PharmAccess Foundation

Annual Accounts 2020

29 September 2021

PharmAccess FOUNDATION

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MANAGEMENT BOARD'S REPORT

Introduction

Twenty twenty has been a year like no other in testing our resolve to achieve universal health coverage (UHC). Over two million people have lost their lives, and many more their livelihoods as a result of the COVID-19 pandemic. The virus and containment measures have resulted in one of the worst global economic shocks in history. The World Bank estimates 71-100 million people will be forced into poverty, pushing many governments around the world to reassess their commitments to the Sustainable Development Goals (SDGs) as they battle to resuscitate their economies.

In Africa, the health sector has been dealt a harsh blow by the pandemic as financial and operational challenges have stalled and delayed many development initiatives. This amplifies the necessity to implement bold economic policies and interventions, including stronger health systems, private sector development and innovations, not only to reach those who are financially excluded but also in terms of pandemic interventions and preparedness. Over the past year, PharmAccess has pursued working towards making inclusive health markets work. We have continued to provide loans to healthcare providers through the Medical Credit Fund (MCF) whilst many financial institutions closed up shop. In some cases, MCF restructured loans so that struggling health facilities could remain open during the pandemic. In Nigeria, the Kwara State Health Insurance Scheme started enrollment in September, whilst in Lagos almost 300,000 people have registered for the state's health insurance scheme. In Kisumu County, Kenya and Zanzibar, Tanzania the groundwork was laid for a real shift towards more sustainable, social insurance-based models for reaching UHC.

In these difficult times we have seen that there is a growing demand for health insurance, and the urgent necessity to improve quality of care, like patient safety and infection control. With that in mind, in Ghana with Med4All we are working towards developing a digital medicine supply chain for affordable, quality medicines, and SafeCare has moved to a next phase, exploring how it can expand the adoption of quality standards and certification to grow its impact beyond Africa by starting in Afghanistan and India.

Our 'affiliated' organizations, who were initiated by PharmAccess but are now governed and financed independently, have also made important progress. The Joep Lange Institute (JLI) has been advocating for digital health and responsible data use, and their work done in Cameroon on Hepatitis C is an example of how outcome-based payments for health facilities can play an important role in driving quality healthcare in the future. Meanwhile, our partners CarePay and Safaricom received recognition for their joint work on M-Tiba, with the latter ranked 7th by Fortune for companies that are 'changing the world' in 2020.

As vaccine roll out early 2021 has raised hopes for recovery throughout Europe and the West, the cost of financing such a vaccine in hard hit African economies as well as the complex planning and logistical operation to deliver it will mean the continent may need to wait longer before pandemic restrictions are fully lifted. We must ensure equitable access to vaccines so that everyone at risk, anywhere in the world is protected. In the meantime, PharmAccess has implemented technology-driven interventions to cope with the rapidly unfolding crisis. More of this can be found in the following chapter 'Our COVID-19 response'.

The novel coronavirus has reinforced the need for African countries to strengthen their health systems to ensure the delivery of basic quality health care services, address the impact of COVID-19 and prepare effectively for future pandemics. PharmAccess is dedicated to strengthening health markets with digital technology so that people can access better services, lead healthier lives, and reach their full potential. Our work echoes the global call for universal health coverage, and we do this by mobilizing private and public resources, to reach those in even the most remote areas with affordable healthcare they can trust.

PharmAccess has country offices in Kenya, Tanzania, Ghana and Nigeria, and a head office in the Netherlands. In 2020, we employed a multidisciplinary team of over 200 professionals, of which 70% are based and operate in our African country offices. Our work is supported by the Netherlands Ministry of Foreign Affairs as well as the Nationale Postcode Lotterij.

A brief history

In 2001, after founding PharmAccess, the late Joep Lange sought to bring groundbreaking HIV drugs to hard-to-reach parts of Africa. Back then it was thought to be impossible and teaming up with the private sector was frowned upon. Partnering with Heineken, he initiated HIV treatment workplace programs for their employees and dependents based in Africa; many other companies followed. This showed that not delivering HIV treatment in Africa was a political choice, not a logistical barrier, blazing a trail for international action.

This early work revealed the broader financing and systems challenge in Africa. In 2006, PharmAccess, the Dutch Ministry of Foreign Affairs (MinBuZa) and several other multinationals created the Health Insurance Fund, tapping into private sector potential to better healthcare in Africa. PharmAccess acted as the implementing agency, while its sister organization AIGHD/AID conducted operational research. In 2015, following the positive evaluation by the Boston Consulting Group, MinBuZa refinanced the partnership for a further seven years.

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

1. accelerate health financing,
2. strengthen the quality of health services,
3. match demand and supply,
4. increase investment in healthcare, and
5. measure impact with research, evaluation, and advocate

Envisioning a virtuous cycle

At PharmAccess, a longstanding contextual analysis guides our Theory of Change. We believe that providing healthcare is a semi-public good where governments can meet the health needs of society. The reality remains, though, that only about half the world's population can access essential health services — which is why the private sector must play a role in delivering healthcare. This is especially true in Africa, where the private sector already delivers approximately 50 percent of health services.

Governments play a critical role in health sector development as only they can intervene at the required scale to enforce financial synergies, risk pooling, strategic purchasing and regulation. However, sub-Saharan Africa countries face challenges to finance, regulate, and enforce health policies. As a result, a large segment of the population, like those at the bottom of the pyramid, are on their own. So called 'free public healthcare' does not

exist and there is little in the way of health insurance. Where insurance is available, the low quality and uncertain availability of health services discourage people from pre-paying for health. Pre-payment is still a challenging concept in the region, and many families face competing priorities for their limited resources. Because of this, most people pay out-of-pocket when they need care, and so millions risk being pushed into poverty due to unpredictable healthcare costs.

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

PharmAccess and our partners (both public and private) aim to break this pattern by moving toward a virtuous cycle of trusted, inclusive markets that use private sector development to benefit low and middle-income groups. Through mobile technology and data, we are strengthening our interventions for better results and impact. The costs and time involved with administrating healthcare programs has been significantly reduced, and recent pilots have shown that fragmented sources of health financing can be unified through mobile health platforms. At the individual level, families and households can now be supported directly through their devices and smartphones — and can be reached at low marginal costs.

The PharmAccess approach

HOLISTIC: At PharmAccess we believe in systems strengthening, while working on interventions at both the demand and the supply side of the market. To work towards the virtuous cycle, we support the development of public private social insurance schemes and aim to increase willingness to pre-pay for healthcare through risk-pooling mechanisms and to pave the way for investments in healthcare. With MCF to provide loans to the broad range of healthcare providers and companies in the health sector, SafeCare to develop quality standards for hospitals, and the AIGHD to conduct impact and operational research.

PARTNERSHIPS: Partnerships are central to everything we do. PharmAccess acts as a catalyst and enables local entities to do the same. For many activities, we work with local implementers, including the private sector, technical assistance partners, banks, Insurance and telecommunication companies, medical equipment providers and pharmacy distributors. Our partnerships with governments, including national and state health insurance agencies and regulators, are fundamental to our ambitions and the sustainability of our impact.

STARTING PRIVATE, GROWING PUBLIC: Strong partnerships are essential for making programs efficient and sustainable. Although health is a public responsibility, the private sector complements public efforts by providing innovative products and services, additional capacity, and financing for healthcare. At PharmAccess, we partner with the private sector to develop and test new approaches and initiatives to improve both healthcare financing and delivery. At the same time, we partner with the public sector to replicate and scale such innovations. Well-functioning PPPs in health are the basis for successfully attaining Universal Health Coverage.

