Evaluation report 2016-2021

Health Insurance Fund

February 2022

Tanzania, 2019, MomCare – nurse and baby during a postnatal health check-up

Colofon

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This evaluation is led by Paul Rutten and Steven le Poole. Other members of the executive team are Niels van Zijl, Wouter Versluijs and Kevin Ren.

Contents

Executive summary

This report provides the independent evaluation of the Health Insurance Fund (HIF)[1] for the grant 'Making inclusive health markets work' of EUR 76 million, provided for the period 2016 to December 2022. HIF is the foundation via which the Netherlands Ministry of Foreign Affairs (MFA) financially supports the activities of PharmAccess.[2] PharmAccess' aim is to develop inclusive health markets in order to increase access to affordable and quality healthcare for low- and middle-income populations in Sub-Saharan Africa (SSA).

PharmAccess successfully applies holistic system thinking and enables private markets to improve health care systems in the complex and continuously changing context of SSA. In SSA, growth in population, non-communicable diseases and continuing presence of communicable diseases stretch health markets that are already limited in access and quality. In a volatile political environment, both local and national, which demands flexibility and endurance, its efforts have resulted in a number of well-known successes, in particular SafeCare, Medical Credit Fund (MCF) and spin-off CarePay. Its approach, which involves innovative financing mechanisms and technological innovations, results in high levels of effectiveness, relevance for its stakeholders as well as coherence with local initiatives, but also with initiatives of other Dutch or international partners. There is large consensus amongst PharmAccess' partners and other stakeholders about their positive impact on healthcare in SSA.

The results in this evaluation are primarily based on the impact of and stakeholders' experiences with the aforementioned well-known successes and more mature initiatives. The current pipeline of other projects doesn't yet have a fact base showing impact or potential as convincing as these existing initiatives. In addition, the evidence of impact is often scattered or not available in structured format. It is a challenge to investigate beyond the anecdotal positive feedback that is available.

With regards to the organization as a whole, our evaluation shows there are opportunities for PharmAccess to improve the sustainability of its progress as well as, more importantly, to build on it. We see an opportunity for PharmAccess to further increase and scale its impact in its target regions and, indirectly, in other regions, by leveraging its experience, successes, and partnership with MFA.

Below, six recommendations for PharmAccess are provided, followed by the approach and summary of the evaluation across three evaluation criteria: relevance, coherence and effectiveness.

Recommendations

This evaluation proposes six recommendations to further improve the impact of PharmAccess. The first three relate to PharmAccess' strategy, while the latter three touch on the way it operates:

1. **Decide on strategic role.** To optimize its impact as a small player in a crowded field, PharmAccess could decide which strategic role it wants to play and the maturity level it aspires to support. Potential roles could be:
    - Incubator of innovations: deliver a proof of concept and hand over to other parties for further development and scaling, i.e. reaching larger groups of beneficiaries;
    - Catalyst of innovations: go further than incubation and develop a self-standing model that is either handed over to a scaling partner or kept in the organization and licensed to other partners (this option is probably closest to its current role);
    - Implementer of innovations: scale and implement proven solutions.
2. **Prioritize initiatives.** PharmAccess could clearly prioritize which initiatives and

[1] See appendix for an overview of all abbreviations used in this report.
[2] For the sake of brevity, we will refer to PharmAccess in the remainder of this report, as PharmAccess is responsible for the implementation of all activities.

geographic areas to focus on, primarily based on scaling potential, and then work consistently on those. Right now, PharmAccess' agenda and geographical scope seem to be stretched given its available resources. This pressure is likely to further increase as the future involvement of other MFA departments may lead to expansion or shift of this scope. By prioritizing, PharmAccess can extend its impact in specific areas of focus.

3. **Engage scaling partners.** PharmAccess could use its expertise to engage scaling partners that can support PharmAccess' initiatives to have greater impact, e.g., Multilateral Organizations (MLO), national governments and local implementation partners. These scaling partners would need to be involved in early phases of an innovation, to ensure full alignment, to prove the initiative works also vis-à-vis their objectives, and to comply with various funding guidelines. Typically, these larger scaling partners have a sharp focus on impact and performance. Knowing PharmAccess has presented itself to MLOs and other large organizations in the past, PharmAccess could consider improving its quantitative performance management as this will increase the likelihood of successful partnership.

4. **Improve (quantitative) performance management.** This action would support organizational leadership to focus on activities that are aligned with the strategy and priorities. Performance management can be used to support strategic discussions with the advisory board and external fund providers, including the MFA. A greater focus in this area would also allow scaling partners to be engaged based on structured impact figures. A culture of performance management would be enhanced by implementing a clear stage-gating process for all initiatives and projects.

5. **Be bold on impact underpinned by data and promote it.** External communication could be more fact-based and data-driven, enabling PharmAccess to build a stronger public profile. This would allow it to strengthen its advocacy role at both government and MLO level. This might require an evaluation of the current staffing of 2.5 FTE in the research department and current research partners to determine whether this setup is sufficient to realize a bolder ambition.

6. **Invest in a concise "why, what, how".** A refined and crisper description of activities, core beliefs and methodology would build PharmAccess' profile as innovative change maker of healthcare in SSA and beyond. Together with more structured collection of data on impact, this action will help other parties to better understand what PharmAccess stands for and may facilitate the creation of new partnerships.

Evaluation

This evaluation focuses on three out of the six criteria in the OECD DAC evaluation framework: relevance, coherence and effectiveness (OECD, 2019). It covers the period 2016 to mid-2021 across PharmAccess' five objectives as stated in its Theory of Change (ToC, see exhibit 3):

1. **Demand:** Develop private pre-payment mechanisms and risk-pooling structures, and mobilize resources;
2. **Supply:** Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers;
3. **Matching supply and demand**[3]**:** Improve efficiency, effectiveness, and transparency to better match demand and supply of healthcare transactions;
4. **Investments:** Mobilize capital into the private health sector;
5. **Research & Advocacy:** Conduct research on the various implemented strategic interventions and advocate those that are successful.

The sources of this evaluation include 65 interviews with various stakeholders, qualitative case study analysis, on-site walkthroughs, and quantitative analysis, among other sources. The scope of this report excludes an evaluation of the organizational model or due diligence of the (local) partners.

[3] The 'matching supply and demand' objective will be referred to as 'matching' in the remainder of this report.

PharmAccess' original ToC or program documentation for this grant does not include quantified targets for these five objectives, which significantly limits the extent to which the effectiveness and efficiency of its achievement can be evaluated.

Relevance[4]

PharmAccess' activities address definite needs of local beneficiaries, healthcare providers and governments at both the regional and national level.

The local beneficiaries benefit from activities linked to all the five objectives, both on a stand-alone (direct, i.e. quality interventions) and a mutually-reinforcing (indirect, investments in local healthcare) basis.

Providers' needs are addressed through activities meeting almost all objectives: quality-related initiatives such as SafeCare, reliability of cashflows through M-TIBA and capital via MCF all contribute to improvement of services.

For governments, the activities are relevant in that they aim to improve the health sector; the most relevant of these is the bespoke technical assistance provided for insurance schemes. An improved healthcare sector is also a relevant outcome for private-sector focused activities.

The relevance of activities for the Netherlands' policy is evaluated against two specific policy goals of the MFA: private-sector development and health-market transformation. Concerning the former, almost all of PharmAccess' activities either directly or indirectly contribute to the private healthcare sector. For the latter, MFA focuses its health market transformation goals primarily on Sexual and Reproductive Health and Rights (SRHR). It is fair to comment that there was not a specific focus on SRHR in the current funding period, as this was not agreed with MFA in 2015.

Stakeholder interviews confirm the increased relevance of PharmAccess during the Covid-19 pandemic in its target areas. Its local partner-network benefitted from PharmAccess' immediate response – being noticeably faster than other organizations or governments. We see no evidence that the relevance of PharmAccess' activities has decreased. As Covid-19 is expected to strongly influence healthcare in the coming years – particularly in SSA – PharmAccess also has an opportunity to further increase its relevance by translating digital tools and helping health systems deal with the Covid-19 challenges.

Coherence: Uniqueness and compatibility[5]

PharmAccess' holistic public-private healthcare sector approach distinguishes it from the large majority of NGOs that do not focus on the private sector. PharmAccess' agility, long-term relationships and characteristic of embracing digital innovation contribute to its distinctive profile in the field – it is seen as a flexible, all-round thought partner. Interviewed stakeholders are not familiar with any other organization that operates in a similar way.

However, stakeholder interviews suggest that PharmAccess' profile is still associated with voluntary private insurance schemes, leading to some suspicion. This view does not reflect the reality of this funding period, during which PharmAccess only tested and implemented public-based (mandatory) insurance schemes in collaboration with local governments.

Coherence with regional and national government initiatives is generally high. PharmAccess' tailored and long-term approach to partnership helps ensure compatibility with existing initiatives. Advocacy work by local PharmAccess employees helps governments to scale initiatives by facilitating legislation being passed through parliaments.

