PharmAccess Foundation

Annual Report 2016

13 September 2017

PharmAccess FOUNDATION

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Amsterdam, the Netherlands

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Currently:
-Clinic owners are reluctant to ask cashiers to switch
-Cashiers are reluctant to ask
Clinic owner plans to use M-TIBA
Cashier asks if patient has M-TIBA
YES
NO
Cashier asks patient to register & patient agrees
Individual
Social

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MOTHER & CHILD CARE
CONSULTATION
EDUCATION
of Diabetes
Frequent urination
W.C.
Dizziness
novo nordisk
OFFICE
MTIBA TRIAL
LIPA NA M-PESA
MTIBA TRIAL
TILL NUMBER
295267

MANAGEMENT BOARD'S REPORT

Introduction

PharmAccess was one of the first non-profit organizations to act on the large untapped potential of the private sector and recognize the need for capital investments in healthcare delivery. We advocated a new paradigm for health in a prizewinning IFC/Financial Times essay in 2007, at a time when this idea was still met with widespread resistance.

Since then, the complementary role of the private sector in delivering an essential social service like healthcare has become increasingly accepted. At the same time, a functioning, inclusive health market requires the state to fulfil an important enabling and equalizing role. Our interventions therefore stimulate and support public sector efforts.

The Dutch Ministry of Foreign Affairs is a committed and long-term funder of our approach through the Health Insurance Fund with the following objectives:

- Develop private pre-payment mechanisms and risk pooling structures, and mobilize resources for organized demand;
- Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers;
- Improve efficiency, effectiveness, and transparency to better match demand and supply of healthcare transactions;
- Mobilize capital into the private health sector;
- Conduct research on the various implemented strategic interventions and advocate those that are successful.

This flexible and long-term funding was essential for testing different innovative financing mechanisms (including health insurance and later M-TIBA), building a strong network of partners and contributing to our mission to achieve a paradigm shift in healthcare in Africa. The support of the Dutch government remains crucial to our work.

Vicious cycle

Health markets are in a vicious cycle of low quality supply and demand. As a (semi-) public good, healthcare requires large government intervention. However, many African countries suffer from limited state capabilities and poor institutions. As a result, many people turn to the private sector and, since insurance is virtually non-existent, pay for healthcare out-of-pocket.

Despite its important role, the private sector is often weakly regulated and highly fragmented. Due to the high investment risk it has limited or no access to the capital required for quality improvement and expansion of its services. And low quality in the clinics means low trust among patients.

The high proportion of out-of-pocket spending and the lack of trust in healthcare provision leads to low and unpredictable income for healthcare providers. This limits their options for investing in the quality, scope and scale of their services even further.

Healthcare markets, especially at the base of the pyramid, are stuck in this vicious cycle of low and unpredictable demand, low and uncertain quality of supply and totally inadequate investments, both public and private. The absence of health insurance leads to catastrophic health expenses, sending millions into deeper poverty every year.

Digital disruption

The above analysis remains relevant today. In fact, the free flow of information through the mobile revolution is making healthcare inequities more visible. Such knowledge comes with responsibility. Now that these inequities are in plain sight, we must also capitalize on the full potential of digital technology to address them. By applying it to our integrated approach of demand-side, supply-side and investment-related interventions, digital technology can play a disruptive role in helping to turn the vicious cycle into a virtuous one, accelerating the quest for inclusive healthcare.

Digital technology as an accelerator

The world is on the brink of what has been dubbed the fourth industrial revolution. This fusion of technologies is creating new ways of serving existing needs and disrupting virtually every industry. Many of us benefit from perks like ordering food online or hailing a cab with two taps on a mobile. However, we need to ensure that this revolution does more than just make just some peoples' lives more convenient.

Fortunately, digital technology is actually pre-eminently suited to exposing as well as mitigating social and economic inequities. The mobile phone is one of the biggest social equalizers on the African continent. More than 90% of people use a simple mobile phone. Africa is also home to M-Pesa, the world's leading mobile money service. This offers huge opportunities to build new healthcare solidarity mechanisms and to tackle Africa's poor health statistics.

By providing transparency, accountability and direct access to end-users, digital technology opens up avenues to close the gap between the top and bottom rungs of the prosperity ladder. We can bring healthcare within reach of people who, until now, were structurally excluded from the system. And - it can be done more efficiently, with strongly reduced transaction costs, at an unprecedented scale and pace.

Matching demand and supply

When Professor Dr. Joep Lange founded PharmAccess in 2001, he was determined to turn his pioneering scientific research on triple-combination drug therapy into action. His drive brought this life-saving AIDS treatment to those who needed it most. Joep's vision of increasing access to affordable and better healthcare for people in sub-Saharan Africa is still at the heart of what we do.

Building on this work on the front lines of HIV/AIDS, our focus has broadened to making healthcare finance and delivery more effective and more inclusive. We work towards this goal by stimulating both the demand and the supply side of the healthcare market to reduce risk and attract investments. Our integrated approach mobilizes public and private resources for the benefit of doctors and patients through a combination of loans for healthcare providers, clinical standards for quality improvement, health insurance and impact research. More and more, we are using digital technology to accelerate this approach.

Transitional year

In many ways, 2016 marked a transition for our organization. Although we've been developing and testing mobile phone-based health solutions since 2013, the past year is when it all started to come together. Not only did we launch the M-TIBA mobile health wallet in Kenya, but our mHealth labs in Tanzania, Ghana and Nigeria have also started to take shape. It was also the year in which we further developed our digital agenda. From 2017 onwards, this digital agenda will be the cornerstone to our approach.

Activities in 2016

PharmAccess is an entrepreneurial organization with a digital agenda dedicated to connecting more people to better healthcare. We serve doctors and patients with mobile platform technology like M-TIBA, loans for clinics, health insurance, quality standards, advocacy and impact research. Below, we present an overview of our activities in 2016.