INNOVATE: Mobile technology enables efficient pooling of financing and scaling of insurance at a low cost as well as providing data to improve healthcare delivery and outcomes. On the supply side, the services can be

tracked to ensure quality standards at affordable prices which, in turn, increases public trust and drives demand. Information generated by electronic transactions improves transparency for all stakeholders and allows healthcare providers to better understand their customers' needs. Digital health will empower citizens to take control of their own health.

Sustainable Development Goals

The 2030 Agenda for Sustainable Development was adopted by all United Nations member states in 2015 to provide a set of goals to end poverty, protect the planet and ensure prosperity for everyone. PharmAccess contributes to these targets, especially (but not exclusively) Goal 3 on good health and Goal 8 on economic growth, by innovating with state-of-the-art technology and novel partnerships to create inclusive health markets in sub-Saharan Africa.

Our COVID-19 response

The coronavirus pandemic has amplified the fragility of sub-Saharan Africa's healthcare system. Most health posts, clinics and hospitals, already dealing with HIV, tuberculosis, and malaria as well as an increasing amount of non-communicable diseases, cannot withstand the onslaught of such a rapidly evolving public health emergency. They lack essential equipment like safety masks or personal protective equipment (PPE), approved test kits, and qualified staff to undertake effective triage and ensure infection control.

National lockdowns to contain the spread of the virus have been effective, but they have also created an additional barrier to accessing healthcare. The corresponding drop in patient numbers and revenue for private health facilities, which serve half of Africa's population, has meant many have had to scale down the services

they provide or shut down altogether. This disproportionately affects the poorest and most vulnerable in society, further adding to their struggle to find quality healthcare that does not put them out-of-pocket.

To respond to the pandemic in Africa, PharmAccess devised a rapid deployment plan based upon our approach, which engages the public and the private sector and innovates using the latest communications technology. This response was financially supported from the MFA, the Dutch Embassy in Ghana, the Achmea Foundation, FMO, Pfizer Foundation and Novartis. Our interventions in Ghana, Nigeria, Tanzania, and Kenya fall into three categories: financing health care providers, connecting doctors with patients and virus surveillance, and maintaining quality standards through effective infection prevention and control.

The Medical Credit Fund (MCF), our impact loan fund, has responded to the cash crunch faced by many healthcare providers due to increased expenditure for COVID-19 (e.g., PPE) on top of working capital expenditure, despite the fall in income. MCF has offered on average 100 new loans per month during the pandemic. In 2020, MCF disbursed $30 million of COVID-19 loans, providing lenders with more flexible repayment terms in these challenging circumstances. Digital loan products like MCF's 'Cash Advance' that do not require face-to-face contact have an important role to play in maintaining services at such exceptional times.

Digital solutions have also helped us bring together patients and doctors when movement has been restricted. Together with Luscii, a Dutch technology company, we implemented CovidConnect, a mobile service in Ghana, Nigeria, and Kenya. It enables individuals to assess their risks for COVID-19 and provides home monitoring and support from remote medical staff. Meanwhile, in Kenya, our MomCare service, a care analytics platform for pregnant mothers, has been adapted to cater for the pandemic. For example, free ambulances were provided during curfew hours, bed stay allowance was extended so women could arrive in plenty of time for their delivery and an SMS text service was provided to inform and increase engagement.

Our connected diagnostics program (ConnDx), which was used to geo-map malaria hotspots, has also been adapted to COVID-19. The new program, COVID-Dx, which uses smart phones to upload the patients' diagnosis, has increased the testing capacity of private Kenyan facilities and linked it to ongoing public efforts. The project focuses on prevention and resilient recovery, mitigating the socio-economic damages of the pandemic. In this case, mobile technology helps with early detection, find gaps in the health market, and make sure that resources are allocated where they are needed most.

In terms of infection prevention and control, we have built on our SafeCare service, a stepwise certification process to improve quality of health. The SafeCare4Covid mobile app prepares staff and facilities in coping with the COVID-19 pandemic. The app describes an approved triage protocol, gives detailed information on prevention and control, and provides training resources. All the materials are available online. To date, SafeCare4Covid has been downloaded in 765 facilities in all our four core countries and many others, some as far afield as Peru. The app may be adapted quickly for future pandemics, conflicts, or natural disasters.

Objective 1: Accelerating health financing

Trust is the key ingredient for creating demand in the health sector and achieving universal health coverage (UHC). By showing people that their health system can provide quality and affordable care we can increase the willingness to participate in health insurance schemes, and thus reduce the out-of-pocket costs that so often lead to financial ruin on the African continent, and around the world. PharmAccess supports such risk pooling mechanisms, where participants receive care for a pre-payment by themselves or (with) third parties such as government subsidies, remittances, employers, or donor funding.

Mobile phones can help reach more people at lower marginal costs, and the data generated by such technology can be used to identify gaps in and improve services, while ensuring that nobody is left out. This increased

transparency and information builds trust, which is further strengthened when combined with SafeCare standards *(see 'Strengthening the quality of health services')*. Over the last 15 years, PharmAccess has been working with public and private partners to develop and set up social health insurance schemes in order to improve access to care and advance UHC.

In Nigeria, PharmAccess supported several states – Lagos, Kwara, and Adamawa – in designing, developing, and implementing statewide health insurance schemes. In Lagos State, almost 300,000 people have been enrolled since December 2019 and in Kwara State, the Kwara State Health Insurance Agency (KW-HIA) began enrolling an initial group of 8,000 indigents to its state health insurance scheme. Meanwhile, in Adamawa State, PharmAccess assisted with the design of the State Health Insurance Scheme. Success in Lagos, the most populous state shows the possibility of scale, whilst success in Kwara, one of the poorest states, shows the viability of such interventions in rural, informal work sector settings.

In Ghana, PharmAccess is supporting the National Health Insurance Authority (NHIA) to improve upon its operational efficiency, sustainability, and coverage. By supporting the rollout of the CLAIM-it app — a digital system within the provider panel of NHIA — we assist in digitizing more claims, support an efficient, transparent process, and help shape a blueprint for what UHC can look like in a 'Ghana Beyond Aid'. PharmAccess is also assisting with the analysis of three years of claims data to provide insights and generate policy briefs and research publications for management decision-making.

In Kenya, to support the Kenyan government's UHC agenda, PharmAccess has partnered with the County Government of Kisumu (CGK) to develop and set up the Marwa Solidarity Health Scheme, supported by the John Martin Foundation. The Scheme aims to demonstrate how UHC may be achieved by passing required legislation, establishing governance and financing structures, by fully digitizing administration and by introducing innovative financing models. Together with CGK, NHIF and technology partner CarePay, PharmAccess also used a socio-economic mapping tool to identify, register, and enroll 45,000 indigent households (approx. 180,000 lives) with subsidized premiums who are able to access care at 49 healthcare facilities in the County from January 2021 onwards.

In Tanzania, the government has adapted the improved Community Health Fund (iCHF) program that was piloted by PharmAccess in partnership with the National Health Insurance Fund (NHIF) and the local District Councils in the Kilimanjaro and Manyara regions in the north of the country. This fund has been rolled out to all 26 regions of the Tanzania mainland. At the end of 2020, more than 1.3 million people were enrolled across Tanzania. Meanwhile, in Zanzibar, PharmAccess has assisted the semi-autonomous local government in digitizing and improving the administration of healthcare financing, assessing, and improving the quality of healthcare facilities, and developing a healthcare financing strategy that includes health insurance.