Coherence with Dutch private-sector development and health-market transformation is high. PharmAccess' activities are complementary to other existing initiatives and there collaborates with, e.g., Dutch NGOs, financing organizations and task forces, and large Dutch multinational organizations such as Heineken and Philips. Due to geographic focus, there is relatively little direct compatibility with other initiatives in the MFA program.

[4] See OECD (2019) definition of Relevance: "The extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change"

[5] See OECD (2019) definition of Coherence is: "The compatibility of the intervention with other interventions in a country, sector or institution." We further incorporate an understanding of the uniqueness of PharmAccess' activities as requested by MFA.

Effectiveness[6]

PharmAccess performs a wide range of activities across all five objectives and its efforts have resulted in a number of well-known effective successes, in particular SafeCare, Medical Credit Fund (MCF) and spin-off CarePay. The evidence of positive impact is often scattered or not available in a structured format. There is certainly a level of effectiveness achieved – substantial anecdotal and case-based evidence of strategy success exists, and stakeholders back this up. But we have not seen enough structured quantitative data to completely substantiate benefits. We believe there is an opportunity to improve efficacy reporting and communication – both internally and externally.

PharmAccess and its local partners operate consistent with its ToC, aspiring towards all of the five objectives in its target countries. Despite a clear focus on private-sector development, we observe that the very low income groups are mainly reached through quality interventions (9 mln very low income beneficiaries, 27% of total beneficiaries) and investment interventions (20 mln beneficiaries, 21%).[7]

In recent years, PharmAccess has been able to scale up several initiatives or allow them to be replicated by other partners. The core initiatives – MCF, SafeCare and spin-off CarePay – have been especially successful in this. Other initiatives have also steadily matured. By applying the six recommendations, we believe PharmAccess should be able to further increase and scale its impact in its target regions and – indirectly – in other regions, to make inclusive health markets work that aim to increase access to affordable and quality healthcare for low- and middle-income populations in Sub-Saharan Africa (SSA).

[6] See OECD (2019) definition of Effectiveness: "The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups."
[7] See definitions provided in Exhibit 11.

Introduction

Purpose of evaluation

The Sustainable Economic Development Department (SEDD) of the Netherlands Ministry of Foreign Affairs (MFA) initiated the independent evaluation of the Health Insurance Fund (HIF) on the grant 'Making inclusive health markets work'. HIF is the foundation via which MFA financially supports the activities of PharmAccess to develop inclusive health markets that aim to increase access to affordable and quality healthcare for low- and middle-income populations in Sub-Saharan Africa (SSA). The grant of EUR 76 million is provided for the period 2016 to 2022 and will expire in December 2022. For the sake of brevity, we will refer to PharmAccess in the remainder of this report, as PharmAccess is responsible for the implementation of all activities.

PharmAccess

PharmAccess was founded by Joep Lange (1954-2014) in 2001 with the mission of making HIV/AIDS treatments widely available in SSA. He famously posed the question why multinationals such as Coca-Cola were able to deliver cold drinks to every corner of SSA, while public organizations seemed unable to do the same with life-saving drugs. As he was adamant not to wait any longer for change to come from public institutions, he went straight to private Dutch multinational companies (e.g., Heineken) instead. Together, PharmAccess and these private companies established workplace programs in SSA to improve access to healthcare for local employees.

After showing what was possible in this way, PharmAccess set up working groups with these companies and MFA to discuss how to build on the outcomes of these workplace programs. This collaboration eventually resulted in the establishment of HIF, and MFA became a long-term funding partner. The first funding period was positively evaluated by the Boston Consulting Group in 2015 and the funding was extended for the period 2016-2022.

PharmAccess currently employs 197 FTE, of which 134 FTE (68%) work in country offices: Kenya and Tanzania in East Africa, and Ghana and Nigeria in West Africa.

PharmAccess has seven beliefs about the market and the required approach that it considers key to understanding the holistic range of initiatives PharmAccess has undertaken and envisions to further implement. The evaluation of these seven beliefs is beyond the scope of this report.

PharmAccess' market beliefs

1. Healthcare is an important driver of economic growth. A healthy population can build a life, community and society. For a working economy, a healthy productive workforce is essential.

2. Healthcare systems in PharmAccess' focus countries cannot meet growing healthcare demand and there is no self-evident standard solution. Growth in population, non-communicable diseases and continuing presence of communicable diseases stretch health markets that are already limited in access and quality. Resources are insufficient and scattered. Local governments are unable to address these issues due structural underinvestment.

3. Healthcare market development is hampered by a vicious circle (see exhibit 1). High out-of-pocket spending which causes catastrophic health events for the population, instability and payment insecurity for the providers which leads to limited capacity. These structural barriers limit providers from structurally investing to improve their quality of care.

PharmAccess' approach beliefs

4. Healthcare should be improved by mutually reinforcing measures. PharmAccess aims to turn this vicious circle into a virtuous one (exhibit 2) by encouraging (private) insurance which smoothens cash flows for both population and providers and encourages capacity investments.

5. Healthcare system improvement should include the private sector. PharmAccess explicitly includes private providers and organizations in its approach, because "when state capabilities are limited, private sector becomes a key player". Roughly, about 50% of the local healthcare providers in its focus countries is private (including faith-based). Its incorporation of the private sector at times attracted questions within the development aid sector, due to, e.g., the for-profit basis of private providers and the fact that these therefore might already be self-supporting. Evaluation of the effectiveness of private sector versus a more publicly financed approach is beyond the scope of this report.
6. The digital and mobile revolution accelerates healthcare system innovation. PharmAccess has been at the forefront of this evolution. A primary example is the M-TIBA/CarePay innovation; mobile phone technology as an enabler of system change by connecting beneficiaries, providers and payors on one platform. Its digital focus is driven by the recent climb in phone uptake and mobile money, e.g., in 2019 the number of mobile money accounts amounted to 469 mln in SSA (GSMA, 2020), which points to potential for game-changing initiatives.
7. Impact can be achieved both directly and indirectly. Implementation of healthcare systems improvements could either take the form of PharmAccess deploying interventions itself, or in conjunction with other parties that are helping improve systems. By providing licensing and white label solutions and/or inspiring others through advocacy, PharmAccess believes it can create a much larger impact than from its own local activities alone. Local governments are especially important enablers of larger impact and larger-scale interventions.

Exhibit 1

The vicious cycle

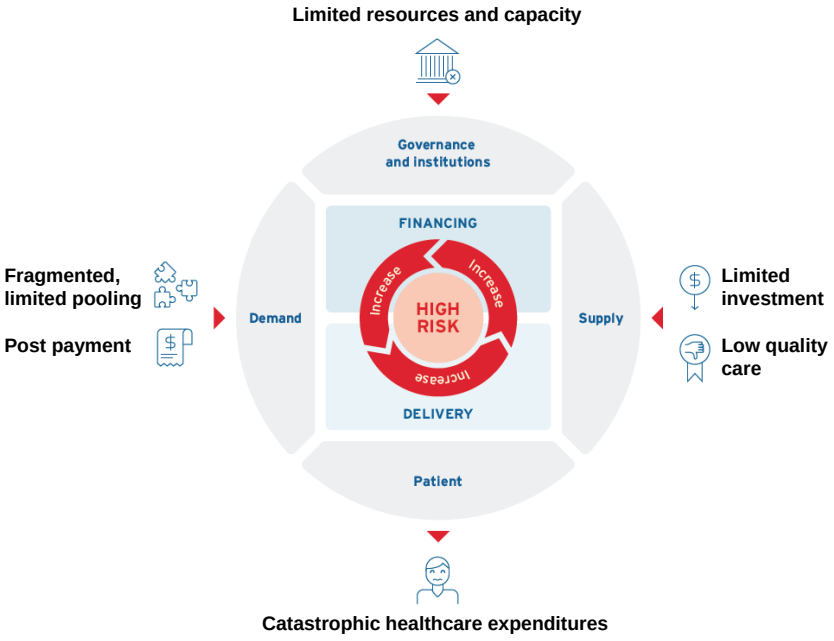
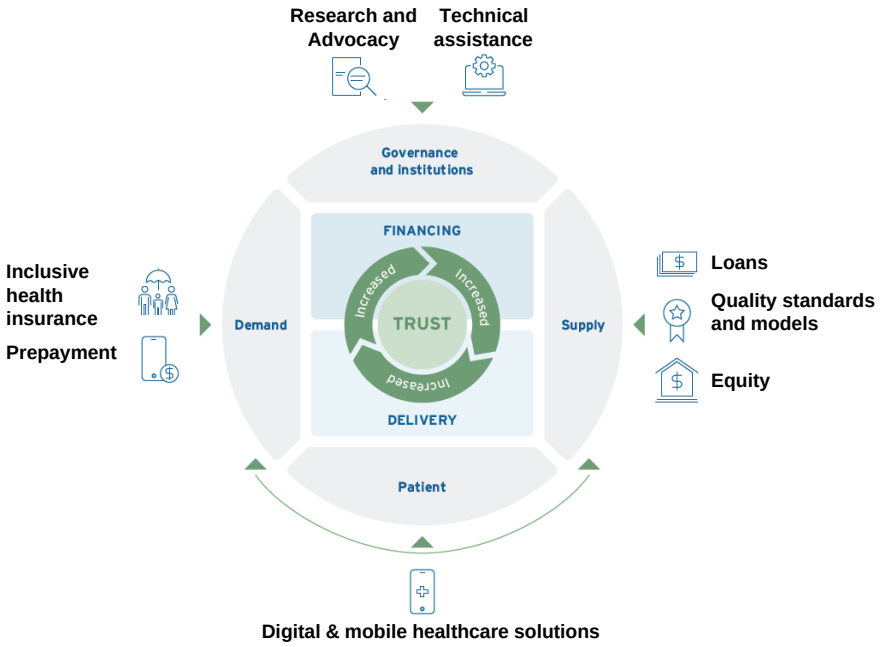