Connecting patients, providers and payers

M-TIBA was developed by PharmAccess, Africa's top mobile operator Safaricom and health payment platform CarePay.

Kenya has a head start on the rest of Africa in terms of mobile penetration. It also boasts the world's leading mobile money-transfer system, M-Pesa. This fertile ground, combined with the challenge to 'make M-Pesa work for healthcare too' made the country a logical place to develop our first mHealth activities. The groundwork we have been doing since 2013 led to the national roll-out of M-TIBA last summer. By the end of January 2017, more

than 235,000 Kenyans had already signed up, and momentum continues to build with over 2,000 new subscribers every day.

M-TIBA is a digital platform for inclusive healthcare that directly connects patients, providers, and payers such as family members, health insurers or donor agencies. It empowers consumers, improves their financial protection, supports better quality of care and generates local and international financing for health. M-TIBA enables people to save, send, receive and pay money for medical treatment through a mobile health wallet on their phone. It's a closed loop with conditional funds that can only be spent on healthcare at selected providers.

The transparency M-TIBA provides will help build a new kind of healthcare solidarity. It allows us to take our approach of stimulating demand and supply with the aim of attracting healthcare investments, to a new level:

- **Boosting demand**. Although M-TIBA is available for every Kenyan with an M-Pesa account, it initially targets people living in urban slums and rural areas. The aim is to connect the poor to savings schemes, benefits and health insurance at very low admin costs. It can help to crowd in funding from solidarity payers like family members, employers, donors or governments, who receive proof that their money is used for healthcare only.
- **Stimulating supply**. Healthcare providers also benefit from being connected to the M-TIBA platform. For one, they gain access to more people that are able to pay for healthcare. M-TIBA also generates a wealth of data on medical treatments and financial transactions. These insights can help providers to improve on both the clinical and business side of operations. Digital payments minimize leakages and enhance efficiency. In addition, we strengthen cost-effectiveness of service delivery through mechanisms like joint procurement systems, access to finance for quality improvement or capacity building through e-learning.
- **Generating more funds for health**. M-TIBA is increasing transparency and reducing risk and transaction costs, making it more attractive to invest in health. The real-time transaction information also makes it much easier and less costly to provide loans for clinics that were previously unable to get a regular bank loan.

Developing organized demand for healthcare

If people don't trust that there will be a doctor when they need one or that there will be enough drugs on stock at their local clinic, why would they pre-pay for health? It's like buying a mobile phone subscription in an area with no network.

Health insurance covers only 5.5% of total healthcare expenditure in Africa. This means that the vast majority of people pay out-of-pocket, from unexpected medical bills to long-term costs for chronic diseases. Most governments have yet to work out an inclusive approach to increase access to care for their citizens. In most cases, public health insurance only covers people working in the formal sector even though those in the informal sector, such as farmers or small market traders, are most in need of coverage.

Integrated approach

PharmAccess has been developing pre-payment mechanisms and risk-pooling structures for low-income families in Africa since 2007. Over the years we have learned that developing such organized demand for healthcare requires investments on the supply side as well as the demand side. Predictable income, for example from health insurance, helps healthcare providers to run their business effectively. At the same time, reducing out-of-pocket

expenditure through insurance or other forms of pre-payment offers financial protection and peace of mind to people in case they fall ill. The combination of loans, measurable standards (SafeCare) and our quality improvement program aims to set in motion an upward spiral of trust, capital, quality and availability of health services.

Partnerships

We work with African companies and governments to design and implement health insurance schemes for lower income groups. In Nigeria and Tanzania, the original community-based structures have evolved into schemes that are supported by regional or national governments through subsidized premiums and increased investments in healthcare infrastructure.

In Nigeria, the **Kwara Community Health Insurance scheme** has helped build a stronger, cost-efficient healthcare system. Impact evaluations show significant improvements in healthcare utilization, health outcomes and financial protection in target communities. It is internationally lauded as an example of how the private health sector can complement public health service delivery. In 2014, the Kwara State Health Insurance program won the Saving Lives at Birth Award and was a finalist in the OECD DAC Prize for Taking Development Innovation to Scale. In June 2016, it won the prestigious FT/IFC Transformational Business Award. The Kwara program is now transitioning into a statewide insurance, with the technical support of the World Bank Group/IFC's Health in Africa Initiative.

Our extensive experience in this area prompted the Lagos State and Ogun State Ministries of Health to ask for **technical assistance** in the development of a (mandatory) health insurance program for the citizens of their states. In 2016, PharmAccess provided support to Lagos State in the form of an actuarial study and operational guidelines. The actuarial study – especially challenging in such a data-limited setting – focused on determining accurate pricing of premiums and reimbursements in order to ensure financial sustainability of the scheme. We worked with Nigerian-based business and management consulting firm Phillips Consulting to formulate operational guidelines based on the Nigerian Health Bill.

The **'improved CHF' (iCHF)**, launched in partnership with the NHIF and district councils in Northern Tanzania, is a voluntary, public-private health insurance scheme. The premium is 100% locally funded. iCHF aims to increase access to quality healthcare for people in the informal sector, mostly rural and low-income groups. Both public and private facilities receive support to improve quality through training, equipment provision and infrastructure upgrading. By December 2016, more than 170,000 people had access to care through iCHF. Significantly, the government of Tanzania sees iCHF as a building block for creating a mandatory insurance scheme for the entire country, an important step towards universal health coverage.

In Ghana, we worked with the IFC / World Bank Group under the AHME program to identify poor households who are eligible for a premium waiver in the National Health Insurance Scheme (NHIS). Using a **digital proxy means testing tool**, almost 110,000 households were screened, just over 25,000 of which qualified for the waiver. An online real-time dashboard tracked the enumeration process.