Objective 2: Strengthening the quality of health services

Some 5 million people die every year because of poor quality of healthcare, causing more deaths than from malaria, HIV and tuberculosis combined. SafeCare is a standards-based, stepwise certification approach which rates, improves and recognizes providers' business and quality performance. Qualified SafeCare assessors visit a facility for an assessment, where compliance against the quality standards is measured. This generates an assessment report, and providers are given a tailor-made quality improvement plan to address their gaps and

challenges, with transparent and achievable goals, and tools that guide them down a motivating and manageable path to improvement.

Accredited by the International Society for Quality in Healthcare External Evaluation Association (IEEA), SafeCare has three products that evaluate a facility's performance. The first, SafeCare Self-Assessments, is a digital self-assessment tools that allow facilities to self-evaluate against a set of criteria, designed around a specific topic such as COVID-19 preparedness, pharmacy, or MNCH. The second, SafeCare STEPS, is a quick assessment tool that rates facilities on a scale of 1 (lowest) to 5 (highest). The third, SafeCare ACCREDITATION, recognizes excellence in performance.

The three-assessment products feed into the SafeCare Quality Platform, which allows healthcare providers to use their assessment scores and benchmark against other facilities, learn about best practices and uses gamification approaches to stimulate quality improvement activities. The Quality Platform can also be accessed by third parties such as governments who can access the data for informed decision making and resource allocation. Investors and banks can access the information for investment risk reduction purposes. In 2020, 88% of the 875 participating facilities have improved in quality. Most were able to move from SafeCare level 1 and 2, to SafeCare levels 3 and 4.

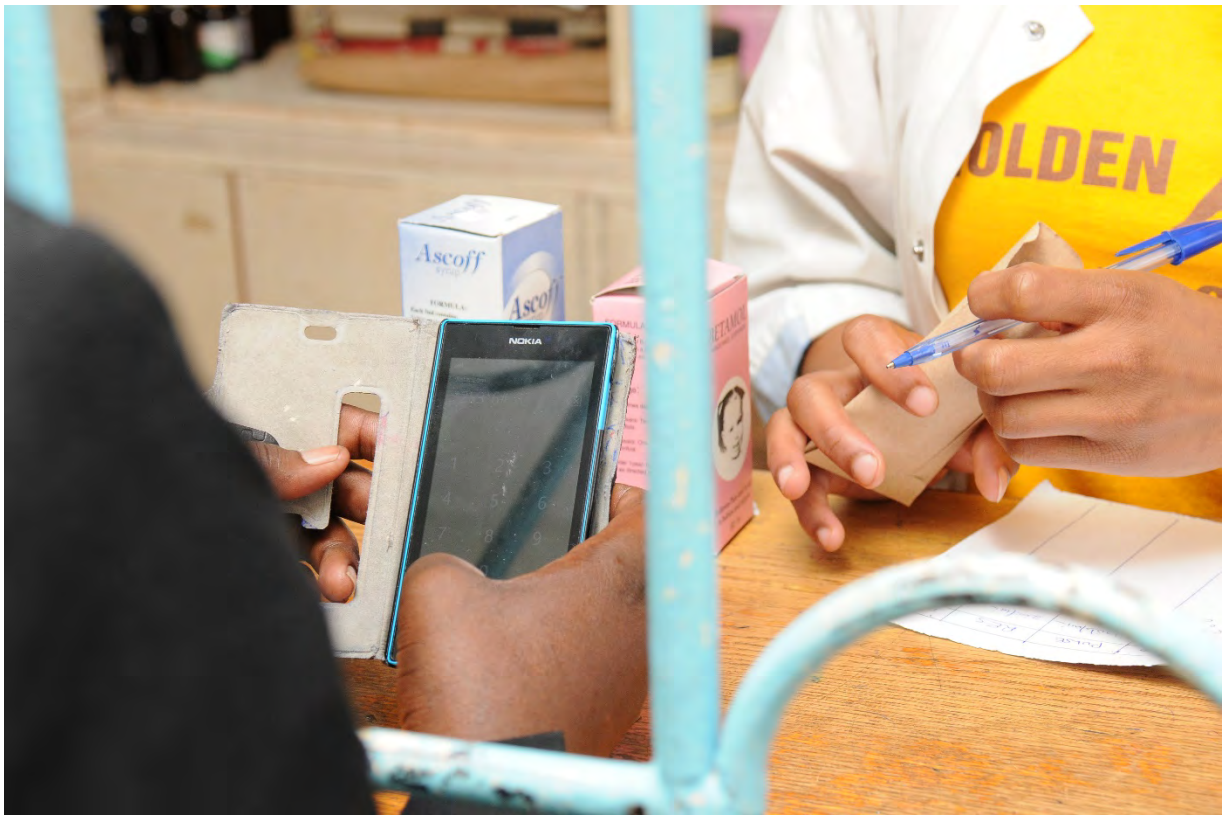
PharmAccess has made significant steps in licensing the SafeCare methodology to public and private partners. For example, in Tanzania, the Christian Social Services Commission (CSSC), the largest private sector (faith based) network, has been taking important steps towards sustainability, with 27 self-paying customers of their network now enrolled in SafeCare. Complementing our licensing work, we continue through capacity building and advocacy to embed SafeCare methodology and standards-based quality approached in the regulatory frameworks. With such clear regulations to adhere to (and enforced), healthcare facilities are more encouraged to up their game in providing quality health services.

In 2020, we also took steps to expand our work beyond the African continent. We signed a contract with Management Sciences for Health, a global nonprofit organization supported by USAID, to participate in a 5-year contract to build an accreditation body for the private sector in Afghanistan using SafeCare. Another Asia expansion is a three-year contract with MSD for Mothers to support Manyata, a large MNCH certification program in India impacting more than 1,000 facilities across the country.

The digitization of SafeCare makes quality assurance and improvement more scalable and sustainable. This is further supported by its embedding within the other initiatives, which allows us to develop and test new health care delivery models that incentivize standards compliance and continued improvement. Examples are Women360 in Ghana; supply chain solutions to improve the quality of medicines, as well as the integration of SafeCare with Medical Credit Fund products, and smart contracting opportunities for pregnant women.

Access to quality drugs is also an essential part of delivering better quality healthcare. PharmAccess has been working with the Christian Health Association of Ghana (CHAG) to set up a digital marketplace (Med4All) that connects trusted Ghanaian manufacturers and importers of medicines directly and transparently to healthcare providers in the value chain at low cost. So far, a digital platform and inventory management tools have been developed and selected healthcare providers have been trained to manage, and order stocks based on demand,

reducing the risks of stock-outs and waste, as well as shelf times and the cost of capital. Forecasting information is also used to pool the procurement of all CHAG facilities, enabling negotiation of better prices with suppliers.



Objective 3: Matching demand and supply

Mobile technology is changing the way health care is organized and paid for, especially in Sub-Saharan Africa, where 10% of transactions are done via phone payments (compared to 2% in Europe and the US). PharmAccess develops innovative care models that use mobile data to prioritize vulnerable patient groups and processes. In Kenya and Tanzania, we provide 'care bundles' to pregnant women and in Ghana we connect doctors to possible COVID-19 patients. In Kenya we identify malaria hotspots to streamline operations, whilst in Nigeria we screen for tuberculosis, both of which are poverty-linked diseases. It is this combination of creativity in solutions and rigorous data analytics that has the best chance of identifying solutions that can be scaled or replicated.