Exhibit 2

The virtuous cycle



Theory of change

From the seven core beliefs, PharmAccess has defined its Theory of Change (ToC, see Exhibit 3), which describes how it aims to make inclusive health markets work. PharmAccess formulated five core objectives for the current funding period:

1. **Demand:** Develop private pre-payment mechanisms and risk pooling structures, and mobilize resources;
2. **Supply:** Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers;
3. **Matching:** Improve efficiency, effectiveness, and transparency to better match demand and supply of healthcare transactions;
4. **Investing:** Mobilize capital into the private health sector;
5. **Research & Advocacy:** Conduct research on the various implemented strategic interventions and advocate those that are successful.

Across these five objectives, PharmAccess works on a wide variety of interventions; see appendix for a complete overview with descriptions. These are developed according to its own four phases approach: (1) Proof of Idea, (2) Proof of Concept, (3) Self-standing model and (4) Replicate/Scale (via other parties).

PharmAccess' original ToC or program documentation for this grant does not included quantified targets for these five objectives, which significantly limits the extent to which the effectiveness and efficiency of its achievements can be evaluated.

Theory of Change

PHARMACCESSGROUP

The challenge

The vicious cycle of high risk and low trust: low and fragmented demand, poor quality health care supply, poor health outcomes, catastrophic health expenses and low investments.

- High disease burden and evolving health needs (e.g NCD's, epidemics; health effects of environmental & climatological changes)
- Poor health outcomes; ~1.1 million people in SSA lose their lives due to poor quality health care each year in LMICs
- Very low total per capita health spending
- Private sector delivers around 50% of healthcare, but is often neglected
- Quality challenges and uncertainty related to health service delivery discourages people to pre-pay for health;
- Unorganized and unpredictable demand, low insurance penetration and low retention means healthcare services are largely post-paid;
- High risk perception and structural lack of investments
- An estimated 40 - 60% or more of sub-Saharan Africa's total healthcare expenses are out-of-pocket.
- Globally, over 800 million people in 2010 incurred catastrophic health spending due to out-of-pocket health expenditures

Demand

- Lack of institutionalized solidarity mechanisms, less than 10% of population is covered by some form of health insurance, limited riskpooling
- Healthcare financing sources are limited, highly fragmented and largely post-paid;, overall the system suffers from distrust
- Lack of transparency of use of resources for demand side financing programs
- Limited capacity to design and implement large scale demand side financing programs (including the private sector)

Supply

- Lack of standards
- Poor (self) regulation and enforcement of quality assurance
- Lack of transparency & data for informed decision making for all stakeholders
- Poor capacity, skills, assets and motivation to i mprove
- Poor business performance and lack of access to capital

Matching Supply & Demand

- Fragmentation of care delivery & financing
- Lack of unified (outcome) standards
- Lack of feedback on patient journeys to improve value of care and financing
- Limited disease management skills & poor health behavior and knowledge

Investments

- Even though 50% of healthcare is provided by the private sector, health entrepreneurs are not conversant with finance and administration leading to poor business performance.
- Private healthcare providers suffer from gaps between incurring costs and getting paid.
- Private healthcare providers have difficulties accessing loans due to lack of collateral, high perceived risk, poor financial administration and lack of appetite at commercial banks.

Research & advocacy

- Lack of effective policies and legislation on health financing, quality of care, digital technology and private sector development.
- Limited government commitment to financing health care.
- Limited evidence on best practices to improve efficiency (reduce costs and increase quality) of health systems in resource-poor settings, particularly with private sector efforts supplementing public sector responses
- Limited independent peer-reviewed scientific evaluation of the performance and impact of (inter) national organizations working in global health
- Limited scale and adoption of effective innovations

Opportunities

- Inclusion of the private sector to deliver quality and equitable essential health care (1)
- Transformational opportunities of digital innovations and mobile technology, and increasing digital readiness in target countries to increase efficiency and effectiveness throughout the system
- Alignment with the SDG's and the goal of Universal Health Coverage (2)

Inputs

Funding
Partnerships
Human resources
Innovative, blended financing
Digital (platform) innovations
Existing evidence base

PharmAccess approach

Phase 1 Proof of idea
Development and testing of an idea.

Phase 2 Proof of concept
Understanding and demonstrating "how things work"

Phase 3 Self-standing model
Developing stand-alone/ blended models to offer to markets

Phase 4 Replicate/ scale (via other parties)
Advocacy (research-based) & support for replication, scaling and institutionalization

Outputs

Demand

- Innovative (digital) models to attract and coordinate funding for health insurance for essential health care, including the private sector
- (digital) Models, products, services, approaches and concepts to improve (cost) effectiveness and efficiency of essential care demand side financing programs and fund management
- (digital) Models, products, approaches, capacity building and concepts to support partners (regulators, governments, insurers, third party administrators) with the design and implementation of demand side financing programs and insurance products for the mass/ informal market
- Digital population income segmentation tools and services
- New strategic (public-private) partnerships and funding mobilized for replication

Supply

- (digital) Certification model(s), products, approaches and concepts
- (digital) Accreditation model, products, approaches and concepts
- (digital) Quality improvement capacity building model(s), innovations, approaches and concepts
- Innovative digital essential care delivery & supply models, products, approaches and concepts
- Growing evidence base on impact & lessons learned
- Public (and) private partnerships, initiatives and funding mobilized/ catalyzed for replication of quality measurement and improvement methodologies and approaches

Matching Supply & Demand

- (digital) Bundled care models, products, approaches & concepts
- Growing evidence base on cost-effectiveness, impact and lessons learned
- New strategic public and private partnerships and funding mobilized for replication
- Performance/value based financing models

Investments

- New digital loan model(s) and products
- Model(s) for 'large' loans
- (Blended) Financial partnership model(s)
- Business support model(s), concepts & approaches to improve invest-ability
- Growing evidence base on investment risk, impact, cost-effectiveness and lessons learned
- (New) strategic (public-private) partnerships and funding for scaling

Research & advocacy

Evidence base supports and demonstrates effects and lessons learned of innovations/ interventions in (digital) health financing and essential care delivery models

Public-private partnerships for health financing and essential care delivery models

Strategic partnerships for resource mobilization, research and implementation

Policy and legislative changes support adoption, adaptation and scaling of (digital) health financing and essential care delivery models

Key stakeholders adopt, adapt and scale interventions

Contextual influences

- Political developments in focus countries
- Developments in international development support
- Developments in (international) financial markets
- Disruptive technological developments
- (global) health crises/epidemics, pandemics
- Climate change
- Other unforeseen factors

Influence › Outcomes Impact

Outcomes

Demand

- Increased population covered by insurance or other health financing products
- Improved coverage of essential health services through social health insurance or other health financing approaches
- Increased contribution into health financing/risk pools by different payers

Supply

- Increased transparency and use of quality data for decision making, enforcement and use of incentives
- Increased capacity to improve performance
- Improved efficiency and effectiveness of essential care delivery and supply models
- Increased adoption and implementation of quality models driven by governments, payers, providers and other partners

Matching Supply & Demand

- Increased financing models for bundled care
- Increased adoption and adherence to evidence based standards
- Increased transparency on costs and outcomes of bundled care
- Improved disease management skills and health behaviors
- Increased adoption of bundled care payment and delivery models driven by governments, payers, providers and other partners

Investments

- Reduced investment risk of healthcare market
- Increased access to and uptake of loan products at all levels of the value chain
- Increased investments in the health service delivery SME sector by different types of financial partners
- Increased adoption of investment/ loan models driven by governments, financial institutions, telco's, payers, providers and other partners

Research & advocacy

Increased use of data, results and findings on interventions in (digital) health financing and essential care delivery models

Increased recognition of the private sector's role and the role of digital innovation in the creation of effective health markets

Increased scale of adoption, adaptation and scaling of interventions in (digital) health financing and essential care delivery models

Increased domestic financing and resources allocated to health care

Indirect outcomes

Jobs created; jobs supported
Local research capacity strengthened
Capacity strengthened of local NGOs, non health SME's
Public-private partnerships for health
New financial products developed
Female entrepreneurs supported
Private sector development strengthened
...

