PharmAccess Foundation

Annual Accounts 2015

14 June 2016

PharmAccess FOUNDATION

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Amsterdam, the Netherlands

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MANAGEMENT BOARD'S REPORT

Introduction

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, Namibia, Kenya and Ghana.

In 2001, Joep Lange founded the PharmAccess Foundation in order to improve access to healthcare for people in sub-Saharan Africa. As the public sector did not yet have the necessary infrastructure, he decided to approach the private sector. Heineken was the first company to see the need for and the potential of this idea. As such, PharmAccess designed and implemented an HIV/AIDS treatment program for Heinekens employees and dependents in sub-Saharan Africa, using local private sector capacity. Other companies and multinationals such as Unilever, Coca Cola, Diageo, Zain and Shell followed suit and PharmAccess supported them to launch similar HIV/AIDS workplace policies and treatment programs. It was soon realized that these programs could be broadened to lay a foundation for the development of functional general health systems in sub-Saharan Africa. This led to a major initiative coordinated by the Dutch Ministry of Foreign Affairs: a working group of Dutch multinationals and PharmAccess Foundation to explore the feasibility of setting up a large scale of PPPs, to develop general healthcare systems in sub-Saharan Africa and thus also contribute to economic development. This working group led to the establishment of PharmAccess Foundation's first spin-off: the Health Insurance Fund (HIF).

HIF was founded late 2005 at a time when the HIV/AIDS epidemic had made clear that despite the positive impact of some of the large vertical initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR), healthcare delivery systems in sub-Saharan Africa were failing. The Dutch government, Dutch multinationals and PharmAccess Foundation joined forces to launch an alternative mechanism to the traditional development approach: a donor fund established to lower the risk for investments and prepayments, to increase trust and to pilot community health insurance for the currently uninsured in sub-Saharan Africa through the local private sector. This fund received a EUR 100 million grant from the Dutch Ministry of Foreign Affairs in 2006 (extended to EUR 104.9 million end 2014) and a grant of USD 6 million from The World Bank in 2009. The HIF programs have the objective to increase access to better basic health care for currently uninsured groups, mainly through private health facilities and to lower the threshold for investment in private healthcare infrastructure. PharmAccess Foundation manages the programs of the HIF.
On behalf of the Ministry the Boston Consulting Group (BCG) conducted an independent assessment of the HIF program. This first funding period was positively evaluated.

"HIF funding allowed to intervene in an area where not many NGOs delve into: the complex public-private healthcare system. In the process they successfully introduced (if not completed) the targeted paradigm shift, accomplished their key objectives and bettered the internal organization and its partners." (source BCG evaluation 2015).

According to the evaluation report, this has contributed to a significant change in the way the role of private sector development in healthcare is perceived today. The grant from the Ministry enabled HIF and its partners to mobilize more than three times its' funding in realized commitments, and more than four times in committed funds, from local governments, local banks, investors, donors and private individuals. BCG deems the Ministry's grant to HIF to be well-invested, consistent with and supportive of the Dutch government's development agenda. The Dutch Ministry of Foreign Affairs has renewed the partnership with HIF for the period 2016-2022 and PharmAccess will continue to manage the HIF programs.

In 2007, and in parallel to the establishment of the HIF, PharmAccess Foundation initiated the development of the Investment Fund for Health in Africa (IFHA). IFHA is a private equity fund focusing on investments in medical infrastructure such as hospitals and medical supply chains and so strengthening the supply side.

In 2009 a third spin-off of PharmAccess Foundation was established: the Medical Credit Fund (MCF). The objectives of MCF are to strengthen the business cases and reduce the risk profile of Small and Medium size Enterprises (SMEs) operating in the healthcare sector and also to improve the quality of their services by providing technical assistance and facilitating access to investment capital through local banks. By the end of 2015, MCF had provided 776 (2014: 617) loans through local partner banks to 586 healthcare providers in Kenya,

Tanzania, Ghana and Nigeria. These loans are totaling about EUR 9.2 million with an overall repayment ratio of 96.8%.

Also, as a spin-off of the quality improvement activities within the HIF programs the 'SafeCare concept' was developed. In 2011 the 'SafeCare Initiative' (SafeCare) was launched as an independent quality improvement and rating label. SafeCare acts as the custodian of internationally recognized standards covering the spectrum of basic health care for defined categories of healthcare providers. It represents the collaboration between PharmAccess Foundation, Joint Commission International (JCI) and the Council for health service accreditation Southern Africa (COHSASA).