New solidarity mechanisms

In Kenya, the emphasis was on preparing and launching the M-TIBA platform for healthcare transactions and data collection. Innovations like M-TIBA can build on existing social solidarity mechanisms to offer new forms of

pre-payment and risk pooling. Patients connect to M-TIBA through a mobile health wallet on their phone that increases access to better healthcare and financial protection. For healthcare providers, M-TIBA helps to lower transaction costs, increases transparency, shortens cash cycles, and improves quality of care and business performance by increased access to loans and a quality improvement program.

One of the first mobile health financing products is the M-TIBA Bonus Scheme, a health savings product. We are currently working with world-renowned behavioral economist and first Joep Lange Chair Professor Dan Ariely to analyze decision-making behavior and determine the best incentives to get people to save for health.

Strengthening healthcare supply through quality standards

Many healthcare providers in sub-Saharan Africa lack sufficient qualified staff, functioning supply chains or even basic resources like power or water. How can we create actionable data that take these challenges into account, and use it to motivate and support clinics in improving their quality?

The healthcare sector in sub-Saharan Africa has a shortage of institutions and standards to ensure objective measurement of the quality of services. **SafeCare** fills this need: by measuring organizational management and processes, clinical quality and safety, we can now benchmark and certify performance. The SafeCare standards, launched in collaboration with Joint Commission International (JCI) and COHSASA, are the first and so far only ISQua accredited clinical standards tailor-made for resource-restricted settings. They create a common language and ensure quality is measured against international standards, while leaving room for application of local solutions to specific challenges.

Quality improvement

The SafeCare standards form the foundation upon which we have built our stepwise quality improvement program. After a SafeCare assessment, healthcare providers receive a detailed report that identifies quality gaps as well as a prioritized quality improvement plan. Rather than applying a pass-or-fail system, SafeCare measures and recognizes incremental progress. As providers demonstrate continued improvement, their progress is rewarded with SafeCare Certificates at five levels to recognize improved clinical and business performance. Stimulating quality improvement on the supply side helps to increase demand for health insurance.

In 2016, the standards underwent a revision to incorporate lessons learned and adapt to the current context by making them leaner and more digitally adept. Also, changes were made in the scoring methodology to make the quality improvement journey as smooth as possible for healthcare providers. The revised standards were accredited in February 2017.

In Kenya, we're taking the first steps to integrate SafeCare and our digital agenda. In order to join the M-TIBA network for example, healthcare providers undergo a SafeCare assessment and receive quality improvement assistance. As quality rating of service in the health sector becomes more transparent, patients can make informed healthcare choices. Providers that are actively improving their services attract more patients and generate more income. Benchmarking enables mechanisms such as pay-for-performance, thereby further stimulating sustainable quality improvement.

To ensure that the methodology fits in the legislative framework of the countries we work in, we have engaged in strategic partnerships with state and national governments.

- In Tanzania, the government has adopted the SafeCare standards and methodology as *the* national system for stepwise certification towards accreditation.
- In Kenya, the NHIF has adopted SafeCare methodology to be used for quality assurance in contracted facilities.
- In Ghana, we have helped develop the roadmap for the national Healthcare Facilities Regulatory Agency (HFRA) to regulate and incentivize healthcare quality in an institutionalized approach.
- In Nigeria, we are helping Kwara, Ogun and Lagos States develop institutionalized quality assurance institutes using SafeCare approaches.

Private partnerships

In 2016, we also further expanded our network of private partners. We started operations in Uganda through a partnership with the Uganda Healthcare Federation (UHF) and PACE. The partnership aims to build a sustainable model in which UHF will be the licensed partner for a national roll-out of the SafeCare methodology.

In Nigeria, we teamed up with PurpleSource Healthcare Ltd to provide quality assurance within its network of private providers. PharmAccess will also work with DrugStoc to provide quality assessment services to stand-alone pharmacies and pharmacies in hospitals.

Stimulating investments

To make informed decisions and more accurate long-term projections, investors need relevant, reliable and comparable data. By creating a framework for transparency of information and benchmarking, SafeCare helps to reduce risks and build trust between all parties in the healthcare sector, as well as to stimulate investment.

Value for patients

In 2016, we started working with the International Consortium for Health Outcomes Measurement (ICHOM) to investigate how principles of value-based healthcare can be applied in low and middle-income countries. This year, we will launch a pilot focusing on pregnancy and childbirth. The idea is to implement a global standard set of outcome indicators and collect administrative and patient reported data from around 200 pregnant women using the M-TIBA platform.

Enabling health investments

Without insight into clinical and business performance, how can banks assess the risks involved in lending to private healthcare providers? And without access to capital, how can these providers grow their business and improve the quality of healthcare services for their patients?

In 2009, we set up the first and only dedicated fund providing loans to small and medium-sized health enterprises (SMEs) in Africa: the **Medical Credit Fund**. Health SMEs often lack a credit history, adequate bookkeeping and accounting systems, financial performance records and sufficient assets to serve as collateral. As a result, they are often unable to secure formal bank loans and struggle to purchase modern equipment or even pay for basic repairs.

Medical Credit Fund mitigates risks for African banks in order to bridge this gap. Our strong partnerships have led to integrated loan products such as Sidian Bank's Tabibu loan in Kenya, uniBank's uniHealth loan in Ghana and Diamond Bank's Mediloan in Nigeria. The strong repayment performance is prompting banks to take an increasingly large share of the funding and repayment risk, a sign that we are helping to build a healthier investment climate for health SMEs.

By combining the loans with our technical assistance program, we help these clinics build a financial track record and become bankable, grow their business acumen and improve the quality of their healthcare services. This quality improvement has become measurable thanks to the SafeCare standards.

Expansion to USD 2.5m loans

Over the years, we observed a growing demand for larger and more flexible loans. In 2015, the Dutch Good Growth Fund and Pfizer Foundation provided support for Medical Credit Fund to prepare an expansion of its mandate. This, in combination with a loan from Calvert Foundation, allowed us to reduce the investment risk for follow-on investors and to further catalyze impact investments.