Indirect Impact on SDG's

SDG 8
- Sustainable economic growth
- Innovate for economic productivity
- Promote policies to support job creation and growing enterprises
- Protect labor rights

SDG 9
- Facilitate sustainable infrastructure development

SDG 10
- Promote universal social, economic and political inclusion
- Adopt social policies that promote equality

Final outcomes

- Improved performance (clinical, business, medical) of health care providers
- Improved epidemic preparedness
- Increased availability of essential health care services
- Increased financial inclusion and reduced OOP for essential health care services
- Improved health seeking behavior
- Increased healthcare expenditure
- Increased investments in health care infrastructure and services
- Increased transparency and access to essential health care (market) data
- Increased knowledge on and evidence of essential health care market interventions
- Increased domestic government financing for health care, including for social health insurance funds

Impact

PharmAccess's founding concept is to devise and implement a strategy to reverse the vicious cycle in health. We want healthcare markets in sub-Saharan Africa to attract more resources and function more efficiently and effectively, leading to an upward spiral of trust among stakeholders including patients, doctors, insurers, investors, and governments. We believe involving the private sector and leveraging digital and mobile technology is key to stimulating efficient, effective and transparent healthcare markets.

- Sustainable delivery of continuously improving essential health care
- Protection from catastrophic health expenditure
- Improved essential health outcomes
- Structural increase in investments in the health sector

Direct Impact on SDGs

SDG 1
- Implement social protection systems
- Equal rights to basic services
- Mobilization of resources to end poverty

SDG 3
- Reduce the global maternal mortality ratio
- End preventable deaths under five years of age
- Fight communicable diseases
- Reduce mortality from NCD's
- Access to sexual and reproductive care, family planning and education
- Achieve Universal Health Coverage
- Increase health financing & support health workforce in developing countries

SDG 5
- Universal access to reproductive health
- Equal rights to financial services
- Promote empowerment of women through technology

SDG 8
- (Universal) access to banking, insurance and financial services
- Promote safe working environments

SDG 9
- Increase access to financial services
- Enhance research

SDG 17
- Mobilize additional financial resources for developing countries from multiple sources
- Respect national leadership for the SDG's
- Enhance the global partnership for sustainable development
- Encourage effective partnerships

1. WHO uses 16 essential health services in 4 categories as indicators of the level and equity of coverage in countries: (a) Reproductive, maternal, newborn and child health; (b) Infectious diseases; (c) Noncommunicable diseases; and (d) Service capacity and access. **2.** UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

Outline of report

Chapter 1 provides an overview of the methodology used for this evaluation – Interviews, quantitative and qualitative analyses – and how this methodology was applied to assess three out of the six criteria in the OECD DAC evaluation framework (relevance, coherence and effectiveness) across PharmAccess' five objectives as stated in its ToC. Criteria were selected and questions were defined by MF.

The following three chapters all cover one of the evaluation criteria: 2. Relevance, 3. Coherence and 4. Effectiveness. For clarity and traceability purposes each research question has been assigned its own subchapter within each of the chapters.

In chapter 5, observations are shared that could not be categorized under relevance, coherence and effectiveness. This content primarily focuses on the other three evaluation criteria of the OECD DAC evaluation framework: impact, sustainability, and efficiency. The report finishes with an overall conclusion (chapter 6) and six core recommendations (chapter 7) for PharmAccess to improve its activities in the period ahead.

Kenya, 2018, i-PUSH – beneficiary, mother with child in an informal settlement

1. Methodology & approach

Evaluation framework

PharmAccess' ToC with its five core objectives is the starting point of the analysis that will be conducted by taking a three-lens approach: relevance, coherence and effectiveness. This approach will be used to answer the research question of this evaluation: To what extent has HIF progressed in making inclusive health markets work? The selection of these three lenses, which is a subset of the full list of lenses of the OECD DAC evaluation framework, has been prescribed by the request of MFA in its Terms of Reference (ToR). All eight sub research questions from the ToR can be categorized under one of the three lenses.

During the evaluation we concluded that the initial set of lenses (relevance, coherence, effectiveness) was too narrow for a comprehensive evaluation of PharmAccess. Hence, we also looked to some extent at the other three OECD lenses of efficiency, impact and sustainability. Our full evaluation framework used is depicted in Exhibit 4.

For efficiency (delivery in economic way), impact (delivery of higher-level effects) and sustainability (delivery of effect will continue) no strict scoring criteria are applied. These assessments will be of a qualitative nature.

Research approach

The goal of the evaluation team is to conduct an independent and non-biased evaluation. Therefore, we have designed our research approach acknowledging also certain challenges related with PharmAccess unique approach, i.e. the innovative nature of its initiatives and the very dynamic environment with weak institutions in which PharmAccess operates:

— We have looked for comparable initiatives, however, benchmarks to assess the relative performance in comparison to peers were not found, largely due to the unique character of PharmAccess' activities in SSA healthcare.

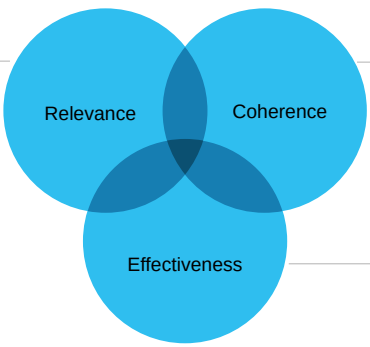
Exhibit 4

PharmAccess' 5 objectives are being evaluated based on a 3 lens approach

Research question: To what extent has HIF progressed towards making inclusive health markets work?

The extent to which the intervention objectives and design respond to:
- Netherlands policy on private sector development
- Netherlands policy on health market development
- Needs of beneficiaries
- Needs of health care providers
- Needs of government in recipient countries
- Needs of private sector in recipient countries

And how this has been adapted to Covid-19



The compatibility of the intervention with other interventions of and uniqueness compared to:
- Dutch initiatives on private sector development
- Dutch initiatives on private sector development
- Government initiatives in recipient countries
- Initiatives of global institutions, such as Multilateral Development Banks (MDB's), Development Finance Institutions (DFI's) and Global Health Initiatives like World Health Organization (WHO), Global Financing Facility (GFF)

The extent to which the intervention achieved, or is expected to achieve the five objectives with respect to:
- Reaching low-income groups
- Using innovative financing mechanisms
- Using technological innovations
- Using public private partnerships
- Achieving scaling or replication of initiatives

And how this has been adapted to Covid-19

Based on our initial findings, we will add the OECD framework lenses of

• Efficiency • Impact • Sustainability

— A comparison with preset targets was not possible. Quantified targets related to the HIF funding were not part of the 2016 ToC. PharmAccess and MFA have decided that these quantified targets would limit the innovation power of PharmAccess.

— Independent data to assess the impact is limited or non-existent. As a consequence, the evaluation team had to rely on data being collected by PharmAccess, related (research or implementation) partners or supported healthcare providers. These data sources are not independent by definition. Where possible, we did collect KPIs that the PharmAccess teams collects (for example the number of patients and providers involved in the initiatives)

— There are few completely unbiased stakeholders in this field, as all parties have interests in healthcare that are either aligned and not aligned with PharmAccess interests. Examples of these biases include: implementation partners and local governments rely on activities and funding provided by PharmAccess, other NGOs or MLOs might see initiatives of PharmAccess as a threat. More in general, healthcare innovation approaches are a sensitive topic in general and there is no consensus on the most effective way to organize healthcare in country.

In order to assess PharmAccess' impact and answer the research questions in the ToR while dealing with the challenges mentioned above, the evaluation team applies consistently the following 4 principles during the evaluation.

1. Multiple sources. An answer to each research questions is based on multiple sources, which is preferably a combination of (at least) two research techniques, e.g., interviews and quantitative analysis. In addition, within each research technique, we aim to have multiple views, e.g., interview responses form internal stakeholders as well as international organizations or other third party stakeholders. Within the interview category, this is consistently being applied by the 'hear and hear' principle.
2. Anonymity. Interviewed stakeholders have been assured full anonymity in order to create a safe environment for sharing their feedback.
3. Triangulation. Related to the first principle, all sources are being combined and weighed up by the evaluation team. If no conclusion can be drawn from the triangulation, the multiple perspectives are shared in the answer to the research question.
4. Expert judgement. The evaluation team is being supported by international experts in development aid, (public) healthcare and digital innovation. Answers to the research questions are being reviewed by these experts with the complex context in SSA in mind.