Projects and programs

During 2015, PharmAccess Foundation supported and offered the following programs and services:

Health plans

PharmAccess Foundation manages and implements the health plans programs of the Health Insurance Fund in Nigeria, Tanzania and Kenya. Technical assistance is provided to programs in Namibia and Mozambique. Over the years for all programs important lessons are learned. To accomplish sustainability, the programs were adapted so that either the local government or the insured themselves increased their commitment. This way the programs decreased their dependency on subsidy.

The most effective way to provide access to better healthcare is to share risks and costs across the population. In this way, people make contributions – through taxation, remittances and/or insurance either compulsory or voluntary – to a pool of funds. They can draw on these funds in case of illness, regardless of how much they have contributed. In sub-Saharan countries the state is not able to deliver public services accessible to the entire population. As the private health sector provides half of the care, the Health Insurance Fund and PharmAccess target the private sector to test and implement different healthcare delivery models and demand-side financing programs.

Many governments are grappling with the complex and daunting task to make healthcare delivery and financing work for the informal sector, i.e. the large majority of the population in low and middle income countries who are not formally employed. The informal sector contributes about 55% of sub-Saharan Africa's gross domestic product and 80% of the labor force working in small kiosks, shops, farms etc.

HIF has supported the implementation of ten different regional demand-side financing models in Kenya, Nigeria, Tanzania, Mozambique and Namibia since 2007. The first demand-side financing model was launched in Nigeria. Local private insurer Hygeia Community Health Care tested the viability of introducing a risk pool through subsidized health insurance for the urban poor in Lagos State and for the rural community in Kwara State. Various other models followed with local parties – insurers, third-party administrators and community groups or cooperatives - in Tanzania (SCHIP, MicroEnsure, KNCU/iCHF), in Kenya with private insurer AAR, third-party administrator Africa Medilink and mobile operator Safaricom (mobile Health Wallet, TCHP, DL Koisagat, Bima Poa and Samburu) and in Mozambique and Namibia.

Taking innovation to scale through strengthening the public-private partnerships

A number of health plans caught the attention of (local) governments in their respective regions and countries. The demonstration effect of these health plans has made these governments eager to incorporate and finance the premium subsidies for these programs and to invest in health infrastructure. The emphasis during the year has been on *transitioning and strengthening the public-private partnerships.*

In Tanzania, the private health insurance program with the coffee farmers of the KNCU (the country's largest and oldest cooperative) was successfully transitioned to a public-private partnership with NHIF to introduced the improved Community Health Fund (iCHF) districts of the Northern Zone of Tanzania. It is still early days for this initiative and, despite initial success in enrollment and expansion, there are challenges in reaching substantial penetration among the population of these districts and in retention of existing members.

At the same time, public-private collaboration also demonstrates the limitations of depending on governments for the (part) financing and (part) implementation of health insurance programs. Most notably, in Kwara State in Nigeria negotiations were held between the Health Insurance Fund, the PharmAccess Group, implementing partner HCHC and the Governor of the State to transfer the responsibility of premium subsidy funding to the State Government. An agreement was reached in November 2015 to establish a dedicated State Health Insurance Fund to be capitalized by the State and HIF by 1 March 2016 with some of the funding to be secured from internal revenue, the Saving One Million Lives Program (SOML) and the National Health Insurance Scheme (NHIS).

As (subsidized) health insurance coverage grows among the populations in Ghana and Kenya issues of meeting financial obligations through tax revenues will put a strain on societies in which the majority of citizens are not active in the formal sector of the economy. Generating funding through taxes and solidarity mechanisms (e.g. cross subsidization) will be challenging, as it requires enforcement by institutions that are currently not well established or well respected.

Delivery infrastructure quality & development

In 2011, SafeCare was formally launched under a joint agreement between PharmAccess Foundation, COHSASA and JCI as a stepwise certification methodology. During the years after 2011 the concept behind SafeCare was further developed and the international attention for this proposition grew enormously. The standards developed by SafeCare as well as the surveyor training processes have been ISQua accredited. Contracts were concluded with the AHME consortium (see below), Population Services International (PSI), the National Social Security Fund in Tanzania (NSSF), ELMA Foundation, HDIF, USAID, Heineken, Shell and MCF.

SafeCare is implemented in clinics in six countries – Ghana, Kenya, Namibia, NigeriaTanzania and since 2015 in Uganda - and is also increasingly being institutionalized by governments in Africa to regulate and monitor their health sectors, both on the public and the private side. Increased government regulation through SafeCare is bringing the private sector and the public system closer together and on a higher level, both of which are instrumental in attracting much-needed private investment capital into African health systems.