In 2016, Medical Credit Fund raised an additional USD 17m from OPIC, Calvert Foundation and two private investors. In 2017, a number of development banks will also join, bringing the fund size to USD 45m. This expansion allows for loans of up to USD 2.5m – a significant step up from the previous USD 350,000 ceiling – and for partnerships with non-bank financial institutions. Including new opportunities for our partnership with Philips, as we can now finance a wider range of equipment. It also opens up financing for other players in the healthcare sector like suppliers of medicines and equipment, and enables partnerships in new countries. In November, we did our first deal in Liberia, working with TLG Capital to disburse a loan for the country's largest private out-patient facility.

Innovative loan products

Following and anticipating opportunities in the market, we continue to develop and test innovative (digital) financing solutions.

More than 4,000 private healthcare providers in Ghana rely on claims payments from the National Health Insurance Scheme (NHIS) for 80% of their revenue, but it can take months for claims to be reimbursed. With uniBank and the National Health Insurance Agency (NHIA), we developed a receivable financing product that allows healthcare providers to address this issue. Healthcare providers receive a self-liquidating loan as an advance on the NHIA claim, automatically paying the interest when the NHIA pays the claim into the uniBank account.

In Tanzania, we relaunched our partnership with NMB Bank and started an innovative financing collaboration with equipment leasing firm Equity for Tanzania (EFTA). The latter opens access to more flexible debt financing by allowing private facilities to use equipment as collateral.

In Kenya, we built a new partnership with the World Bank and Capital Tool Company to implement an invoice-financing scheme for the pharmaceutical supply chain.

The growing role of the mobile phone in day-to-day financial services like sending mobile money or paying electricity bills or school fees also opens up new opportunities for innovative financing products. Mobile payment mechanisms that make risks transparent will allow us to expand and increase loan disbursements parallel to the more traditional banking channel.

In partnership with CarePay, we have developed a mobile cash advance product that uses M-TIBA to lower risks and transaction costs. This short-term loan for healthcare providers uses digital patient revenues as a means of security in that it is automatically repaid based on a fixed percentage of these digital patient revenues. This allows for a very low-cost and low-risk financing solution for facilities, benefiting especially smaller healthcare facilities who typically have the most difficulty accessing capital. The cash advance product was successfully piloted at a small number of healthcare providers in Nairobi and we will be working to make this product more widely available.

African Health Markets for Equity (AHME)

AHME is a five-year partnership that aims to increase the use of quality essential health services by the poor in Ghana, Kenya and Nigeria. AHME is funded by the Bill & Melinda Gates Foundation and the UK's Department for International Development (DFID), and led by Marie Stopes International with Population Services International, Population Services Kenya, Society for Family Health, PharmAccess Foundation, and the IFC/World Bank Health in Africa Initiative as collaborating partners.

Initiatives address both the supply and the demand side of the healthcare system, and ways to integrate them into a single well-coordinated program. As part of this program, the healthcare providers in the partners' franchise networks (Marie Stopes International, Population Services International and Society for Family Health) have access to loans through the Medical Credit Fund as well as support in business and quality improvement using the SafeCare standards.

Operational research and impact evaluation

Without in-depth research into our programs, how can we assess what works and what needs adjustment? We use scientific proof of principle to improve approaches, maximize impact and advocate successful programs to scale.

Global health issues require scientific rigor to define the size and scope of challenges and provide robust evidence if and how interventions work. This has been an integral part of our mission from day one. We investigate areas like quality of care, financial healthcare transactions, disease incidence, health outcomes, poverty maps, connected diagnostics and stakeholder experiences in order to test and validate different models of healthcare

financing and delivery. Several landmark papers were published in prestigious journals like JAMA, British Medical Journal and The Lancet.

Data-driven

Data are the new currency for healthcare exchanges. Systematic data collection, management and analysis generates a wealth of information on the operations and impact on both the demand and the supply side of the health system. Data collection is moving towards 'real-time' and 'big data.' New skills and analytical methods are required to process big data and extract meaningful information. Digital technology is opening up new scientific avenues and playing an increasingly prominent role in our research agenda.

We conduct two types of research:

- **Operational research** that provides more in-depth knowledge about PharmAccess activities with the objective of improving day-to-day operations.
- **Impact evaluation** that encompasses longer-term research that evaluates the impact of PharmAccess operations on health and economic development.

M-TIBA generates GPS-tagged, near real-time data on financial healthcare exchanges. In the near future, we will build on this opportunity through research endeavors around poverty mapping, monitoring of disease outbreaks, medical decision support systems, clinical path tracking and connecting diagnostics to treatment.

Research partnerships

The Amsterdam Institute for Global Health and Development (AIGHD) remains a preferred partner in assessing biomedical and socio-economic impact of our programs. Another special relationship is with the Joep Lange Institute, which aims to push the envelope in global health, drive policy change and make health markets work for the poor. It provides complementary leveraging funding to deepen and broaden PharmAccess research, especially research that catalyzes the impact of digital technology in healthcare.

Over the years we have also been building relationships with other international research institutes. Some of the more recent collaborations include:

- **London School of Hygiene and Tropical Medicine**
  To improve understanding of the business case of quality improvement through SafeCare and the broader impact of this work, the London School of Hygiene and Tropical Medicine is conducting a major study on the work of the HDIF-funded Business of Quality program in Tanzania.
- **National Health Insurance in Ghana, the University of Ghana and three Dutch universities**
  To increase understanding of insurance enrollment behavior into the Ghanaian National Health Insurance, a four-year study funded by WOTRO was conducted in Ghana and completed in 2015. The study explored and compared perceptions of clients, healthcare providers and the Ghana National Health Insurance staff. The research was supported by University of Amsterdam, Groningen University and VU University.
- **Duke University's Center for Advanced Hindsight**
  To learn more about behavioral issues that affect sustainable financing of and adherence to quality healthcare, we joined forces with the Joep Lange Institute, the Nairobi-based African Population Health Research Centre (APHRC) and behavioral economist Professor Dan Ariely of the Center for Advanced Hindsight (CAH). Ariely's team is leading a study in slum areas of Nairobi to learn more

about what drives decision-making behavior involved in pre-paying, saving and giving for healthcare. This study explores different ways in which we can motivate the poor to set money aside for healthcare using M-TIBA.