As a consequence of these principles and the emerging observation regarding the lack of independent data, the evaluation team had to increase the number of interviewed stakeholder from the initially agreed group of 30-35 to the final number of 65 during the evaluation period.

The results of this evaluation techniques are provided by scoring marks per question, visualized by a 5 point system (empty moon, ¼ moon, ½ moon, ¾ moon and full moon). The definitions per scoring mark are tailored for each of the evaluation criteria: relevance, coherence and effectiveness. Per question, an overarching scoring mark per question, as well as a scoring mark per question for each of PharmAccess' five objectives.

Research techniques

This methodology is considered to provide a balanced view per research question. Below, a description is given of the different methodologies. Exhibit 5 provides a full overview of the applied research technique per question and objective. For the interview part this is specified for the consulted types of stakeholders, e.g., internal stakeholder interview, patient interview.

Interviews

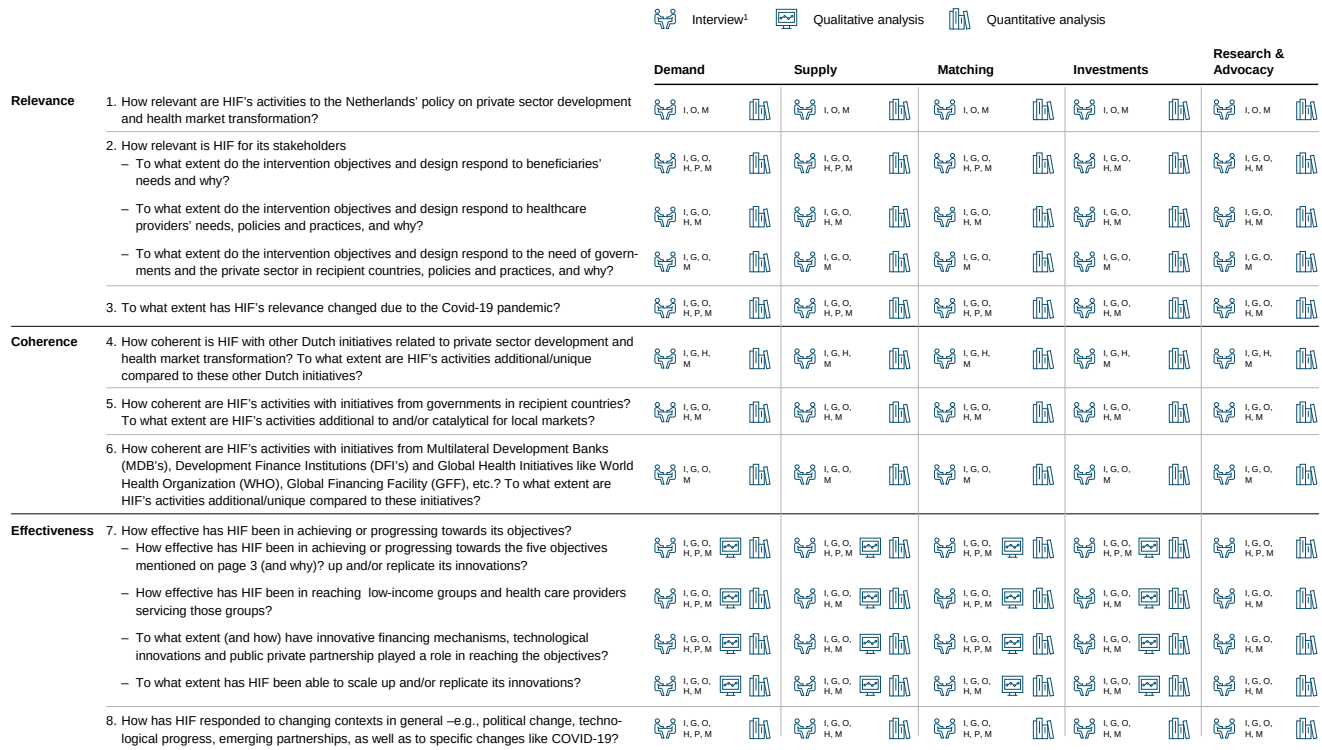
Structured interviews were held with stakeholder representatives, in particular PharmAccess management, donors, beneficiaries, supervisors, local governments, partners. They were held in remote virtual 60-minute sessions, using a structured interview guide. In a few instances, two interviewees were interviewed simultaneously due to expected synergies or agenda challenges.

In total, 65 stakeholders were interviewed with the complete interview list having been composed by combining three sources. First, PharmAccess provided a list with interviewees from its network, for which we encouraged it to include both advocates and critics of its

Exhibit 5: Research methodologies

ToR research questions are being addressed by differentiated research methodologies

Evaluation approach mapping



		Demand	Supply	Matching	Investments	Research & Advocacy
Relevance	1. How relevant are HIF's activities to the Netherlands' policy on private sector development and health market transformation?	I, O, M	I, O, M	I, O, M	I, O, M	I, O, M
	2. How relevant is HIF for its stakeholders – To what extent do the intervention objectives and design respond to beneficiaries' needs and why?	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, M
	– To what extent do the intervention objectives and design respond to healthcare providers' needs, policies and practices, and why?	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M
	– To what extent do the intervention objectives and design respond to the need of governments and the private sector in recipient countries, policies and practices, and why?	I, G, O, M	I, G, O, M	I, G, O, M	I, G, O, M	I, G, O, M
	3. To what extent has HIF's relevance changed due to the Covid-19 pandemic?	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, M
Coherence	4. How coherent is HIF with other Dutch initiatives related to private sector development and health market transformation? To what extent are HIF's activities additional/unique compared to these other Dutch initiatives?	I, G, H, M	I, G, H, M	I, G, H, M	I, G, H, M	I, G, H, M
	5. How coherent are HIF's activities with initiatives from governments in recipient countries? To what extent are HIF's activities additional to and/or catalytical for local markets?	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M
	6. How coherent are HIF's activities with initiatives from Multilateral Development Banks (MDB's), Development Finance Institutions (DFI's) and Global Health Initiatives like World Health Organization (WHO), Global Financing Facility (GFF), etc.? To what extent are HIF's activities additional/unique compared to these initiatives?	I, G, O, M	I, G, O, M	I, G, O, M	I, G, O, M	I, G, O, M
Effectiveness	7. How effective has HIF been in achieving or progressing towards its objectives? – How effective has HIF been in achieving or progressing towards the five objectives mentioned on page 3 (and why)? up and/or replicate its innovations?	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, P, M	I, G, O, H, P, M
	– How effective has HIF been in reaching low-income groups and health care providers servicing those groups?	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, M
	– To what extent (and how) have innovative financing mechanisms, technological innovations and public private partnership played a role in reaching the objectives?	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, M
	– To what extent has HIF been able to scale up and/or replicate its innovations?	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M	I, G, O, H, M
	8. How has HIF responded to changing contexts in general –e.g., political change, technological progress, emerging partnerships, as well as to specific changes like COVID-19?	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, P, M	I, G, O, H, M	I, G, O, H, M

1. Different types of stakeholders: I = Internal, G = Local and national government, O = International organization, H = Healthcare provider, P = Patient, M = Implementation partner

approach. Second, the evaluation team added names to the list based on own experience, expert input and suggestions from MFA. Third, input from the Reference group as well as suggestions from the interviewees were added.

This resulted in interviews with (Exhibit 28):

— 12 Supervisory Board and Management Team members
— 4 Country directors
— 25 National and international Partners
— 6 Local partners in recipient countries
— 9 National partners in recipient countries
— 5 Clinic stakeholders during on-site visits (management and patients)
— 4 McKinsey experts

In order to provide color to observations and conclusions, we put quotes from the interviews in this report. As some interviewees indicated to prefer anonymous quoting, we will use the following typology to indicate the source of the quotes: internal stakeholders, local and national government stakeholders, international organizations, healthcare providers, patients, implementation partners. The evaluation team has an overview of the source of each quote.

Qualitative analysis

In addition to the interviews, we performed qualitative analyses of the materials available on PharmAccess' activities, such as internal documentation and research reports, as well as independent evaluations and case studies of its activities. Information from these sources was synthesized and combined with insights from the interviews and quantitative analyses to obtain a full picture.

Ideally, on-site visits would have constituted a more central part of the evaluation. However, Covid-19 related travel restrictions meant the project team was not able to travel. As an alternative, insights gathered during the on-site visit of one of the provider locations (Mwangaza Medical Center) conducted by an Africa-based expert as well as the virtual clinic visit (Olive Link Clinic) were used to support our analysis.

Quantitative analysis

The third leg of the analyses pertains to the quantitative section with the aim of creating insights into reach, accessibility, and impact. These analyses will be linked to the outputs and outcomes as defined in PharmAccess' ToC. When possible, we aimed to link this to resulting health outcomes, but here we were subject to the available data and information from PharmAccess, governments or other parties that have performed analyses on intervention effectiveness. The evidence of impact is often scattered or not available in structured format. It is a challenge to investigate beyond the anecdotal positive feedback that is available.