In 2015 the total number of providers in the healthcare delivery model increased from 1,628 in 2014 to 2,248. The number has continued to grow steadily since SafeCare's inception in 2011, notably due to partnerships with private sector organizations such as APHFTA, KMET but also the social franchises of Marie Stopes, PSI, and Society for Family Health and FHI360. Apart from HIF subsidy, most of these activities were funded by international donors B&MGF and/or DFID (AHME, HDIF), ELMA Foundation and USAID. In 2015 the methodology continued to attract self-paying clients (hospitals directly contracting PharmAccess for this service). The collaboration with the public sector intensified through closer partnerships with the Ministry of Health & Social Welfare in Tanzania and the NHIF in Kenya. In addition to the activities listed above, PharmAccess Group used the SafeCare methodology for the comparison and selection of clinics for its health plans. For example, the methodology was used to select facilities for the Health Plans in the Improved Community Health Insurance Fund (iCHF) in Tanzania. A total of 2,379 assessments had been conducted by the end of 2015.

SafeCare assessments for facilities accessing loans through the Medical Credit Fund also expanded further. Until 2015, PharmAccess and the Medical Credit Fund (MCF) had applied a distinction between clinical and business TA, with the MCF providing services to strengthen the business cases of healthcare facilities, and PharmAccess performing SafeCare assessments and providing TA to stimulate improvement of the clinical processes in healthcare facilities. Building on lessons learned in the five years of Medical Credit Fund operations, the

management of the Medical Credit Fund and PharmAccess decided to concentrate and align the full TA offering related to the healthcare providers within PharmAccess in 2015. This shift of TA to PharmAccess enabled to optimize the services to the healthcare providers by including the much requested business support elements.

AHME African Health Markets in Equity (Kenya, Nigeria, Ghana)

PharmAccess Foundation, SafeCare and MCF participate in a five-year program - the African Health Markets in Equity (AHME) - that intends to strengthen the healthcare market and provide affordable care in Nigeria, Ghana and Kenya. The AHME program is led by Marie Stopes International and funded by BMGF and DFID. The program includes a considerable component for health insurance, which is managed by PharmAccess Foundation together with the WorldBank/IFC. The other participating members of the consortium include Society for Family Health Nigeria and Population Services International.

National Social Security Fund (NSSF, Tanzania)

SafeCare is working with the NSSF and jointly introducing the SafeCare methodology to facilities providing health services to beneficiaries of the NSSF and Social Health Insurance Benefit (SHIB). Also technical assistance is provided to the NSSF to expand their informal sector enrollment.

Corporate programs (consultancy and workplace programs)

The consultancy team consists of expert advisors on public-private partnerships, with a focus on strategic advisory services and technical assistance as well as HIV/AIDS workplace treatment programs in Africa. Over the years PharmAccess Consultancy has developed a stronger focus on health infrastructure development with the aim to reduce risks for investors and, as a result of its activities in this field, has generated several business opportunities:

Examples of such opportunities include the following activities:

- In November 2014 PharmAccess officially commenced a project in Ghana, based on the Project Proposal 'Building the business of Sexual & Reproductive Care; Setting a standard for high quality and affordable sexual and reproductive care for middle income groups'. This grant was awarded by the Minister of International Trade and Development Cooperation by decision dated 30 September 2014. The funding is provided through the Embassy of the Kingdom of the Netherlands in Accra, Ghana. With this project PharmAccess aims to test an operational model which provides high quality care to a broader group of clients while also strengthening the business performance of the facilities and laying the foundation for a commercial franchise. In 2015 PharmAccess managed to form a partnership with two private hospitals in Accra who provide high quality services in Obstetrics, Gynecology and Pediatric care serving middle class patients. Together with these partners the concept was further thought through and a business plan was developed. The model is now being operationalized and implemented in the two hospitals.

- Supported by a "Facility for Sustainable Entrepreneurship and Food Security" grant of the Netherlands Ministry of Foreign Affairs, a partnership was started in Kenya with Strathmore Business School, World Bank IFC, a Kenya-based consultancy firm called Health Management Solutions, and the Ministry of Health, amongst others, to develop integrated business development support services to improve the performance of healthcare facilities. Strathmore Business School, PharmAccess and the Medical Credit Fund jointly

developed a curriculum for a “Managing Healthcare Business” mini-MBA designed for doctors, nurses and clinical officers in the program. The courses are complemented with one-to-one coaching and consultancy services provided by SME consultants.