Selected programs and developments

Over the years, PharmAccess has been supporting HIV/AIDS workplace treatment programs as well as developing expertise in health infrastructure development.

HIV/AIDS workplace program for Tanzanian Armed Forces

PharmAccess has been supporting a PEPFAR/US Department of Defense funded HIV workplace program for the Tanzanian Peoples' Defense Forces since 2006.

There is evidence that HIV prevalence among uniformed personnel is higher than that of the general population. A recent UNAIDS meta-analysis using data from armies around the world showed that with 13.8%, the Tanzania army had the highest. Soldiers and their families have a heightened risk due to their mobility and engagement in unprotected sex. As such, they may serve as a bridge for transmission to the general population.

PharmAccess supports a comprehensive package of targeted prevention interventions, both at community and facility level. The workplan is guided by the latest WHO and PEPFAR test and treat directions, aiming at the 90-90-90 targets. Main activities are sharing of sexual and behavior change communications materials, voluntary male circumcision and HIV testing and counseling. Interventions include renovation and maintenance of clinics, procurement of equipment and test kits, as well as training of healthcare staff.

So far, 74 military health facilities have been scaled up. These clinics are open for the 32,000 army staff and their dependents, about 10,000 young recruits and tens of thousands of people living in the vicinity of these clinics. In 2016, more than 80,000 people were tested for HIV, including more than 9,000 pregnant women.

Building a franchise model for maternal and child care in Ghana

As the middle class in Ghana grows, so does demand for quality care. With a grant from the Embassy of the Kingdom of the Netherlands in Accra, PharmAccess is working with two private hospitals in Accra to develop and pilot a commercial franchise model for pregnancy and birthing services.

The aim of Woman 360 is to offer efficient healthcare services through a hub and spoke network of cooperating private clinics. Specially trained midwives will work from small, easily accessible clinics under the supervision of a gynecologist at a specialist hospital. The midwives handle basic routine visits and only refer women who require more skilled attention to gynecologists at a centralized, well-equipped hospital.

By standardizing all services in the network and optimizing patient flows, both the quality of care and the business potential become more predictable and transparent and therefore attractive for patients, entrepreneurs and investors. The task shifting results in reduced waiting times and better health outcomes based on early risk selection. Both hospitals are exploring the use of a mobile app and an electronic health information system. The fact that capital intensive resources like specialist equipment are concentrated in one location, combined with heightened operational efficiency, will also make it possible to lower the tariffs for antenatal care. The business

structure and high level of standardization means this model can potentially be replicated within Ghana and the wider region in a franchise model.

Resolve Medical Services and Airport Women's Hospital were selected for their ambition and entrepreneurial mindset. In 2016, we developed clinical guidelines and protocols, and facilitated trainings for midwives from both hospitals have received training. The next step is further developing the franchise formula, including manuals and contracts. Construction of the first two spoke clinics will start in 2017.

Our work in Namibia transferred to local partners

Our work in Namibia, which started in 2004, was successfully transferred to local partners at the end of December 2016. Over the years, our 'Mister Sister' mobile health clinics have proven a (cost) efficient and effective way to provide primary care for difficult to reach groups like farm workers and people in informal settlements. Operations are now fully domestically funded and will continue under the umbrella of the Healthworks Business Coalition (previously known as NABCOA, the Namibia Business Coalition on AIDS), an NGO PharmAccess has worked with since the start.

One of the main research projects done in Namibia was an impact evaluation of low-cost health insurances for lower-middle income people. Over 8,000 people participated in the survey. Extensive data was collected on demographics, socio-economic status and welfare, health, healthcare spending and health behavior. In addition, several biomedical markers were tested: blood pressure, height, weight, HIV status, cholesterol and blood sugar. Although the introduction of the health insurance eventually was 'crowded' out by international donor funding, the unique data allowed for one of the best-documented urban HIV incidence estimations in Africa and important publications in PLoS One, eLife and The Lancet.

Dutch Postcode Lottery

Between 2013 and 2016 the Dutch Postcode Lottery has supported PharmAccess with an annual donation of 500,000 euros. In addition, PharmAccess and Amref Flying Doctors were awarded 9,950,000 euro by the Dutch Postcode Lottery in 2016. With its Droomfonds (Dream Fund), the Dutch Postcode Lottery offers the opportunity to realize trailblazing dream projects. This opportunity enables the development of innovative mobile based tools to increase access to good healthcare for women in Kenya, directly through their mobile phone. Cleverly combining healthcare knowledge, quality and financing through the M-TIBA mobile health wallet. In 2017, the project will begin in Kenya first targeting 100,000 women and their families.

Financial

Total income in 2016 amounts to EUR 23.8 million (2015: EUR 26.7 million) and the operating result is EUR 136,524 negative (2015: EUR 232,520). Together with financial result, PharmAccess Foundation has managed to the end the year of 2016 with a total surplus of EUR 117,014 (2015: EUR 518,988).

After appropriation of the result the equity amounts to EUR 2,122,861 (2015: EUR 2,005,847). 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-, and HealthPlans 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 2017 and beyond

Over the coming years, PharmAccess will continue to design, implement and test market-based health financing and delivery innovations, with a growing focus on the digital opportunities that can accelerate this process.

To better match demand and supply, we aim to improve efficiency, effectiveness and transparency of healthcare transactions. Starting in Kenya, we focus on working with local partners in developing a more comprehensive digital healthcare marketplace around M-TIBA.