Care bundles

The MomCare bundle is designed around the expecting mother; empowering her to access the care she requires throughout her pregnancy 'journey' - no matter what complications may arise. Some 200,000 women die every year giving birth in sub-Saharan Africa. In the first visit, the healthcare facility sets out the recommended path, which includes ante-natal care and delivery. The expectant woman agrees to the care program (currently covered by a combination of social health insurance, donors, and co-payments) at the clinic directly through her mobile phone; ensuring treatment data is captured and checked according to medical protocol and her risk status.

This service is powered by an underlying care analytics platform, a set of digital tools that helps process clinical and operational healthcare data. That same powerful medium, supports the mother throughout the pregnancy journey outside of the clinic, providing care information, appointment reminders, and giving her a voice in care

satisfaction and outcome reporting. This transparency builds trust. And the valuable data collected during each touch point of the journey helps care providers to mitigate risks for their patients, moving towards better health outcomes for mother and child. To date, we have enrolled over 25,000 women in 42 clinics in Kenya and Tanzania.

The data-driven approach supports providers to continuously measure and improve the quality of their services. In addition, the predetermined costs of the care bundle offer a reliable income to the care provider that is often lacking. This can be used to invest in his or her business. Moving toward evidence- and value-based care not only helps clinics spend their time where it counts; it also helps payers, insurance, donors, and policymakers make more informed decisions. With near-real time data, the impacts of investments and interventions become clear and fully transparent, which appeals to payers, whether they be international donors or private. MomCare is supported by ELMA, CIFF, MSD for Mothers and a private Dutch donor.

The same care analytics platform that underpins MomCare can be adapted for other healthcare conditions such as HIV/AIDS, or even non-communicable diseases (NCD). For our work on hypertension and diabetes (supported by Bohringer and Sanofi), PharmAccess and partners registered 1,626 patients from a clinic serving an impoverished community in Kenya on a mobile-based NCD management platform. Patients received devices to measure their own blood pressure or blood glucose levels at home and could relay their measurements to their healthcare provider on a mobile phone application (AfyaPap). In addition, through the app, patient support groups were created, and health education messages were shared.

The majority of patients (75%) used this model of care and patients who measured their blood pressure at home and participated in peer support groups had a 18% higher likelihood of controlled blood pressure compared to those who measured but did not participate in peer support groups. Additionally, dietary risk factors reduced substantially during follow-up among the patients who participated in peer support groups and home-based self-measurements. Our findings provide crucial evidence on the value of patients' engagement for self-care through technology-driven approaches and peer support groups.

Connected diagnostics

The ongoing coronavirus pandemic has uncovered new opportunities for more patient-centered health care as provision moved from 'onsite' to remote only. Digital care models had not been fully appreciated before, but now many clinics found cell phones to be the only way to keep track of their patients' health. As experts in digital health, we have been able to support clinics with patient information (e.g., lists of high-risk patients to reach out to), financial solutions (e.g., room to purchase more hypertension drugs in one visit to reduce the need for travel) and digital tools (e.g., home measurement of blood pressure).

'Connected Diagnostics' (ConnDx), the use of smart phones to diagnose patients and channel funds conditional to the diagnostic result, allows you to upload rapid diagnostic test results into the cloud and target payments using mobile health platforms such as M-TIBA. In Kenya, we identified hotspots of malaria in semi-real time and could indicate which people suffered most from this disease (gender, age, geo-location, socio-economic status). We recorded and quantified over prescription behavior of doctors, performance of lab technicians and how patients vote with their feet with respect to visiting certain providers and certain (rush) hours and did this in semi-real time. This information could be used for significantly improved targeting of funds to the poor in the

context of UHC. Moreover, it provided essential information for markedly improved management of malaria patients service delivery.

When the pandemic struck, we quickly adapted our technology to identify coronavirus hotspots, so interventions could be put in place to disrupt transmission. This shows that no matter what the ailment, diabetes, hypertension, malaria, tuberculosis, HIV, dengue, schistosomiasis, or COVID-19, if diagnostics are digitizable, ConnDx can play a role in identifying patients, targeting interventions, and bringing together private and public sector capacity and funding streams to respond accordingly. ConnDx also allows for 'horizontalizing vertical funds' while keeping track of the specific condition the vertical fund is interested in, critical if we want to reach UHC by 2030.

Objective 4: Increasing investments in healthcare

In sub-Saharan Africa, healthcare providers struggle to obtain financing to grow their businesses and hence improve the quality of care they deliver. This is partly due to banks with limited knowledge of the health sector, high collateral requirements and the difficulty in assessing credit risk for these micro-, small- and medium-enterprises (MSME). As over 50% of Africa's population is served by the private health sector, this can have a significant impact on reaching universal health coverage.

The Medical Credit Fund (MCF), is a loan impact fund which helps health MSMEs access loans so they can buy equipment, expand their facility, pay bills, remunerate staff, or as seen recently, to pay for personal protective equipment and other coronavirus containment measures. Essentially, this avoids clinic closures and ensures not only that smaller businesses are financially included, but also that people with lower income, who these clinics often serve, can continue to have access to good quality healthcare.

In 10 years, MCF has disbursed some USD 100 million in local currency loans to over 1,800 healthcare providers, of which 22% are female entrepreneurs. These loans were not only to the private sector, but also to not-for-profit and faith-based organizations. The repayment rate has been 96% leading up to the pandemic and 94%

during, providing further proof of our lending model that has mobile technology at its heart. The clinics that are supported by MCF have around 365,000 visits per month across the six sub-Saharan countries.

In 2020, MCF disbursed 1,440 loans with a total loan volume of around USD 35 million (60% more than in the same period in 2019). And despite the closure of most financial institutions in the wake of the pandemic in Africa, at least for new loans, MCF has continued to provide over 100 loans per month, the same as before the pandemic. The current financers of MCF are the CDC, IFC, DFC, AFD, EIB and other private lenders as well as the Netherlands Ministry of Foreign Affairs.

MCF offers a unique combination of loans and technical assistance. The latter includes linking clinics to SafeCare to improve the quality of care delivered, as well as providing business support such as training of staff through business courses like we have in Kenya and Nigeria. Providing capacity building is crucial for improving the treatment of major diseases such as HIV/AIDS, and non-communicable illnesses like diabetes or hypertension, as well as for strengthening essential primary care services that provide the foundation for health systems everywhere.

Objective 5: Measuring impact with research, evaluation, and advocacy

Research, and evaluations

Evidence-based work is at the heart of our approach, hence our investment in independent research to evaluate and improve our products and services. Our own operational research has been published in peer-reviewed scientific papers, policy briefs, case studies and disseminated through workshops and conferences. Increasingly

posting on social media has meant we could engage the next generation of thinkers to tackle the challenges of inclusive health care in Sub Saharan Africa. In 2020, the coronavirus pandemic stole all the headlines and delayed our projects through closure of universities and the halting of international travel. Despite the challenges, we still provided powerful new insights in achieving quality health care for all.

Key findings (highlights)

Poor quality care is a significant cause of mortality and morbidity worldwide. Our research found that improvements in care quality measured using the SafeCare standards over an 18-month period were related to significant increases in patient numbers and staff in 491 facilities studied in Tanzania, Ghana, Kenya, Nigeria, amongst other countries. These facilities were of public, private, and faith-based ownership and were dispensaries, healthcare centers and primary hospitals. The results underline how providing quality care translates into better business performance, which in turn incentivizes facilities to stay on the path to better quality.

Staying on the topic of quality of care, our research in Tanzania used SafeCare data to analyze how well-prepared primary and secondary private healthcare facilities were to respond to pandemics. We looked at infection prevention and control, patient and staff safety, hand washing and personal protective equipment. Our research found that most facilities were grossly under-prepared in the event of a pandemic. The data from our research in Tanzania was critical in informing the design of our SafeCare4Covid app, free of cost and globally available for healthcare providers with practical support on COVID-19 protocols in low-resource settings.