- PharmAccess has supported the HIV/AIDS Workplace Program of the Tanzania Peoples Defense Force (TPDF) since 2006. The Program is funded by PEPFAR through the US Department of Defense. Activities include HIV prevention, counseling and testing, prevention of mother-to-child transmission, male circumcision, care and treatment, harmonization of HIV and TB services and support to orphans and vulnerable children. So far a total of 74 TPDF clinics have been refurbished and equipped and staff has been trained to provide these services. Clinics are open for army personnel and civilians. Last year over 100,000 persons have been tested for HIV and more than 14,000 patients are currently on treatment.

mHealth

MHealth and mobile money are the most important innovations that can make investments in affordable quality healthcare more effective and efficient, while mobile money is also a great instrument to attract further investments in mHealth. It is increasingly recognized that developments in information and communications technology such as cloud computing, big data and particularly mobile (money) technology have the potential to completely transform the health sector in Africa by increasing trust, empowering patients, lowering transaction costs drastically and by accelerating prepayment and risk-pooling products for health services.

Introducing mobile technology will facilitate the demand as well as the supply of the healthcare system. Mobile money will increase the efficiency of transactions throughout the healthcare sector (payments of demand-side

financing products, claim payments, donor funding, etc.) and create the possibility to efficiently collect standardized data.

It is therefore PharmAccess' priority to incorporate mHealth and mobile money into the programs. Kenya leads the world in mobile money with mobile-money system M-PESA, which was launched in 2007 by Safaricom, the country's dominant mobile-network operator. M-PESA has 19 million registered users, 12.7 million of whom are active. It has a household penetration of 96%; many of the people on low income use M-PESA from time to time, for instance to receive mobile remittances from their family in the cities. Over six million transactions are carried out over the service daily, more than Western Union does globally. It has an 85,000 strong agent network—more than any bank in Kenya can ever dream of.

Safaricom invited PharmAccess Group in 2012 to "make M-PESA work for healthcare too". It recognized the opportunities to transform healthcare financing and delivery in Kenya. A partnership was formed with the frontrunners in mobile money in Africa – Kenya's M-PESA Foundation, Safaricom / Vodafone – and AAR, the largest insurer in East Africa, in 2013 which was later joined by the Global Fund in 2014.

By linking health payment transactions between patients and providers via the mobile phone to the M-PESA network the partnership is building together a mobile health payment and data platform that connects directly patients, providers and payers (insurers, funders, peer-to-peer funders, governments and other stakeholders), enabling real-time transactions between all parties. Trust is created among patients, healthcare providers and payers, thereby reducing drastically investment risks, increases liquidity immediately and drastically lowers transaction costs. A mobile health payment platform for healthcare transactions piggybacks on the trust in M-PESA and can accelerate a virtuous cycle in the health system by connecting all stakeholders, just like M-PESA did for ordinary transactions.

mHealth Lab

Having started in Nairobi, Kenya, in 2013, the mHealth Research Labs expanded operations into Nigeria and Tanzania in 2015, performing 21 tests in total. 44% of its work was conducting experiments among patients and healthcare providers relating to information & communication while 56% of the tests focused on financial transactions. On the patient side, most activities involved the use of the mobile health wallet, e.g. if patients are willing to save for healthcare themselves. On the healthcare provider side, we test among others Cashless Clinic (i.e. a clinic that did not accept any cash for a period of 6 weeks), and with a Cash Advance. The latter is a loan for which mobile money revenue streams serve both to determine the creditworthiness of the facility, and to repay the loan by automatically deducting repayments and interest from the health wallet transaction.

Knowledge translation, learning and Analysis

To improve program effectiveness and support innovation, recursive learning cycles of implementation and research are essential: scientific knowledge is integrated in practice and operational and impact research builds scientific proof of principle. This includes testing and validating different models of financing and healthcare delivery and information on quality improvements. These data and resulting lessons are being shared in various ways to increase understanding of how interventions work in different contexts. They offer a basis for addressing the local realities relevant to PharmAccess Group projects and programs. Moreover, scientific proof of principle and independent evidence of impact are powerful tools, used by the PharmAccess Group to influence

international funders, policy makers, regulators, implementing parties and other stakeholders. Building on the completed and ongoing studies of the first funding period (2006 – 2015) a new Research Agenda was developed. Other results of 2015 include 8 peer reviewed scientific papers, various posters and presentations on international conferences, 16 research briefs (two-pagers), 3 documentaries and case studies, 12 reports, 7 charts, 18 power point presentations, 2 PhD degrees and 3 Master degrees.

