch Code of Ethics).

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Explanatory emphasis on the impact of COVID-19

The coronavirus also has consequences for the PharmAccess International Foundation. Management has disclosed the current impact and intends to disclose these circumstances in the notes of the financial statements. Management also indicates that it is currently not possible for them to properly estimate the future impact of the coronavirus on the financial performance and health of the PharmAccess International Foundation. Our opinion has not changed on this point.

REPORT ON THE OTHER INFORMATION INCLUDED IN THE ANNUAL ACCOUNTS

In addition to the financial statements and our auditor's report thereon, the annual accounts contains other information that consists of:

- Management Board's Report.
- Other information.

Based on the following procedures performed, we conclude that the other information:

- Is consistent with the financial statements and does not contain material misstatements.
- Contains the information as required by The Dutch Accounting Standard 640 "Not-for-profit organizations".

We have read the other information. Based on our knowledge and understanding obtained through our audit of the financial statements or otherwise, we have considered whether the other information contains material misstatements.

By performing these procedures, we comply with the requirements of the Dutch Standard 720. The scope of the procedures performed is substantially less than the scope of those performed in our audit of the financial statements.

Management is responsible for the preparation of the other information, as required by the Dutch Accounting Standard 640 "Not-for-profit organizations".

DESCRIPTION OF RESPONSIBILITIES REGARDING THE CONSOLIDATED FINANCIAL STATEMENTS

Responsibilities of management for the consolidated financial statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with Dutch Accounting Standard 640 "Not-for-profit organizations". Furthermore, management is responsible for such internal control as management determines is necessary to enable the preparation of the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

As part of the preparation of the consolidated financial statements, management is responsible for assessing the foundation's ability to continue as a going concern. Based on the financial reporting framework mentioned, management should prepare the financial statements using the going concern basis of accounting unless management either intends to liquidate the foundation or to cease operations, or has no realistic alternative but to do so.

Management should disclose events and circumstances that may cast significant doubt on the foundation's ability to continue as a going concern in the financial statements.

Our responsibilities for the audit of the financial statements

Our objective is to plan and perform the audit assignment in a manner that allows us to obtain sufficient and appropriate audit evidence for our opinion.

Our audit has been performed with a high, but not absolute, level of assurance, which means we may not detect all material errors and fraud during our audit.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. The materiality affects the nature, timing and extent of our audit procedures and the evaluation of the effect of identified misstatements on our opinion.

We have exercised professional judgement and have maintained professional skepticism throughout the audit, in accordance with Dutch Standards on Auditing, ethical requirements and independence requirements. Our audit included e.g.:

- Identifying and assessing the risks of material misstatement of the financial statements, whether due to fraud or error, designing and performing audit procedures responsive to those risks, and obtaining audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the foundation's internal control.

- Evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Concluding on the appropriateness of management's use of the going concern basis of accounting, and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the foundation's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the foundation to cease to continue as a going concern.

- Evaluating the overall presentation, structure and content of the financial statements, including the disclosures.

- Evaluating whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

Because we are ultimately responsible for the opinion, we are also responsible for directing, supervising and performing the group audit. In this respect we have determined the nature and extent of the audit procedures to be carried out for group entities. Decisive were the size and/or the risk profile of the group entities or operations. On this basis, we selected group entities for which an audit or review had to be carried out on the complete set of financial information or specific items.

We communicate with the Managament Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant findings in internal control that we identified during our audit.

Amsterdam, June 24, 2020

Deloitte Accountants B.V.

Signed on the original: S. Kramer

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PharmAccess
FOUNDATION