In Nigeria, our research found that as in other sub-Saharan African countries, informal medicine vendors are an important provider of health services for rural and low-income populations, even for households who are covered by insurance. Patent and proprietary medicine vendors (PPMVs), as they are known, are rarely included in insurance schemes therefore adding to households' out-of-pocket health expenditures. In addition, they also often provide lower quality healthcare. Our published research shows that to reach UHC, the position of PPMVs within the primary healthcare system and within health insurance schemes needs to be reconsidered and quality management systems require further development.

Finally, last year saw a major review of our Medical Credit Fund (MCF) in Kenya, by SEO Amsterdam Economics. It showed that health SME's were struggling to secure loans from banks, especially during COVID-19, and that MCF helped to fill that gap. In making a success of it, MCF lead the way for other banks to follow in health care financing. Two further evaluations were completed by the London School of Hygiene and Tropical Medicine as well as University College Berkeley on our SafeCare initiative. More details on the outcome of those studies can be found in our Progress Report.

Advocacy

Our advocacy has focused on creating an enabling environment and policy change for innovations, private sector participation and scaling of our successful interventions in digital financing, health insurance and quality improvement in Ghana, Nigeria (Lagos and Kwara States), Tanzania and Kenya (Kisumu County). These countries have adopted UHC, where governments, in spite of budget constraints, have expressed commitment to partly subsidize health insurance for poor people. This commitment marks a shift in the way that healthcare is financed for millions of underserved populations. The need for greater domestic ownership in financing for health is not

only about government financing but also highlights the importance of individual contributions to augment the public efforts to achieve UHC.

The strength of our advocacy lies in the quality of our relationships. Over the years, PharmAccess has built unique expertise in bringing diverse partners together. Whether it be public or private, national or global, patients or provider, advocacy is critical in building these partnerships to create an enabling environment for the development of inclusive health markets, emphasizing the benefits of using private sector capacities and investments, and the digitalization of health financing and delivery. We also use the capacity of the public sector and the international community to bring our interventions to scale.

Building partnerships

The Netherlands Ministry of Foreign Affairs (MFA) has been a committed and long-term funder of PharmAccess. It has led the way in the policy dialogue on the 'Aid and Trade Agenda', and its embassies have been instrumental in providing political leverage and strategic advice in the countries where we operate. For example, MCF launched a new partnership with 7.5 million Euro support from MFA, to continue the supporting private healthcare provision in sub-Saharan Africa.

In all our advocacy efforts, we always seek to include the private sector. In sub-Saharan Africa, the private sector provides 50% of health services. Engaging them in this digital era boosts innovations in health, complements the services of the public sector and contributes to access to better care and increased coverage. For example, we collaborated with Africa Health Business and FMO to connect African and Dutch health entrepreneurs at the Annual World of Health Care held by the Dutch Task Force Health Care.

Government ownership is critical for creating enabling environment for scaling and providing funding to ensure that the poorest get served. PharmAccess builds partnerships at local, state, and national level to facilitate health insurance and ensure that health facilities deliver care according to agreed standards. For example, in Nigeria, Kwara and Lagos began the roll-out of the health insurance scheme, illustrating the need for health systems strengthening to address COVD-19 and achieve UHC.

Together with the Joep Lange Institute (JLI), we engaged I-DAIR (International Digital Health & Artificial Intelligence Research) on the digitalization of health financing and delivery. PharmAccess and JLI have also become core members of two global digital health coalitions. The Transform Health Coalition unites organizations and institutions across sectors who are committed to achieving UHC by harnessing digital technology and data to benefit all, including women and young people. The Digital Connected Care Coalition (DCCC), which we co-initiated with Philips and Dalberg, brings together over 20 cross-disciplinary organizations to form a networking-and-action-platform to support efficient partnerships for the digital transformation of health for UHC in LMICs.

Financial

The total income in 2020 amounts to EUR 21.3 million (2019: 24.3 million) and the operating result is EUR 527,339 (2019: EUR 82,083). Together with financial result, PharmAccess Foundation's records show a surplus of EUR 201,215 for the year 2020 (2019: EUR 63,759).

As the maximum amount of the special purpose reserve has been reached in previous years the total surplus has been added to the continuity reserve. After appropriation of the result the total equity amounts to EUR 2,685,171 (2019: EUR 2,483,956). To secure the continuity of PharmAccess Foundation, management continuously is looking for additional funding possibilities and is seeking to further improve the capital structure.

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

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

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

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

Outlook 2021 and beyond

The COVID-19 crisis is a wake-up call, a reminder that resilient healthcare systems are essential for economic and social prosperity, and international security. It has demonstrated that health is a global responsibility that requires cross-sector collaborations for universal health coverage. It has also driven wide-spread acknowledgement that digital technology and data form a core pillar of healthcare, with effective innovations

being deployed for prevention, infection control and mitigating spread, including track and trace apps, telemedicine, symptom trackers and dashboards as well as tools to build capacity and improve delivery.

In the wake of COVID-19, an opportunity has emerged for African countries to build stronger, more resilient data-driven healthcare systems which are better prepared for the next pandemic and can deliver basic quality healthcare for all citizens. The increasing penetration of mobile technology and digital platforms in Africa will be key for fast-tracking health system transformation, allowing all individuals to be digitally connected, covered and empowered to access care. Technology provides real-time data, thus ensuring transparency in the delivery, utilization, and costs of care to guide decision making for patients, healthcare providers and governments.

This has proved vital during the crisis when it has been critical to both address the outbreak and to commit resources to other healthcare needs. PharmAccess will continue to capitalize on digital technology to improve the financing and delivery of health care. For example, we will further develop smart contracting and value-based care interventions for mother and child healthcare and HIV, expanding services to support vulnerable socioeconomic groups. With lifestyle diseases, on the rise in Africa, we will also develop digital services for NCD care as well as platforms and tools, including online health information to empower people to take better informed decisions about their health and healthcare.

Given the limited and fragmented nature of healthcare funding in the countries that we support, and with donor funding on a downward trend, mobile technology also brings the opportunity to combine scarce funding sources while reducing transaction costs. By increasing efficiency and transparency, it can ensure that more marginalized individuals are covered while paving the way to implement new pay for performance models which generate data to guide governments in resource allocation. In the years ahead, we will support the integration of vertical programs into a more horizontal and integrated healthcare approach.

Further investments in healthcare quality remain crucial. We will continue to scale SafeCare and MCF, which proved critical throughout the pandemic. MCF's flexible and digital loans have offered much need support for health SMEs during the crisis with SafeCare helping to ensure infection prevention and control, while prioritizing staff and patient safety in clinics. Going forward, we will continue to use digital technology and data to improve the quality standards of healthcare facilities as well as share our expertise and lessons learnt with new countries. MCF will focus on digital lending to health SMEs, enabling them to overcome the requirement of a collateral security that impedes their access to financing.

We will also focus on strengthening public and private partnerships to create an enabling environment for scaling. We will advocate for increased government spending on health, including contributions toward social health insurance schemes, which is needed to sustainably finance UHC. The use of (digital) poverty mapping to segment the populations and target subsidies efficiently will be critical. While supporting the implementation of digital tools, we will also provide technical support to ensure that African countries can create more value out of the data that they generate. We will provide data analytics training to national health insurance agencies, ministries of health and clinics so that they can better leverage data to inform their own decision making. We will also further strengthen local capacity in areas of policy and legislation, governance and leadership, and research.