Nationale Postcode Loterij

In 2015, for the third year, PharmAccess Foundation is supported by the Nationale Postcode Loterij (EUR 500,000). This enabled PharmAccess (a) to further work on innovative mobile (mHealth) proposition, specifically on mHealth Lab tests in Kenya, (b) to continuously work on effective systems, in particular, for the SafeCare proposition, to invest in data management and reporting infrastructure (AfriDB) for small and medium-sized clinics and (c) to further invest in knowledge development of as well the PharmAccess organization as of our African partners.

Financial

Total income in 2015 amounts to EUR 26.7 million (2014: EUR 22.5 million) and the operating result is EUR 232,520 (2014: EUR 176,137). Together with financial result, PharmAccess Foundation has managed to the end the year of 2014 with a total surplus of EUR 518,988 (2014: EUR 230,531).

After appropriation of the result the balance of income and expenditure amounts to EUR 2,005,847 (2014: EUR 1,486,859). To secure the continuity of PharmAccess Foundation, management 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 managed by 'head office' based in Amsterdam. Apart from general management, financial management, HR and ICT the 'head office' is staffed with a SafeCare-, a HealthPlans- and a Consultancy team managing the respective programs. The actual implementation of the programs takes place in the African countries for which PharmAccess has offices in Tanzania, Kenya, Nigeria, Ghana and Namibia. 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 the risk assessment and risks management process is addressed on quarterly basis. The monitoring and managing of risks takes 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 by the foundation 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;
- Reputational risks – mitigated by attention for external communication and advocacy.

Outlook 2016 and beyond

With the support of the Dutch government, PharmAccess and the related entities of the PharmAccess Group have been able to make a major contribution to a shift in the development paradigm for healthcare in Africa by:

- initiating private sector investments, risk was reduced and investments stimulated thus realizing substantial leverage with private and public funds;
- starting innovative approaches for inclusive and affordable access to quality healthcare and delivering proof of principle to enable scale-up to structural change;
- implementing and institutionalizing quality standards improving access to quality healthcare and reducing risk to increase access capital;
- demonstrating and promoting effectiveness through rigorous scientific impact evaluation, advocacy and policy change.

These achievements were also highlighted in the external evaluation conducted by the Boston Consulting Group in early 2015.

Strategy and objectives for the future

BCG confirms that the theory of change, problem analysis and integrated approach of PharmAccess and Health Insurance Fund have proven their value and remain valid. Through the learning by doing approach, and by working with a great variety of partners, many lessons have been learned. The initiatives merit further application by improving, supporting adoption and expansion of existing interventions, as well as by developing and testing new delivery and finance innovations. Moreover, recent trends on the continent, including technological and mobile payment developments provide hitherto unknown opportunities to make a next step towards inclusive African health markets. PharmAccess will continue its approach of working through strategic public-private partnerships and building local capacity, focusing on the following objectives:

1. Develop private pre-payment mechanisms, risk pooling structures, and mobilize public resources for organized demand - both with the ultimate goal to stimulate health insurance;
2. Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers;
3. Improve efficiency, effectiveness, and transparency to better match demand and supply of healthcare transactions;
4. Mobilize capital into the private health sector;
5. Conduct research on the various models and advocate those that are successful.

Sustainability and scaling will be pursued by transferring successful innovations to public and private health stakeholders like governments, banks, insurance companies and national insurance schemes who will be supported to adopt, integrate and expand them. However, most countries in Sub-Saharan Africa continue to experience significant economic turbulence. As a result some countries become cash strapped, expect a lower growth in the medium term and are still unable to deliver basic services to the citizens. Most countries also launched a general crack-down on all forms of public sector corruption which is a very important change and generally popular. These development will continue to cause significant complexity and risks to the pace of transition of our interventions towards locally funded and economically sustainable models for access to better and affordable healthcare, like our partners face f.i. in Nigeria in Kwara State and Ogun State. Especially the private health sector participants will need further assistance during these challenging times. At the same time, the continued increased interest by the public and private sector towards quality improvement, investments in expansion of services, introduce prepayment through health insurance, supported by the increased utilization of connecting mobile technologies, vitalize our partner to remain committed towards achieving our mutual goals. The unparalleled opportunities of new technology on the continent will be at the center of the strategy for the coming years. This can fundamentally transform healthcare markets for insurers, funders, patients and providers alike.