For the Effectiveness section, we analyzed KPIs to assess reach and accessibility of PharmAccess' core initiatives per strategic objective e.g., number of patients, number of enrollees and healthcare facilities reached. Furthermore, a few initiatives are highlighted for which impact KPIs on economic, social or health impact were measured in e.g., percentual decrease in out-of-pocket expenditures (for health insurance scheme) or percentual increase in skilled child deliveries (due to a value-based pregnancy bundle).

For the Scaling and replication section, we used multiple complementary analyses. First, a simple analysis of the growth in reach of health insurance schemes, SafeCare facilities and MCF facilities over the period 2016-2021 was conducted as a proxy for scaling. Furthermore, for each strategic objective, a progress chart was made of all PharmAccess activities over the course of 2016-2021 (expressed in its ToC approach as phase 1 to phase 4). In practice, this showcases the maturity and growth of initiatives in 2016 compared to 2021 while also depicting which new initiatives were established. Lastly, it also provides a succinct overview of all activities undertaken by PharmAccess. The last analysis is related but is of semi-qualitative nature.

As PharmAccess, in addition to its direct impact, also has the goal of realizing a paradigm shift, this analysis looks at three scopes of impact: (1) direct impact – described in Effectiveness section, (2) white label impact where PharmAccess works together with other parties and co-develops initiatives tailored for that party (i.e. adapted SafeCare for local government to use under its name) and (3) inspired impact where other institutions have followed in PharmAccess' footsteps but for which evidence is hard to gather (i.e. the implementation of quality standards very similar to SafeCare in a country but without direct consultation of PharmAccess).

For the Social impact section, we quantify and look at the number of beneficiaries PharmAccess has reached with its core interventions that are from low-income groups, are female and/or children.

For the Efficiency section, we plotted the growth in reach of health insurance schemes, SafeCare facilities and MCF facilities against the allocated budget to each of these activities over the period 2016-2021 with the aim of finding patterns in cost effectiveness.

The data needed to perform the analyses were provided by PharmAccess and further enriched with independent data sources, primarily provided by the research department of the evaluation team.

Scope of evaluation

The report evaluates the activities of PharmAccess during the period 2016 to June 2021. The geographical scope is limited to the activities of PharmAccess in Kenya, Tanzania, Ghana and Nigeria. By exception, interventions from MCF or SafeCare outside this geographical focus area are considered when deemed relevant for the purpose of evaluation.

The scope of this report excludes an evaluation of the organizational model or due diligence on the (local) partners.

Duration of evaluation

The evaluation team has conducted its independent evaluation in the period between June 28 and July 30, 2021. In this period, all interviews, data collection, data analyses, qualitative analyses, expert consultation, virtual and on-site clinics visits, and validation took place. After this period, final editing and visual enhancement were conducted.

Independence of evaluation team

The members of the evaluation team are completely independent from PharmAccess, have not conducted work on design or implementation of PharmAccess' interventions and have not been affiliated with an organization related to the design or implementation of PharmAccess' interventions.

MFA has engaged us for the evaluation following a public procurement process. None of the members of the evaluation team have worked for MFA or PharmAccess in the past.

During the first few interviews with local stakeholders, PharmAccess' country managers stayed in the call after the introduction at the request of PharmAccess. We believe that this restricted some interviewees in their freedom to express feedback, which is why subsequently we have asked PharmAccess to limit its presence to the introduction and leave the call afterwards.

Limitations and bias of evaluation

The analyses presented here obviously have various limits. As a consequence of the Covid-19 related travel restrictions, the evaluation team could not conduct on-site visits in locations where PharmAccess deploys its interventions. Physical visits to the target countries could have potentially led to a better understanding of the local organization and the local context in which PharmAccess operates. By requesting an Africa-based expert to conduct an on-site visit, conducting a digital clinic visit and consulting our development aid colleagues, we believe we have mitigated some of this impediment.

In addition, we acknowledge potential biases in the evaluation, caused by the following four circumstances:

1. Most data on performance and impact have been made available by PharmAccess. This might lead to a potential selection bias, which might result in a more positive evaluation. We have mitigated this by looking for independent sources, but those are less detailed.
2. Most local interviewees were selected by PharmAccess, based on our request. This might have led to an interviewee selection bias, which might result in a more positive evaluation. We have mitigated this by interviewing experts outside of PharmAccess' network.
3. As listed above, in some one-on-one interviews we thought there might be a courtesy bias of some of the interviewees, due to their dependence on and long-term relationship with PharmAccess. Especially questions regarding improvement areas were not responded to by some stakeholders. We have mitigated this by increasing the number of interviews so that we can balance our perspective.
4. During our on-site visit in Mwangaza we had to rely on interpretation support of PharmAccess, as our consultant was not able to interview a patient in the local language. This might lead to a positive bias, due to possible selective translation.

There are no comparable initiatives to PharmAccess anywhere in the world as far as we know. This means that it is hard to benchmark or compare PharmAccess' approach and establish relative efficiency or effectiveness. We have to look at the absolute contribution of PharmAccess, and look at its contribution in the ecosystem.

Overall, this evaluation was time-bound and budget-bound. This limits the scope for primary data collection. We mitigated this by interviewing widely, and looking for a variety of data sources.

We are fully aware of these potential biases and have build all our conclusions and recommendations on multiple sources, to ensure complete triangulation.

Validation

Conclusions and outcomes in this report have been validated in several ways to check on quality and correctness. To this end, we have shared a draft version of this report with PharmAccess and discussed the first version in an in-person meeting. Factual feedback has been considered and, where the evaluation team considered this warranted, incorporated. Any guidance or suggestions on framing have been ignored, as this would harm the independence of the report.

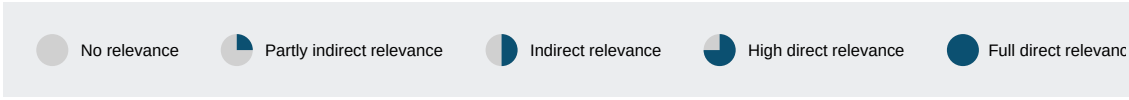
Next to validation of PharmAccess, the evaluation team has tested emerging outcomes and conclusions during the evaluation period with interviewees to get their perspective. In addition, outcomes, conclusions and the draft report have been shared with external experts linked to the evaluation team for quality and factual checks.

During the evaluation period, we have engaged with the Reference group to discuss our approach and first findings on July 19, 2021. Recommendations and suggestions of the Reference group have been incorporated in the final version of this report.

Nigeria, 2020, nurse during the Covid-19 pandemic

2. Relevance

This chapter addresses ToR research questions 1 to 3 on relevance. For relevance we focus on to what extent the intervention responds to the needs of beneficiaries, healthcare providers and governments.



Q1a. How relevant are PharmAccess' activities to the Netherlands' policy on private sector development?

High direct relevance

The Netherlands' policy on private sector development formulates three long-term global goals[8]:

1. The financial sector offers a larger range and volume of inclusive financial MSME[9] products in an increasingly diverse and conducive financial ecosystem.
2. MSMEs utilise these inclusive financial products to grow and provide jobs and other opportunities to marginalised groups
3. This contributes to ongoing reduction in poverty and inequality.

Based on our assessment of the set-up of PharmAccess' major activities, two types of PharmAccess' activities are directly relevant for the goals in the Netherlands' policy:

PharmAccess' investment-related activities are directly relevant for goal 1: the MCF provides a range of innovative financial products to SMEs such as the mobile cash advance loans. The demand-related activities are also directly relevant for goal 1: these contribute to a supportive financial ecosystem for providers.

Most other PharmAccess' activities are indirectly relevant to the Netherlands' policy on private sector development: these aim to strengthen the private (healthcare) sector, but do not directly provide financial products. This indirect contribution is made by providing technical assistance, creating public-private partnerships and by providing quality frameworks and strength-based assessments (SafeCare).[10]

[8] Source: "Narrative DDE Financieel Cluster / ToC narrative", Portfolio 3, 07 May 2021
[9] Micro, Small and Medium Enterprises
[10] This view has been shared in interviews by local government officials and local implementation partners and is confirmed in interviews with stakeholders from international organizations.

The relevance for the Netherlands' policy on private sector development is also reflected in PharmAccess' ToC, which encompasses many aspects of economic development. Herein, the ToC formulates both final outcomes (e.g., "Increased investments in health care infrastructure and services") as well as indirect outcomes (e.g., "Jobs created; jobs supported").

In addition to the policy on private sector development, PharmAccess makes a direct contribution to the Dutch "Digital Agenda for Foreign Trade and Development" (2019). Although not an explicit criterion within this evaluation, government stakeholders indicated that initiatives such as M-TIBA and mobile cash advance loans contribute to positioning the Netherlands as a digital frontrunner.