In the years to come, PharmAccess, and the Joep Lange Institute will continue to work with key partners and coalitions on global health diplomacy and the digitalization of health financing and delivery. The impact of technology has been demonstrated on the African continent, but the global health community and funders are yet to embrace its value. Through our joint advocacy efforts, we will promote thought leadership, share lessons learned, publish research results, initiate policy dialogue, and build partnerships to accelerate the role of digital technology in UHC.

Institutional development

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

As per January 1, 2020 Christiaan Rebergen (Treasurer-General of the Dutch Ministry of Finance) and Mirjam van Praag (President of the Vrije Universiteit, Amsterdam) joined the Supervisory Board. The other Supervisory Board members (Pauline Meurs (Chair a.i.), Willem van Duin, Ben Christiaanse, Ruud Hopstaken, Peter van Rooijen and Lidwin van Velden) stayed in their position.

Monique Dolfing-Vogelenzang and Jan Willem Marees stayed in their role of resp. CEO and CFO of the Executive Board.

In 2020, the number of staff decreased to a total of 197.8 FTE per year-end (2019: 205.8 FTE per year-end). Out of the 197.8 FTE, 132.0 FTE are employed in Africa. The average number of full-time equivalents during the financial year 2020 was 195.7 (2019: 210.0). This decrease can be largely explained by the development of the contract portfolio in Tanzania.

Signing of the Management Board's report

Amsterdam, 29 September 2021

J.W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang J.W. Marees

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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 2020

(After appropriation of the result)

	Note		31.12.2020		31.12.2019
			EUR		EUR
Assets					
Fixed assets					
Intangible fixed assets	1	-		29,688	
Tangible fixed assets	2	348,038	348,038	383,444	413,132
Current assets					
Receivables:					
Debtors	3	1,469,140		1,391,147	
Other receivables	4	813,003	2,282,143	834,327	2,225,474
Cash	5		9,239,095		9,819,723
			11,869,276		**12,458,329**

	Note		31.12.2020		31.12.2019
			EUR		EUR
Equity and liabilities					
Equity					
Continuity reserve	6	2,485,171		2,283,956	
Special purpose reserve	7	200,000	2,685,171	200,000	2,483,956
Current liabilities					
Creditors	8	585,965		1,044,979	
Taxes and social security contributions	9	189,410		255,912	
Deferred income	10	6,594,436		6,175,950	
Other liabilities and accrued expenses	11	1,814,294	9,184,105	2,497,532	9,974,373
			11,869,276		**12,458,329**

Consolidated statement of income and expenditure for the year 2020

	Note		2020		2019
			EUR		EUR
Income	12		21,276,161		24,267,142
Operating expenses:					
Direct project costs	13	9,222,868		12,840,260	
Personnel expenses	14	10,101,849		9,968,033	
Amortization and depreciation		154,983		154,037	
Other operating expenses		1,269,122	20,748,822	1,222,729	24,185,059
Operating result			***527,339***		***82,083***
Financial income and expenses:					
Financial expenses	15	(346,313)		(22,057)	
Financial income	16	20,189	(326,124)	3,733	(18,324)
Result			***201,215***		***63,759***
Appropriation of the result:					
Continuity reserve			201,215		63,759
Special purpose reserve			-		-
			201,215		**63,759**

Consolidated cash flow statement for the year 2020

(Based on the indirect method)

		2020		2019
		EUR		EUR
Operating result		***527,339***		***82,083***
Adjustments for:				
Depreciation (and other changes in value)		154,984		154,037
Changes in working capital:				
• movements operating accounts receivable	(56,669)		772,834	
• movement deferred income	418,486		(2,659,568)	
• movements other current liabilities	(1,208,754)	(846,937)	440,972	(1,445,762)
Cash flow from business activities		(164,614)		(1,209,642)
Interest received/paid		4,081		(14,085)
Cash flow from operating activities		*(160,533)*		*(1,223,727)*
Investments in (in)tangible fixed assets		(94,680)		(59,613)
Disposals of (in)tangible fixed assets		4,790		-
Cash flow from investment activities		*(89,890)*		*(59,613)*
Net cash flow		***(250,423)***		***(1,283,340)***
Exchange gains/(losses) on cash at banks and in hand		(330,205)		(4,239)
Movements in cash		**(580,628)**		**(1,287,579)**

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

Cash as at 1 January	9,819,723	11,107,302
Movements in cash	(580,628)	(1,287,579)
Cash as per 31 December	**9,239,095**	**9,819,723**

Notes to the consolidated financial statements

General

Foundation

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

The financial statements have been prepared in euro's.

As from 2020 the foundation is confronted with the consequences of the corona virus. Although the consequences of the corona virus are uncertain in the long term, the foundation does not expect any consequences for the continuation of the activities.

Objectives

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

Group structure

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

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

Consolidation principles

Financial information relating to group companies and other legal entities controlled by Stichting PharmAccess International or where central management is conducted, has been consolidated in the financial statements of

Stichting PharmAccess International. The consolidated financial statements have been prepared in accordance with the Dutch-Generally Accepted Accounting Principles (NL-GAAP).

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

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

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

Accounting principles

General

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

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

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

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

Consolidated Balance sheet

Intangible fixed assets

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

Tangible fixed assets

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

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

Receivables

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

Cash

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

Provisions

Provisions for employee benefits

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

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

Current liabilities

Deferred income

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

Other current liabilities

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

Principles for the determination of the result

Consolidated Statement of income and expenditure

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

Income

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

Other income relates to other non-project related items.

Direct project costs

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

Recognition of transactions in foreign currency

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

Financial instruments

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

Principles for preparation of the consolidated cash flow statement

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

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

Notes to the specific items of the consolidated balance sheet

1. Intangible fixed assets

	2020	2019
	EUR	EUR
Book value as at 1 January	29,688	60,253
Amortization during the year	(29,688)	(30,565)
Book value as at 31 December	**-**	**29,688**
Purchase value as at 31 December	167,361	167,361
Accumulated amortization	(167,361)	(137,673)
Book value as at 31 December	**-**	**29,688**

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

2. Tangible fixed assets

	2020	2019
	EUR	EUR
Book value as at 1 January	383,444	447,303
Additions during the year	94,680	59,613
Depreciation during the year	(125,296)	(123,472)
Disposal of assets	(4,790)	-
Book value as at 31 December	**348,038**	**383,444**
Purchase value as at 31 December	953,453	970,640
Accumulated depreciation	(605,415)	(587,196)
Book value as at 31 December	**348,038**	**383,444**

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

2020

	Computer equipment EUR	Refurbish-ment EUR	Office Furniture EUR	Other EUR	Total EUR
Book value as at 1 January	89,700	252,213	27,946	13,584	383,444
Additions during the year	94,680	-	-	-	94,680
Depreciation during the year	(71,422)	(37,229)	(11,604)	(5,040)	(125,296)
Disposal of assets	(4,790)	-	-	-	(4,790)
Book value as at 31 December	108,168	214,984	16,342	8,544	348,038
Purchase value as at 31 December	458,111	348,388	94,041	52,913	953,453
Accumulated amortization	(349,944)	(133,404)	(77,698)	(44,369)	(605,415)
Book value as at 31 December	**108,168**	**214,984**	**16,342**	**8,544**	**348,038**