In parallel and where possible connected to M-TIBA, we are increasingly digitizing our existing activities:

- **Boosting demand and facilitating solidarity**
  We will continue to work with partners and local governments to build on the demand-side financing models that show promise and transition them into new public or private structures. Developing, testing and introducing new digital products and services tailored to the specific healthcare financing need of patients, both as individuals and in groups, will be key. Also, new (digital) opportunities are arising in supporting administration and delivery of national health insurance schemes as many African governments are pursuing healthcare reforms towards Universal Health Coverage.
- **Stimulating quality supply**
  Measuring clinical and business quality using the SafeCare standards will remain a central part of our work. At the same time, we continue to work with our partners on technical assistance to improve performance. As quality improves, demand for healthcare will grow as well. Digital technology will help to increase the scale, effectiveness and efficiency of these activities.
- **More money for health**
  Mobilizing capital into the private health sector will remain a focus. Through the Medical Credit Fund we continue to lower the investment risks for banks, both through the transparency delivered by the SafeCare standards and by shouldering some of our partner banks' financial exposure. We will co-develop or perform due diligence on health SME business plans and provide transaction advisory services to larger clients. Finally, we will continue developing (digital) financial innovations that tackle sector-specific obstacles like collateralization requirements and working-capital shortages.
- **Research**
  We will expand internal learning through fact-based and rapid evaluations to improve operations, and continue to build an evidence base for the effectiveness and impact of our work. We will strengthen partnerships with academic institutions in Africa as well as with the Joep Lange Institute, which can help advocate to scale those innovations and approaches that have proven successful.

Building and implementing our digital agenda will be the main focus moving forward. We cannot wait to see the potential of digital technology leveraged for the benefit of those who are currently left behind and look forward to working with a growing number of partners to make this happen.

Institutional development

Over 2016, PharmAccess Foundation was supervised by: Mr. M.J.O. Coppoolse (chairman), Mr. W. Griekspoor, Mr. D.P. van Rooijen and B.M. van der Vorm. B.M. van der Vorm resigned as per June 2016.

Onno Schellekens (CEO), Monique Dolfing-Vogelenzang (COO as per January 1st, 2016), Nicole Spieker (Director Quality) and Jan Willem Marees (CFO) formed the Board of Directors of PharmAccess Foundation. As before, the Board of Directors carries all legal and financial responsibilities for the foundation.

Economically effective as from January 1, 2017 the governance structure of Stichting PharmAccess International (PharmAccess Foundation) has been revised.

Stichting PharmAccess International was founded in 2001 and has since expanded into a group of organisations with closely related objectives and activities: the, so called, PharmAccess Group. This Group has grown significantly over the past years with new initiatives and activities. Some of these were set up in separate legal entities. This has been done for pragmatic reasons, but over time this resulted in inefficiencies. Increasingly PharmAccess received feedback that the coherence and inter-relationship was not always clear, which was also reflected in a report of the Boston Consultancy Group (evaluation 2015). The Ministry of Foreign Affairs has requested a revised governance model proposal as a condition precedent under the renewed financing (2016-2022).

The key features of the governance structure are:

All PharmAccess group entities will be managed by the same executive board. For this purpose a new foundation, Stichting PharmAccess Group Foundation (PGF), has been incorporated. The statutory responsibility for all PharmAccess group entities (i.e., Stichting PharmAccess International, Stichting Health Insurance Fund, Stichting Medical Credit Fund and Stichting SafeCare) is vested with PGF, represented by its executive board (statutair bestuur) under the supervision of one Supervisory Board, the PGF Supervisory Board.

Consequences for PharmAccess Foundation
As a consequence, the existing Supervisory Board of PharmAccess Foundation has been dissolved. Supervisory duties and responsibilities are assumed by the newly instituted Supervisory Board of PGF (and its committees), through supervision of PGF's executive board.

In 2016, the number of staff increased to a total of 203 FTE per year-end (2015: 192.5 FTE per year-end). Out of the 203 FTE, 129 FTE are employed in Africa. The average number of full-time equivalents during the financial year 2016 was 196.7 (2015: 177.6).

Signing of the Management Board's report

Amsterdam, 13 September 2017

J. W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

O.P. Schellekens

J.W. Marees

M.G. Dolfing-Vogelenzang


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ULIOBORESHWA

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 2016

(After appropriation of the result)

	Note		31.12.2016		31.12.2015
			EUR		EUR
Assets					
Fixed assets					
Intangible fixed assets	1	123,396		156,868	
Tangible fixed assets	2	119,826	243,222	138,410	295,278
Current assets					
Receivables:					
Debtors	3	1,117,270		476,248	
Other receivables	4	2,135,479	3,252,749	2,688,996	3,165,244
Cash	5		9,197,673		8,622,617
			12,693,644		**12,083,139**

	Note		31.12.2016		31.12.2015
			EUR		EUR
Equity and liabilities					
Equity					
Continuity reserve	6		2,122,861		2,005,847
Current liabilities					
Creditors		889,004		1,891,247	
Taxes and social security contributions	7	216,235		214,402	
Deferred income	8	6,451,209		3,562,243	
Other liabilities and accrued expenses	9	3,014,335	10,570,783	4,409,400	10,077,292
			12,693,644		**12,083,139**

Consolidated statement of income and expenditure for the year 2016

	Note		2016		2015
			EUR		EUR
Income	10		23,773,221		26,725,874
Operating expenses:					
Direct project costs		12,315,952		15,877,216	
Personnel expenses	11	10,107,833		9,124,883	
Amortization and depreciation		112,311		77,285	
General and administrative expenses		1,373,649	23,909,745	1,413,970	26,493,354
Operating result			***(136,524)***		***232,520***
Financial income and expenses:					
Financial expenses	12	(17,603)		(20,656)	
Financial income	13	271,141	253,538	307,124	286,468
Result			***117,014***		***518,988***
Added to:					
Equity - continuity reserve			117,014		518,988
			117,014		**518,988**