On September 3rd, 2015 the Dutch Ministry of Foreign Affairs confirmed that the new Health Insurance Fund proposal, which covers a seven-year period (2016-2022), has been approved. This approval gives PharmAccess the opportunity to further develop and implement their pioneering healthcare initiatives.

The management of PharmAccess Foundation is aware of the dependency on donor funds. Continuous attention is therefore given to cost versus income with an increased focus on a more business and output oriented approach.

Institutional development

Mr. M.J.O. Coppoolse succeeded our founder and chairman Joep Lange (Professor of Medicine, University of Amsterdam) after his death in 2014 as chairman ad interim. Next to Mr. M.J.O. Coppoolse, Mr. W. Griekspoor and Mr. B.M. van der Vorm constituted the Supervisory Board in 2014. Mr. D.P. van Rooijen joined the Supervisory Board on March 15th, 2015. Mr. S. van Keulen serves in an advisory capacity to the Supervisory Board.

Onno Schellekens (Managing Director), Nicole Spieker (Director Quality) and Jan Willem Marees (Director Operations & Finance) stayed in their position and formed the Board of Directors of PharmAccess Foundation. As before, the Board of Directors carries all legal and financial responsibilities for the foundation.

In 2015, the number of staff increased to a total of 192.5 FTE per year-end (2014: 158.6 FTE per year-end). Out of the 192.5 FTE, 124.5 FTE are employed in Africa. The average number of FTE during the financial year 2015 was 177.6 (2014: 161.6).

Signing of the Management Board's report

Amsterdam, 14 June 2016

Board of Directors:

O.P. Schellekens

J.W. Marees

M.G. Dolfing-Vogelenzang

N. Spieker

Supervisory Board:

M.J.O. Coppoolse
(Interim Chairman)

W. Griekspoor

B.M. van der Vorm

D.P. van Rooijen


DOCTOR

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 2015

(After appropriation of the result)

	Note		31.12.2015		31.12.2014
			EUR		EUR
Assets					
Fixed assets					
Intangible fixed assets	1	156,868		12,818	
Tangible fixed assets	2	138,410	295,278	95,227	108,045
Current assets					
Receivables:					
Debtors	3	476,248		990,914	
Other receivables	4	2,688,996	3,165,244	1,428,669	2,419,583
Cash	5		8,622,617		6,259,119
			12,083,139		**8,786,747**

	Note		31.12.2015		31.12.2014
			EUR		EUR
Equity and liabilities					
Equity					
Balance of income and expenditure	6		2,005,847		1,486,859
Current liabilities					
Creditors		1,891,247		765,085	
Taxes and social security contributions	7	214,402		192,625	
Deferred income	8	3,562,243		3,807,811	
Other liabilities and accrued expenses	9	4,409,400	10,077,292	2,534,367	7,299,888
			12,083,139		**8,786,747**

Consolidated statement of income and expenditure for the year 2015

	Note		2015		2014
			EUR		EUR
Income	10		26,725,874		22,534,987
Operating expenses:					
Direct project costs		15,877,216		13,718,818	
Personnel expenses	11	9,124,883		7,539,233	
Amortization and depreciation		77,285		79,913	
General and administrative expenses		1,413,970	26,493,354	1,020,886	22,358,850
Operating result			***232,520***		***176,137***
Financial income and expenses:					
Financial expenses	12	(20,656)		(86,806)	
Financial income	13	307,124	286,468	141,200	54,394
Result			***518,988***		***230,531***
Added to:					
Balance of income and expenditure			518,988		230,531
			518,988		**230,531**

Consolidated cash flow statement for the year 2015

		2015		2014
		EUR		EUR
Operating result		***232,520***		***176,137***
Adjustments for:				
Depreciation (and other changes in value)		77,285		79,913
Changes in working capital:				
• movements operating accounts receivable	(745,661)		(531,954)	
• movement deferred income	(245,568)		2,956,479	
• movements operating accounts payable	3,022,972	2,031,743	(1,167,644)	1,256,881
Cash flow from business activities		2,341,548		1,512,931
Interest received/paid		286,468		54,394
Cash flow from operating activities		*2,628,016*		*1,567,325*
Investments in (in)tangible fixed assets		(264,518)		(64,452)
Cash flow from investment activities		*(264,518)*		*(64,452)*
Net cash flow		***2,363,498***		***1,502,873***
Cash as per 1 January		6,259,119		4,756,246
Cash as per 31 December		8,622,617		6,259,119
Movements in cash		**2,363,498**		**1,502,873**

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, Ghana and Namibia.