2019

	Computer equipment EUR	Refurbish-ment EUR	Office Furniture EUR	Other EUR	Total EUR
Book value as at 1 January	101,393	289,442	39,889.22	16,578	447,303
Additions during the year	56,225	-	-	3,388	59,613
Depreciation during the year	(67,918)	(37,229)	(11,942.74)	(6,382)	(123,472)
Disposal of assets		-	-	-	-
Book value as at 31 December	**89,700**	**252,213**	**27,946.48**	**13,584**	**383,444**
Purchase value as at 31 December	475,298	348,388	94,041.00	52,913	970,640
Accumulated amortization	(385,598)	(96,175)	(66,094.00)	(39,329)	(587,196)
Book value as at 31 December	**89,700**	**252,213**	**27,947.00**	**13,584**	**383,444**

3. Debtors

	31.12.2020	31.12.2019
	EUR	EUR
Debtors	1,469,140	1,315,566
Related foundation: Health Insurance Fund (HIF) - accounts receivable	-	53,196
Related foundation: Medical Credit Fund (MCF) - accounts receivable	-	22,385
Provision for doubtful debts	-	-
Balance as at 31 December	**1,469,140**	**1,391,147**

4. Other receivables

	31.12.2020	31.12.2019
	EUR	EUR
Other	497,429	217,013
Prepayments	238,932	238,551
Accrued income	-	310,576
Advances partners related to projects	70,640	60,780
Pension and other personnel insurances	6,002	7,407
Balance as at 31 December	**813,003**	**834,327**

5. Cash

	31.12.2020	31.12.2019
	EUR	EUR
ABN-AMRO-AMRO accounts Netherlands - EUR	1,720,710	4,818,827
ABN-AMRO-AMRO accounts Netherlands - USD	6,186,427	2,930,929
ABN-AMRO-AMRO accounts Netherlands - GBP	111,512	-
Bank accounts Tanzania - TZS	52,255	148,857
Bank accounts Tanzania - EUR	20,574	36,690
Bank accounts Tanzania - USD	87,331	57,289
Bank accounts Tanzania - GBP	-	10,661
Bank accounts Kenya - KES	85,815	572,016
Bank accounts Kenya - EUR	167,254	13,262
Bank accounts Kenya - USD	4,329	145,817
Bank accounts Nigeria - NGN	464,030	665,010
Bank accounts Nigeria - EUR	22,788	29,790
Bank accounts Nigeria - USD	46,898	257,707
Bank accounts Nigeria - GBP	9,911	7,168
Bank accounts Ghana - GHC	84,353	23,525
Bank accounts Ghana - EUR	171,843	99,151

Cash in hand	3,065	3,024
Balance as at 31 December	**9,239,095**	**9,819,723**

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

6. Continuity reserve

	2020	2019
	EUR	EUR
Balance as at 1 January	2,283,956	2,220,197
Result current year	201,215	63,759
Balance as at 31 December	**2,485,171**	**2,283,956**

Result appropriation for the year

Due to the appropriation of the result, an amount of EUR 201,171 has been added to the continuity reserve.

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

7. Special purpose reserve

	2020	2019
	EUR	EUR
Balance as at 1 January	200,000	200,000
Result current year	-	-
Balance as at 31 December	**200,000**	**200,000**

Result appropriation for the year

There has been no movement on the special purpose reserve as the maximum has been reached and no use was made during 2020.

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

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

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

8. Creditors

	2020	2019
	EUR	EUR
Creditors	584,035	989,659
Related foundation: Health Insurance Fund (HIF) - accounts payable	-	53,390
Related foundation: Medical Credit Fund (MCF) - accounts payable	1,930	1,930
Balance as at 31 December	**585,965**	**1,044,979**

9. Taxes and social security contributions

	31.12.2020	31.12.2019
	EUR	EUR
Value added tax	9,152	76,908
Wage tax	178,416	179,596
Social security contributions	1,842	(592)
Balance as at 31 December	**189,410**	**255,912**

10. Deferred income

	31.12.2020	31.12.2019
	EUR	EUR
Received from donors related to projects	92,402,379	85,885,417
Realized revenue on projects	(85,807,943)	(79,709,467)
Balance as at 31 December	**6,594,436**	**6,175,950**

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

	2020	2019
	EUR	EUR
Balance as at 1 January	6,175,950	8,835,518
Received from donors related to *active* projects	6,516,962	(10,792,490)
Realized revenue on *active* projects	(6,098,476)	8,132,922
Balance as at 31 December	**6,594,436**	**6,175,950**

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 11,291,395 (2019: EUR 7,167,137) for by donors pre-financed projects (credit) and an amount of EUR 4,696,959 (2019: EUR 991,187) for reimbursement projects (debit).

11. Other liabilities and accrued expenses

	31.12.2020	31.12.2019
	EUR	EUR
Accrued expenses	1,167,680	1,290,105
Holiday allowance	199,082	179,619
Liabilities projects	32,516	435,569
Liability Health Insurance Fund / MoFA	15,554	15,504
Other liabilities	399,462	576,735
Balance as at 31 December	**1,814,294**	**2,497,532**

The liability projects include an amount of EUR 18,457 (2019: 431,636) as liability to a 'related foundation', Medical Credit Fund (MCF).

Contingent assets and liabilities

Regarding the current project portfolio PharmAccess Foundation received from donors' commitments for grants for an amount of about EUR 119 million (2019: EUR 108 million). Of this amount EUR 92 million (2019: 86 million) has been received. PharmAccess Foundation has the obligation to use these funds in accordance with the contractual donor requirements.

Financial instruments

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

Currency risk

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

Liquidity risk

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

Credit risk

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

Non-recognised assets and liabilities and contingent assets and liabilities

Although it is not a contractually agreed commitment, PharmAccess has the intention to yearly allocate up to EUR 2 million of the HIF-funding (Ministry of Foreign Affairs) to the Medical Credit Fund (MCF). The exact yearly budgets are to be determined during the yearly activity planning and budgeting process within the PharmAccess Group, and finalized before November 1st, prior to the budget year.

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

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

12. Income

	2020	2019
	EUR	EUR
Realized income related to projects	21,424,035	24,328,120
Other income	(147,874)	(60,978)
	21,276,161	**24.267,142**

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

Ministry of Foreign Affairs - HIF	9,153,889	10,750,391
Children's Investment Fund Foundation (CIFF)	1,798,918	1,353,859
Medical Credit Fund (MCF)	1,045,217	1,128,500
Nationale Postcode Loterij	900,000	900,000
Achmea Foundation	887,403	51,306
Merck Sharp & Dohme Corp. (MSD) - Merck for Morthers	871,349	455,087
USAID - Palladium International LLC	722,785	394,425
The Leona M. & Harry B. Helmsley Charitable Trust (Helmsley)	669,805	59,128
Global Fund - ICI-Santé	642,953	218,846
John C. Martin Foundation	573,127	324,553
Sint Antonius Stichting	504,173	500,597
CDC Group plc - DFID - UK	426,285	94,144
FDOV MoH - Healthy Business	363,313	362,905
Palladium International Ltd. - UK	333,247	-
Nationale Postcode Loterij - Amref: I-Push	271,186	1,490,729
The Henry M. Jackson Foundation (HJF)	266,998	271,108
Nederlandse Financierings-Maatschappij voor Ontwikkelingslanden N.V. (FMO)	252,801	-
Grand Challenges Canada	231,665	-
Society for Family Health (SFH)	207,524	219,331
Enabel	197,496	-
HealthConnect Foundation	150,000	-
Pfizer	135,906	-
The ELMA Relief Foundation	123,193	-
The Safaricom Foundation	104,603	76,675
Boehringer Ingelheim	102,491	701,033
Gilead Sciences, Inc.	80,443	10,818
Sanofi Aventis Groupe (SAG)	76,603	316,654
Heineken International B.V.	50,420	920
Embassy of the Kingdom of the Netherlands (EKN) - Accra Ghana	45,244	74,150