Consolidated cash flow statement for the year 2016

(Based on the indirect method)

		2016		2015
		EUR		EUR
Operating result		***(136,524)***		***232,520***
Adjustments for:				
Depreciation (and other changes in value)		112,311		77,285
Changes in working capital:				
• movements operating accounts receivable	(87,505)		(745,661)	
• movement deferred income	2,888,966		(245,568)	
• movements other current liabilities	(2,395,475)	405,986	3,022,972	2,031,743
Cash flow from business activities		381,773		2,341,548
Interest received/paid		253,538		286,468
Cash flow from operating activities		*635,311*		*2,628,016*
Investments in (in)tangible fixed assets		(60,255)		(264,518)
Cash flow from investment activities		*(60,255)*		*(264,518)*
Net cash flow		***575,056***		***2,363,498***
Cash as per 1 January		8,622,617		6,259,119
Cash as per 31 December		9,197,673		8,622,617
Movements in cash		**575,056**		**2,363,498**

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. 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

	2016	2015
	EUR	EUR
Book value as at 1 January	156,868	12,818
Additions during the year	0	152,826
Amortization during the year	(33,472)	(8,776)
Book value as at 31 December	**123,396**	**156,868**
Purchase value as at 31 December	167,361	167,361
Accumulated amortization	(43,965)	(10,493)
Book value as at 31 December	**123,396**	**156,868**

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

2. Tangible fixed assets

	2016	2015
	EUR	EUR
Book value as at 1 January	138,410	95,227
Additions during the year	60,255	111,692
Depreciation during the year	(78,839)	(68,509)
Book value as at 31 December	**119,826**	**138,410**
Purchase value as at 31 December	475,965	486,402
Accumulated depreciation	(356,139)	(347,992)
Book value as at 31 December	**119,826**	**138,410**

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

	31.12.2016	31.12.2015
	EUR	EUR
Debtors	1,117,270	476,248
Provision for doubtful debts	0	0
Balance as at 31 December	**1,117,270**	**476,248**

4. Other receivables

	31.12.2016	31.12.2015
	EUR	EUR
Revenues to be invoiced	25,866	26,673
Advances partners related to projects	1,488,941	675,734
Pension and other personnel insurances	4,387	40,524
Other	616,285	1,946,065
Provision for doubtful 'Other receivables'	0	0
Balance as at 31 December	**2,135,479**	**2,688,996**

Comparative figures for ‘Advances partners related to projects’ and ‘Other’ have been adjusted to better align the definitions.

5. Cash

	31.12.2016	31.12.2015
	EUR	EUR
Bank balance in the Netherlands	2,985,760	3,873,876
Bank balance dedicated project accounts in the Netherlands:		
- ABN-AMRO PEPFAR	916,296	2,401,422
- ABN-AMRO ELMA	327,253	390,168
- ABN-AMRO HIF/BuZa	2,855,658	136,787
Bank balance local offices	2,107,206	1,812,042
Cash in hand	5,500	8,322
Balance as at 31 December	**9,197,673**	**8,622,617**

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

6. Continuity reserve

	2016	2015
	EUR	EUR
Balance as at 1 January	2,005,847	1,486,859
Result current year	117,014	518,988
Balance as at 31 December	**2,122,861**	**2,005,847**

Result appropriation for the year

The result for the year is added to the continuity reserve (EUR 117,014). 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. Taxes and social security contributions

	31.12.2016	31.12.2015
	EUR	EUR
Value added tax	13,922	48,268
Wage tax	171,285	166,134
Social security contributions	31,028	0
Balance as at 31 December	**216,235**	**214,402**

8. Deferred income

	2016	2015
	EUR	EUR
Balance as at 1 January	3,562,243	3,807,811
Received from donors related to *active* projects	20,904,680	21,643,931
Realized revenue on *active* projects	(18,015,714)	(21,889,499)
Balance as at 31 December	**6,451,209**	**3,562,243**

Per year-end the cumulative amount for 'Received from donors related to *active* projects' amounts to EUR 138,657,604 (2015: EUR 117,752,924) and the 'Realized revenue on *active* projects' amounts to EUR 132,206,395 (2015: EUR 114,190,681).

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 7,677,429 for by donors pre-financed projects (credit) and an amount of EUR 1,226,220 for reimbursement projects (debit).

9. Other liabilities and accrued expenses

	31.12.2016	31.12.2015
	EUR	EUR
Holiday allowance	210,138	212,888
Liabilities projects	321,106	56,916
Salaries	0	24,766
Other liabilities	2,483,091	4,114,830
Balance as at 31 December	**3,014,335**	**4,409,400**

The other liabilities consist of:

Accrued expenses	1,883,311	1,748,278
Liability insurance programs - HCHC IBNR/UPR	0	2,144,918
Liability Health Insurance Fund / MoFA	226,936	214,974
Other	372,844	6,660
Balance as at 31 December	**2,483,091**	**4,114,830**

Contingent assets and liabilities

Regarding the current project portfolio PharmAccess Foundation received from donors' commitments for grants for an amount of about EUR 161 million. Of this amount EUR 139 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.

Off-balance sheet commitments

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.