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, Namibia, 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
- Stichting PharmAccess International	Namibia
- PharmAccess Namibia	Namibia
- 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 accounting principles of Stichting PharmAccess International.

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 (before 2015: REAAL / Zwitserleven)). 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 is 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.

Notes to the specific items of the consolidated balance sheet

1. Intangible fixed assets

	2015	2014
	EUR	EUR
Book value as at 1 January	12,818	27,841
Additions during the year	152,826	0
Amortization during the year	(8,776)	(15,023)
Book value as at 31 December	**156,868**	**12,818**
Purchase value as at 31 December	167,361	75,115
Accumulated amortization	(10,493)	(62,297)
Book value as at 31 December	**156,868**	**12,818**

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

2. Tangible fixed assets

	2015	2014
	EUR	EUR
Book value as at 1 January	95,227	95,665
Additions during the year	111,692	64,452
Depreciation during the year	(68,509)	(64,890)
Book value as at 31 December	**138,410**	**95,227**
Purchase value as at 31 December	486,402	615,751
Accumulated depreciation	(347,992)	(520,524)
Book value as at 31 December	**138,410**	**95,227**

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% and for office furniture and other assets a depreciation of 20% is used.

3. Debtors

	31.12.2015	31.12.2014
	EUR	EUR
Debtors	476,248	994,756
Provision for doubtful debts	0	(3,842)
Balance as at 31 December	**476,248**	**990,914**

4. Other receivables

	31.12.2015	31.12.2014
	EUR	EUR
Revenues to be invoiced	26,673	575,580
Advances projects	393,628	271,995
Pension and other personnel insurances	40,524	0
Other receivables	2,228,171	581,094
Balance as at 31 December	**2,688,996**	**1,428,669**

5. Cash

	31.12.2015	31.12.2014
	EUR	EUR
Bank balance in the Netherlands	3,873,876	3,900,059
Bank balance dedicated project accounts in the Netherlands:		
- ABN-AMRO PEPFAR	2,401,422	391,486
- ABN-AMRO ELMA	390,168	386,985
- ABN-AMRO HIF/BuZa	136,787	59,435
Bank balance local offices	1,812,042	1,511,967
Cash in hand	8,322	9,187
Balance as at 31 December	**8,622,617**	**6,259,119**

6. Balance of income and expenditure

	2015	2014
	EUR	EUR
Balance as at 1 January	1,486,859	1,256,328
Result current year	518,988	230,531
Balance as at 31 December	**2,005,847**	**1,486,859**

The balance between income and expenditure is available to use in line with the described objectives of the foundation as stated in article 2 of the Articles of Association.

7. Taxes and social security contributions

	31.12.2015	31.12.2014
	EUR	EUR
Value added tax	48,268	37,536
Wage tax	166,134	154,584
Social security contributions	0	505
Balance as at 31 December	**214,402**	**192,625**

8. Deferred income

	31.12.2015	31.12.2014
	EUR	EUR
Received from donors related to projects	117,752,924	96,108,993
Realized revenue on projects	(114,190,681)	(92,301,182)
Balance as at 31 December	**3,562,243**	**3,807,811**

9. Other liabilities and accrued expenses

	31.12.2015	31.12.2014
	EUR	EUR
Holiday allowance	212,888	193,393
Liabilities projects	56,916	222,978
Salaries	24,766	0
Other liabilities	4,114,830	2,117,996
Balance as at 31 December	**4,409,400**	**2,534,367**

The other liabilities consist of:

Accrued expenses	1,748,278	1,608,105
Liability insurance programs - HCHC IBNR/UPR	2,144,918	290,629
Interest to be settled	214,974	215,948
Other liabilities	6,660	3,314
Balance as at 31 December	**4,114,830**	**2,117,996**

Contingent assets and liabilities

Regarding the current project portfolio PharmAccess Foundation received from donors' commitments for grants for an amount of about EUR 145 million. Of this amount EUR 118 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. The credit risk for head office is mitigated by banking at a governmental acquired bank (ABN-AMRO MeesPierson). For the local branch offices, the credit risk is mitigated by providing only a two months rolling advance.