"PharmAccess' activities are very relevant for our goal of private sector development. It shows that aspects that are normally done by the public sector, can also be done by private parties, especially when done in collaboration: the famous Dutch PPP model. It does that fantastically with for instance M-TIBA in its collaboration with Safaricom."
Government stakeholder

Demand

Based on PharmAccess' activities within their demand-related objective, we see a relevance for private sector development in multiple ways:

— Public-private partnerships for insurance schemes, such as the iCHF covering private facilities (sometimes representing a majority of the providers in a region)

— Improvement of the certainty and timeliness of revenue streams for private healthcare providers, enhancing financial security to private providers to develop a sustainable business (e.g., through M-TIBA)

— Unique collaborations with the private sector, such as the collaboration with Safaricom for M-TIBA

This impact fits within the ToC of DDE, as also illustrated by the strategy for long-term goal 2: "To have impact on underserved groups, the financial products offered should meet their actual demand, or create such demand, and should be easy to take up by their target groups. This requires financial innovation and close engagement with and knowledge of these underserved groups."

Supply

Supply-related initiatives mostly focus on quality of healthcare providers, especially for the private sector. We assess this as an indirect effect on DDE's long-term goals, as improved quality can lead to enhanced business performance.

SafeCare also contributes to DDE's agenda by its connection to MCF loans. This combination creates quality-improvement driven loans while reducing risk for investors. Thereby, this is a contribution to a "conducive" financial ecosystem as formulated in long-term goal 1.

In addition, when not directly tied to an MCF loan, SafeCare can contribute to the development of the health sector: the SafeCare scores provide a proxy of the functioning and compliance of a provider and can thereby stimulate investments and insurance contracting.

Matching

All matching initiatives strive to use mobile connections, transaction platforms and data to help allocate healthcare resources more effectively by improving health outcomes, lowering transaction costs, and increasing transparency for high-burden patient groups e.g., chronic illness, communicable diseases. Hence, PharmAccess' activities such as connected diagnostics, NCD model and MomCare contribute to flourishing private sector development. The core of CarePay was initially established within PharmAccess and then spun off into the private sector as a separate organization.[11]

Investments

The MCF provides a range of financial products for SME health facilities, ranging from USD 10K cash advance loans for small equipment purchases, to USD 1 mln syndicate loans for large projects. Based on this range of financial products, we see a full direct relevance for DDE's long-term goal 1: to offer "a larger range and volume of inclusive financial MSME products".

Research & Advocacy

A significant part of the advocacy and outreach is related to PharmAccess' "public-private" approach to healthcare system improvement. PharmAccess showcases their impact from their work with the private sector. Stakeholders explained in our interviews that this can have an inspiring function for both other organizations and governments. In this way, these advocacy activities indirectly contribute to the three long-term goals of private sector development.

[11] See CDC Investment Works. (2020). What is the impact of improved access to finance for healthcare facilities in Kenya?

Q1b. How relevant are PharmAccess' activities to the Netherlands' policy on health market transformation?

Indirect relevance

The Netherlands' policy on health market transformation since 2014[12] focuses on sexual and reproductive health and rights (SRHR). Four result areas are formulated[13]:

1. Better information and greater freedom of choice for young people about their sexuality
2. Improved access to and use of (reproductive) health commodities
3. Better sexual and reproductive health care, including safe abortions
4. More respect for the sexual and reproductive rights of groups who are currently denied these rights.

The activities of PharmAccess do not directly cover this SRHR agenda: none of the activities explicitly focus on either of the result areas with the exception of MomCare. PharmAccess' funding was not related to this part of the agenda of Netherlands' policy on development aid in the years 2016-2021 and this narrower health focus also falls beyond the scope of the previous funding contract and the evaluation of that funding period.

PharmAccess' activities still are of considerable indirect relevance to the agenda of the MFA Social Development Department (DSO). This agenda argues that a well-functioning health system is required for achieving results in sexual and reproductive health. Since most PharmAccess activities focus on improving the sustainability and quality of the local health systems, a positive indirect effect as pursued by the Netherlands' policy is expected. Additionally, the policy mentions that the service delivery can best be organized in a context-appropriate mix of private and public providers, which is a clear focus of many of PharmAccess' activities.

[12] Based on "Kamerstuk 32 605 Beleid ten aanzien van ontwikkelingssamenwerking", State Secretary of Foreign Affairs, May 7 2012
[13] Source: "Narrative DSO, Buitenlandse Handel en Ontwikkelingssamenwerking, Theories of Change Speerpunten en Prioritaire Thema's", summer 2015

Demand

Demand-related activities between 2016 and 2021 have no explicit link to SRHR. However, there is an indirect relevance, as these activities contribute to a better functioning and inclusive healthcare system which subsequentially improves access to SRHR.

Supply

SafeCare standards do measure SRHR related topics:[14]

- Checks on sufficient guidance of supplies for safe service delivery in cases where family planning services are provided
- Checks on appropriateness of guidance and resources for effective service delivery in cases where Provider-Initiated Testing and Counseling (PITC) or Voluntary Counseling and Testing (VCT) services are provided
- Guidance to staff for effective service provisions in cases where antiretroviral treatment (ART) services are provided

Other supply-related activities have no specific focus on SRHR. By contributing to improving healthcare quality, these activities still are of high indirect relevance to result area 3 of DSO, highlighted by the statement in the policy: "a well-functioning health system, that addresses all key aspects of the right to the highest attainable standard of health, is a necessary condition for achieving the other SRHR results." SafeCare contributes to a well-functioning health system, playing its role as quality standard and risk assessment.

Matching

MFA formulates lower maternal and child mortality as part of its mission. Based on its activities, MomCare is highly relevant to lowering maternal mortality (using innovative data-gathering and patient journey interventions) and thereby the DSO agenda. The other matching-related activities are of indirect relevance as these do not have an explicit focus on the SRHR agenda but do have an indirect impact.

Investments

Similar to supply-related activities, Investment-related activities have no explicit link to SRHR. The activities have a high indirect relevance, as these are designed to make healthcare more accessible and sustainable for the local population.

Research & Advocacy

At its inception, many of PharmAccess' publications focused on HIV/AIDS research, which is one of the focus areas of the Dutch SRHR agenda. In the timeframe 2016-2021 we still found cooperation by PharmAccess' researchers in several publications related to this disease[15], even though this is no explicit focus of PharmAccess' research and advocacy agenda.

[14] See PharmAccess Group. 2020. SafeCare Healthcare Standards Version 4.0.

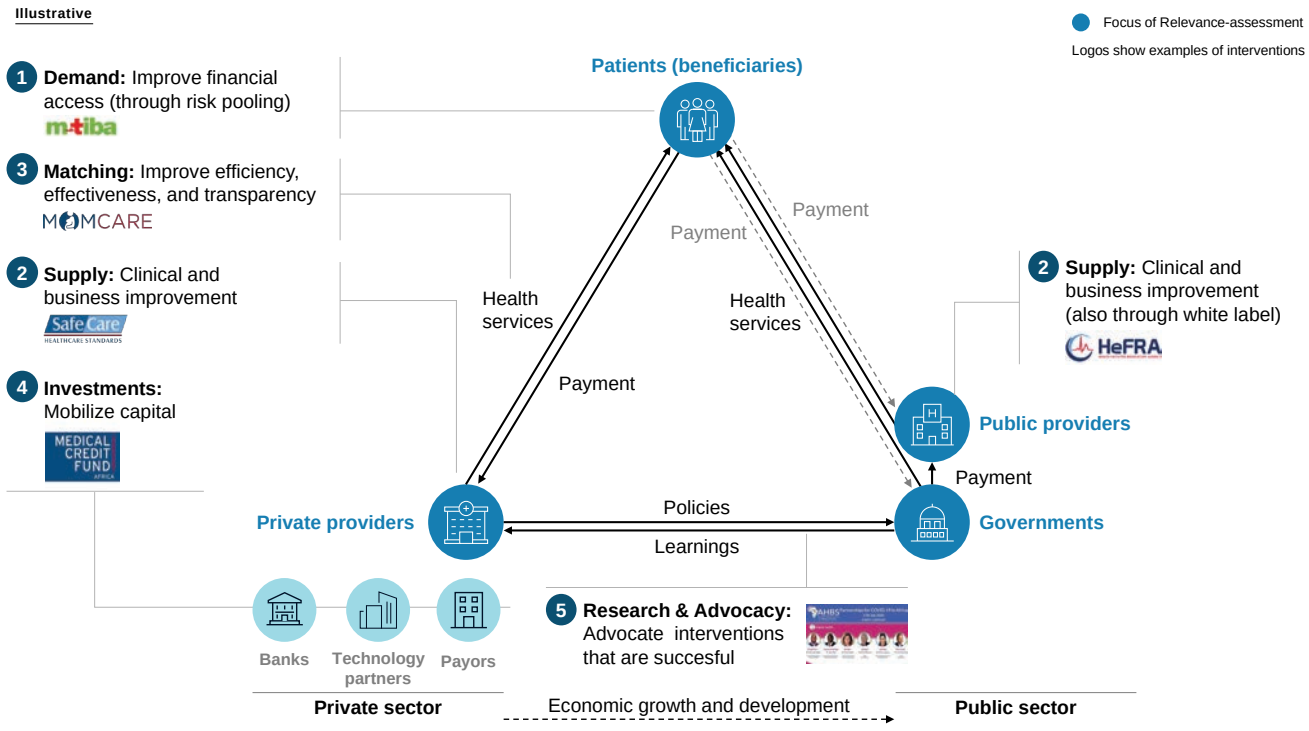
[15] See for example Boerma, Schellekens et al. (2019). Reaching 90-90-90: outcomes of a 15-year multi-country HIV workplace programme in sub-Saharan Africa; Inzaule, Hamers et al. (2019) . Curbing the rise of HIV drug resistance in low-income and middle-income countries: the role of dolutegravir-containing regimens; and Inzaule, Hamers et al. (2016). Stringent HIV Viral Load Threshold for Virological Failure Using Dried Blood Spots: Is the Perfect the Enemy of the Good?