The Philips Foundation	34,726	29,701
Stichting Cordius	24,998	-
Joep Lange Institute (JLI): HCV Treatment	20,762	172,901
Financial Sector Deepening Trust (Kenya) (FSD Trust)	20,124	-
National Hospital Insurance Fund (NHIF), Kenya	13,848	1,144,168
Foundation Botnar - JLI	10,487	-
Heineken Global Health & Safety	9,100	40,090
M-PESA Foundation	6,564	346,071
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH	4,661	61,091
Pfizer Foundation - Health Wallet & Chamas	40	102,774
AmsterdamDiner Foundation - Aidsfonds: Mozambique	11	36,967
PEPFAR	-	1,103,338
Human Development Innovation fund (HDIF)	-	167,549
Marie Stopes International (MSI): AHME	-	312,230
Ministry of Foreign Affairs - JLI: FT-conference	-	400,000
USAID - Saving Lives at Birth: Kwara	-	163,122
AmsterdamDiner Foundation - Aidsfonds: 2017	-	-
KNCV - DGIS Nigeria	-	19,486
Other	89,677	473,473
	21,424,035	**24,328,120**

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

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

13. Direct project costs

	2020	2019
	EUR	EUR
PAI - Netherlands	4,810,551	5,824,680
PAI - Kenya	2,223,630	3,814,921
PAI - Tanzania	975,596	1,979,594
PAI - Nigeria	727,840	765,109
PAI - Ghana	485,251	455,956
	9,222,868	**12,840,260**

14. Personnel expenses

	2020	2019
	EUR	EUR
Salaries	8,059,897	7,765,692
Social security contributions	1,058,637	1,020,550
Pension costs	556,916	520,490
Other personnel expenses	426,399	661,301
	10,101,849	**9,968,033**

Indirect cost calculation

Ratio: 'Fringe benefits' as a percentage of 'salaries'

Based on the 2020 figures, on average the 'fringe benefits' expressed as a percentage of 'salaries' is 25.3% (2019: 29.4%) resulting in an average of 28.1% over the last three years (2019-2017: 30.1%).

Personnel expenses

	2020	2019
	EUR	EUR
Salaries	*8,059,897*	*7,765,692*
Social security contributions	1,058,637	1,020,550
Pension costs	556,916	520,490
Other personnel expenses	426,399	661,301
Subtotal fringe benefits	*2,041,952*	*2,202,341*
Total personnel expenses	10,101,849	9,968,033

Ratio

	2020	2019
	%	%
'Fringe benefits' as a percentage of 'salaries'	25.3%	28.4%
Average last two years	26.8%	29.4%
Average last three years	28.1%	30.1%
Average last five years	29.0%	

Ratio: 'Indirect costs' as a percentage of 'personnel expenses'

Based on the 2020 figures, on average the indirect costs expressed as a percentage of total personnel cost (gross salaries plus fringe benefits) is 14.1% (2019: 13.8%) resulting in an average of 12.9% over the last three years (2019-2017: 13.4%).

Operating expenses

	2020	2019
	EUR	EUR
Direct project cost	9,209,558	12,840,260
Personnel expenses	*10,101,849*	*9,968,033*
Amortization and depreciation	154,983	154,037
Other operating expenses	1,269,122	1,222,729
Subtotal indirect costs	1,424,105	1,376,766
Total operating expenses	20,735,512	24,185,059

Ratio

	2020	2019
	%	%
Average 'indirect costs' as a percentage of 'personnel expenses'	14.1%	13.8%
Average last two years	14.0%	12.3%
Average last three years	12.9%	13.4%
Average last five years	13.8%	

15. Financial expenses

	2020	2019
	EUR	EUR
Exchange rate differences	330,224	2,838
Bank interest and charges	16,089	17,818
Other	-	1,401
	346,313	**22,057**

16. Financial income

	2020	2019
	EUR	EUR
Bank interest	20,170	3,733
Other	19	-
	20,189	**3,733**

Other notes

Number of employees

The average number of full-time equivalents during the financial year 2020 was 195.7 (2019: 210.0). This decrease can be largely explained by the development of the contract portfolio in Tanzania.

Remuneration Directors and Supervisory Board

The remuneration of Directors during the financial year 2020 amounted to EUR 341,052 (2019: EUR 323,726). This remuneration consists of gross salary and a defined pension contribution:

	2020	2019
	EUR	EUR
Gross salary	307,733	294,888
Pension contribution	33,319	28,874
	341,052	**323,762**

The average number of full-time equivalents for the Board of Directors in 2020 was 2.0 (2019: 2.0).

2020

	M.D. Dolfing-Vogelenzang	J.W. Marees	Total
	CEO	CFO	
	EUR	EUR	EUR
Gross	142,212	140,180	282,392
Holiday allowance	11,377	10,214	21,591
Total remuneration DG-standard	153,589	150,394	303,983
Health insurance contribution	2,250	1,500	3,750
Total gross salary	155,839	151,894	307,733
Costs allowance			
Pension contribution	16,686	16,633	33,319
Total remuneration WNT	172,525	168,527	341,052
Period of engagement:			
Engaged from	01.01.2020	01.01.2020	
Engaged to	31.12.2020	31.12.2020	
FTE%	100%	100%	

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

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

2019

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

Subsequent events

There are no events to report.

Signing of the consolidated financial statements

Amsterdam, 29 September 2021

J.W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang J.W. Marees

SIEMENS
Patient Applications Trans View Image Tools Scroll Evaluation System Options Help
HRA
CRESTVIEW RADIOLOGY
MAGNETOM_ESSENZA
STUDY 1
10/16/2019
11:01:16 AM
IMA 6 / 30
LUMBAR SPINE
WAARE REBECCA
RAF
MF 1.00
10cm
Viewing
Filming
3D
Composing
Tools
Image
View
Patient
Exam
ADC
Waiting for scan instructions.
SIEMENS
BOSE
cisco

OTHER INFORMATION

Independent auditor's report

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

Independent auditor's report

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Independent auditor's report

To the Management Board of Stichting PharmAccess International

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS 2020 INCLUDED IN THE ANNUAL ACCOUNTS

Our opinion

We have audited the accompanying financial statements 2020 of Stichting PharmAccess International, based in Amsterdam.

In our opinion the accompanying financial statements give a true and fair view of the financial position of Stichting PharmAccess International as at 31 December 2020, and of its result for 2020 in accordance with Dutch Accounting Standard 640 "Not-for-profit organizations".

The financial statements comprise:

1. The consolidated balance sheet as at 31 December 2020.

2. The consolidated statement of income and expenditure for 2020.

3. The notes comprising a summary of the accounting policies and other explanatory information.

Basis for our opinion

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

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

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

REPORT ON THE OTHER INFORMATION INCLUDED IN THE ANNUAL ACCOUNTS

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

- Management Board's Report.

- Other information.

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

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

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

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

Management is responsible for the preparation of the other information, as required by the Dutch Accounting Standards 640 "Not-for-provit organisations".

DESCRIPTION OF RESPONSIBILITIES REGARDING THE FINANCIAL STATEMENTS

Responsibilities of management for the financial statements

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

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

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

Our responsibilities for the audit of the financial statements

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

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

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

2109D1B995/CP/2

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

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

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

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

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

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

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

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

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Deloitte.

We communicate with 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 identified during our audit.

Amsterdam, 29 September 2021

Deloitte Accountants B.V.

Signed on the original: S. Kramer

2109D1B995/CP/4

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PharmAccess
FOUNDATION