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

10. Income

	2016	2015
	EUR	EUR
Realized income related to projects	23,740,842	26,643,063
Other income	32,379	82,811
	23,773,221	**26,725,874**

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

Ministry of Foreign Affairs *	10,445,133	15,190,581
PEPFAR	3,284,551	3,743,954
AHME	2,297,464	2,137,246
HDIF	943,749	599,642
Pfizer Foundation - Health Wallet & Chamas	804,104	180,314
Dutch Postcode Lottery	500,000	500,000
Achmea - Samburu	384,215	59,887
St. Antonius M-Tiba	366,661	-
FDOV MoH - Healthy Business	334,183	135,209
ELMA Foundation	333,083	165,170
USAID - Saving Lives at Birth: Kwara	255,840	23,424
Gilead Sciences, Inc.	244,934	-
HJF - GEIS	232,507	64,423
Embassy Kingdom of the Netherlands in Accra, Ghana	218,031	302,476
AmsterdamDiner	10,112	579,148
Other	3,086,275	2,961,588
	23,740,842	**26,643,063**

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

11. Personnel expenses

	2016	2015
	EUR	EUR
Salaries	7,806,656	7,084,872
Social security contributions	1,047,435	890,234
Pension costs	496,138	435,083
Other personnel expenses	757,604	714,694
	10,107,833	**9,124,883**

12. Financial expenses

	2016	2015
	EUR	EUR
Bank interest and charges	17,603	17,382
Other	-	3,274
	17,603	**20,656**

13. Financial income

	2016	2015
	EUR	EUR
Bank interest	18,734	52,815
Exchange rate differences	246,624	254,309
Other	5,783	-
	271,141	**307,124**

Other notes

Number of employees

The average number of full-time equivalents during the financial year 2016 was 196.7 (2015: 177.6).

Remuneration Directors and Supervisory Board

The remuneration of Directors during the financial year 2016 amounted to EUR 521,137 (2015: EUR 400,714). This remuneration consists of gross salary and a defined pension contribution:

	2016	2015
	EUR	EUR
Gross salary	476,043	366,017
Pension contribution	45,094	34,697
	521,137	**400,714**

The average number of full-time equivalents for the Board of Directors in 2016 was 3.60 (2015: 2.93).

2016

	O.P. Schellekens CEO	M.D. Dolfing-Vogelenzang COO	J.W. Marees CFO	N. Spieker Director Quality	Total
	EUR	EUR	EUR	EUR	EUR
Gross	81,000	128,250	127,640	98,400	435,290
Holiday allowance	6,480	10,260	9,211	7,872	33,823
Total remuneration DG-standard	87,480	138,510	136,851	106,272	469,113
Health insurance contribution	1,890	1,890	1,260	1,890	6,930
Total gross salary	89,370	140,400	138,111	108,162	476,043
Costs allowance	0	0	0	0	0
Pension contribution	8,844	13,262	13,218	9,771	45,094
Total remuneration WNT	98,214	153,662	151,329	117,933	521,137
Period of engagement:					
Engaged from	01.01.2016	01.01.2016	01.01.2016	01.01.2016	
Engaged to	31.12.2016	31.12.2016	31.12.2016	31.12.2016	
FTE%	60%	100%	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.

2015

	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%	

Subsequent events

There are no events to report.

Signing of the consolidated financial statements

Amsterdam, 13 September 2017

J. W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

O.P. Schellekens

J.W. Marees

M.G. Dolfing-Vogelenzang

OTHER INFORMATION

Independent auditor's report

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

Independent auditor's report

Deloitte Accountants B.V.
Gustav Mahlerlaan 2970
1081 LA Amsterdam
P.O.Box 58110
1040 HC Amsterdam
Netherlands

Tel: +31 (0)88 288 2888
Fax: +31 (0)88 288 9737
www.deloitte.nl

Independent auditor's report

To the Management Board of Stichting PharmAccess International

REPORT ON THE CONSOLIDATED FINANCIAL STATEMENTS 2016 INCLUDED IN THE ANNUAL ACCOUNTS

Our opinion

We have audited the consolidated financial statements 2016 of Stichting PharmAccess International, based in Amsterdam.

In our opinion the consolidated financial statements included in the annual accounts give a true and fair view of the financial position of Stichting PharmAccess International as at December 31, 2016, and of its result for 2016 in accordance with the Dutch Accounting Standard 640 "Not-for-profit organizations".

The consolidated financial statements comprise:
1. The consolidated balance sheet as at December 31, 2016.
2. The consolidated statement of income and expenditure for 2016.
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 consolidated financial statements" section of our report.

We are independent of Stichting PharmAccess International in accordance with the "Verordening inzake de onafhankelijkheid van accountants" bij assurance-opdrachten (ViO) and other relevant independence regulations in the Netherlands. Furthermore we have complied with the "Verordening gedrags- en beroepsregels accountants" (VGBA).

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

REPORT ON THE OTHER INFORMATION INCLUDED IN THE ANNUAL ACCOUNTS

In addition to the consolidated financial statements and our auditor's report, the annual accounts contain 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 consolidated financial statements and does not contain material misstatements.
- Contains the information as required by The Dutch Accounting Standard 640 "Not-for-profit organizations".

Deloitte.

We have read the other information. Based on our knowledge and understanding obtained through our audit of the consolidated 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 Accounting Standard 640 "Not-for-profit organizations" and the Dutch Standard 720. The scope of the procedures performed is substantially less than the scope of those performed in our audit of the consolidated financial statements.

Management is responsible for the preparation of the Management Board's report and the other information as required by the Dutch Accounting Standard 640 "Not-for-profit organizations".

DESCRIPTION OF RESPONSIBILITIES FOR 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 the 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 consolidated financial statements using the going concern basis of accounting unless management either intends to liquidate the company 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 consolidated financial statements.

Our responsibilities for the audit of the consolidated 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 have detected all material errors and fraud.

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 consolidated 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 judgment 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 consolidated 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

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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 consolidated 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 company to cease to continue as a going concern.

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

- Evaluating whether the consolidated 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 Management 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 identify during our audit.

We provide the Management Board with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

Amsterdam, September 13, 2017

Deloitte Accountants B.V.

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

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PharmAccess Foundation
AHTC, Tower C4
Paasheuvelweg 25
1105 BP Amsterdam
+31 (0)20 210 3920
www.pharmaccess.org

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