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

10. Income

	2015	2014
	EUR	EUR
Realized income related to projects	26,643,063	22,354,280
Other income	82,811	180,707
	26,725,874	**22,534,987**

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

Ministry of Foreign Affairs	15,190,581	13,232,267
PEPFAR	3,743,954	3, 387,856
AHME	2,137,246	1,308,664
AmsterdamDiner	579,148	0
HDIF	599,642	136,483
Nationale Postcode Loterij	500,000	500,000
Embassy Kingdom of the Netherlands in Accra, Ghana	302,476	79,663
Other	3,590,016	3,709,347
	26,643,063	**22,354,280**

11. Personnel expenses

	2015	2014
	EUR	EUR
Salaries	7,084,872	5,890,858
Social security contributions	890,234	789,404
Pension costs	435,083	295,385
Other personnel expenses	714,694	563,586
	9,124,883	**7,539,233**

In order to provide an accurate overview of the "personnel expenses", these expenses have not been allocated to "Direct project costs". The "pension costs" consist of a defined contribution per employee.

12. Financial expenses

	2015	2014
	EUR	EUR
Bank interest and charges	17,382	18,810
Other	3,274	67,996
	20,656	**86,806**

13. Financial income

	2015	2014
	EUR	EUR
Bank interest	52,815	17,897
Exchange rate differences	254,309	123,303
	307,124	**141,200**

Other notes

Number of employees

The average number of employees during the financial year 2015 was 177.6 (2014: 161.6).

Remuneration Directors and Supervisory Board

The remuneration of Directors during the financial year 2015 amounted to EUR 400,704 (2014: EUR 377,124). This remuneration consists of gross salary and a defined pension contribution:

	2015	2014
	EUR	EUR
Gross salary	366,007	360,606
Pension contribution	34,697	16,518
	400,704	**377,124**

The average number of full-time equivalents for the Board of Directors in 2015 was 2.93 (2014: 3.0).

	O.P. Schellekens Managing Director	**J.W. Marees** Director Operations & Finance	**N. Spieker** Director Quality	**Total**
	EUR	EUR	EUR	EUR
Gross	118,664	126,500	90,000	335,164
Holiday allowance	9,493	9,120	7,200	25,813
Total remuneration DG-standard	128,157	135,620	97,200	360,977
Health insurance contribution	1,890	1,260	1,890	5,040
Total gross salary	130,047	136,880	99,090	366,017
Costs allowance	0	0	0	0
Pension contribution	12,536	12,949	9,212	34,697
Total remuneration WNT	142,583	149,829	108,302	400,714
Period of engagement:				
Engaged from	01.01.2015	01.01.2015	01.01.2015	
Engaged to	31.12.2015	31.12.2015	31.12.2015	
FTE%	93%	100%	100%	

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.

Signing of the consolidated financial statements

Amsterdam, 14 June 2016

Board of Directors:

O.P. Schellekens

J.W. Marees

M.G. Dolfing-Vogelenzang

N. Spieker

Supervisory Board:

M.J.O. Coppoolse
(Interim Chairman)

W. Griekspoor

B.M. van der Vorm

D.P. van Rooijen

OTHER INFORMATION

Independent auditor's report

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

Result appropriation for the year

The result for the year is added to the balance of income and expenditure (EUR 518,988). The balance between income and expenditure is available to use in line with the described objectives of the foundation as stated in article 2 of the Articles of Association.

Subsequent events

There are no events to report.

Independent auditor's report

Deloitte.

Deloitte Accountants B.V.
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Independent auditor's report

To the Supervisory Board of Stichting PharmAccess International

We have audited the accompanying financial statements 2015 of Stichting PharmAccess International, Amsterdam, which comprise the consolidated balance sheet as at December 31, 2015, the consolidated statement of income and expenditure for the year then ended and the notes comprising a summary of the accounting policies and other explanatory information.

Board of Directors responsibility

The Board of Directors is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with the Guideline for annual reporting 640 "Not-for-profit organisations" of the Dutch Accounting Standards Board and for the preparation of the Management Board's report in accordance with the Guideline for annual reporting 640 "Not-for-profit organisations" of the Dutch Accounting Standards Board.

Furthermore, the Board of Directors is responsible for such internal control as it determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Dutch Law, including the Dutch Standards on Auditing. This requires that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error.

In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements 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 entity's internal control.

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Deloitte.

An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board of Directors, as well as evaluating the overall presentation of the consolidated financial statements.

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

Opinion

In our opinion, the consolidated financial statements give a true and fair view of the financial position of Stichting PharmAccess International as at December 31, 2015 and of its result for the year then ended in accordance with the Guideline for annual reporting 640 "Not-for-profit organisations" of the Dutch Accounting Standards Board.

Amsterdam, July 27, 2016

Deloitte Accountants B.V.

Signed on the original: M.G.W. Quaedvlieg

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PharmAccess
FOUNDATION