Q2. How relevant is HIF for its stakeholders

In this section, we evaluate the relevance of PharmAccess' activities in relation to the needs of local beneficiaries (i.e. population), health providers and governments. Exhibit 6 provides a conceptual overview of how the stakeholders relate to each other, and how the activities relate to these stakeholders. As can be seen, each activity has some relevance for each of the stakeholders. In the following sections, this will be further evaluated per stakeholders and per objective.

Exhibit 6 - Conceptual stakeholder overview

High relevance for beneficiaries, provides and governments through healthcare systems-approach



Q2a. To what extent do the intervention objectives and design respond to beneficiaries' needs and why?

High direct relevance

Interviewed stakeholders are almost unanimous in indicating that PharmAccess has created ground-breaking interventions to improve local healthcare systems. They especially mention the M-TIBA mobile wallet, MCF loans, and implementation of SafeCare for thousands of small providers. These interventions have improved the lives of millions of beneficiaries in the countries in which PharmAccess is active[16]; through financial access to care, improving the local quality of care, providing saving loans, and many other interventions.

In terms of relevance for beneficiaries, we can distinguish two types of activities:

1. Activities related to the Demand and Matching. They are directly highly relevant for beneficiaries as these directly improve the access to healthcare
2. Activities related to Supply, Investment and Research & Advocacy. These are also highly relevant, but have a more indirect positive effect on beneficiaries. These activities primarily target other stakeholder groups, such as the providers and governments. Through these improvements however, the access to quality healthcare for beneficiaries is improved.

[16] See chapter on Effectiveness for quantitative figures.

Demand

Demand-related initiatives target beneficiaries' needs by reducing out-of-pocket spending, the risk of catastrophic health events, and increasing access to (modern) healthcare.[17] These effects together are aimed at improving trust in healthcare, contributing to timely usage of healthcare and relief of stress for local communities.

"Before M-TIBA was there, it was very stressful when I fell ill. I had to go begging for money from people, exposing myself. Now I feel safe because I have NIHF and do not have to borrow money from anyone. Also it does not matter when I fall ill, I can now easily walk into the hospital."
Patient

Supply

Supply-related activities focus on business and clinical performance improvement of healthcare providers. Business improvement has an indirect relevance for beneficiaries given they do not directly benefit from this. However, when clinical performance is improved this can more directly translate to health benefits for beneficiaries; poor quality of health care is a major driver of excess mortality in these regions.[18] Thus, while a part of the supply-related activities might be indirectly relevant, when executed well most quality related activities will be of high direct relevance to beneficiaries.

Matching

Based on the activities PharmAccess conducts under the matching-related objective, we see a direct relevance for the beneficiaries participating in the specific programs, e.g.: moms in MomCare or patients with specific NCDs for the NCD-related programs. These programs are relevant by aiming to improve the access, timeliness and efficacy of medical interventions.

Investments

Increased capital into the private health sector can indirectly meet beneficiaries' needs through better access, quality or decreased costs of care.[19]

Research & Advocacy

Beneficiaries are likely to benefit indirectly from research and advocacy, through e.g., policy changes or extra funding.

"In scaling the health insurance, if we had done enough advocacy, the role-out would have been a success for more regions and more people"
Internal stakeholder

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[17] This view has been shared in interviews with patients and local government stakeholders.
[18] See Kruk, Gage (2018). Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. The Lancet, 2203-2212.
[19] See CDC Investment Works. (2020). What is the impact of improved access to finance for healthcare facilities in Kenya?

Q2b. To what extent do the intervention objectives and design respond to healthcare providers' needs, policies and practices, and why?

Fully direct relevance

PharmAccess' activities are highly relevant for local healthcare providers' needs. Each activity strengthens to some extend local healthcare providers, whether that is through financing directly, through demand-related activities, through improving patient journeys in matching, or through quality improvement.

To complement its core activities, PharmAccess' flexible approach also aims to "fill in the gaps" where needed to strengthen local providers. Each interviewee commended PharmAccess for its listening capabilities and ability to provide help where required the most in terms of need, e.g., through specific training, counseling, or technical assistance.

Currently, the majority of benefiting healthcare providers are private providers. Through the scaling of demand-related programs and licensing SafeCare to governments, an increasing number of public providers benefit from PharmAccess' activities.

"PharmAccess is a partner that is prepared to complement government in providing affordable healthcare. It assumes independent positions with innovative means."
Implementation partner

Demand

Demand-related activities can benefit the needs of local providers in a myriad of direct and indirect ways:

First, the insurance-related activities often bring a shift from unpredictable budgets to activity-based reimbursement with more autonomy. These mechanisms ensure a more stable cashflow for providers, which can allow for the start of (investments in) quality improvement.

Second, the insurance programs can be linked to SafeCare, such as in iCHF. In this way, continuous quality improvement is enabled.

Third, the demand-related activities include a lot of data gathering that can help providers to understand their population and improve their range of services.

Fourth, demand-related activities aim to improve access to healthcare, thereby increase healthcare utilization and this improving stable revenue streams for healthcare providers, enabling growth.

Supply

Supply-related activities are of complete direct relevance to healthcare providers.

SafeCare provides an innovative tool that helps providers to improve their quality within their own accountability. During interviews, providers made clear that they were very content with the SafeCare tool and the technical assistance they receive with it. For many, there are currently no good alternatives. They also value how it is strength-based and that the 'quality improvement plans' are practical, so they can be carried out by the providers themselves, often with a local team.[20]

An important part of SafeCare is that it helps providers to professionalize their governance and administration. Evidence from a randomized control trial indeed showed that there is improved "structural and managerial quality of health facilities".[21]

In addition, the Women360 and Quality Platform initiatives primarily focus on improving providers' performance.

"SafeCare guides us step by step to improve. We are in this together. Quality is not a one-time improvement, we worked together from day 1."
Healthcare provider 1

"SafeCare is so great because it is an assessment instead of an inspection. It is not punitive but collaborative"
Healthcare provider 2

Matching

Matching-related activities predominantly focus on developing the most effective health interventions and payment models, based on data-driven and platform-based transparency. This type of innovation is used to improve care for, e.g., mother and child, malaria and tuberculosis. Dependent on the specific area, improvements are made directly together with the providers, or more indirectly by improving patient pathways,thereby preventing costly complications or improving the alignment of financial incentives. Also, the provider-related activities come with improvements across the board that should also spill out in other activities for the providers.

[20] See Syengo, Suchman. (2020). Private Providers' Experiences Implementing a Package of Interventions to Improve Quality of Care in Kenya: Findings From a Qualitative Evaluation.
[21] See King, Powell-Jackson et al. (2021). Effect of a multifaceted intervention to improve clinical quality of care through stepwise certification (SafeCare) in health-care facilities in Tanzania: a cluster-randomised controlled trial.

Investments

MCF is highly relevant for providers; it can be an important source of income that they would otherwise not have had, and it can be used to improve their quality or range of services. As MCF is often combined with technical assistance, SafeCare implementation and other initiatives, healthcare providers can be further met in their needs.

"We would not be where we are today were it not for the MCF. We would be glad to introduce anyone to PharmAccess, also aside from funding we have improved a lot."
Healthcare provider

Research & Advocacy

There is an indirect relevance of the research and advocacy activities for healthcare providers. PharmAccess is active in supporting local healthcare federations such as the Kenya Health Care Federation and the Association of Private Health Facilities in Tanzania. It also works as technical advisor to national bodies on health innovations. In this way, it supports providers in the broader context. Additionally, PharmAccess can help local governments and organizations to take effective measures, based on its own learnings. As an example, PharmAccess has been able to show that quality standards are viable in the SSA context; new similar (licensed) initiatives have now been started to benefit an even broader range of providers.[22]

"We have shown that it is possible to measure and improve quality of providers. Now others are copying or being inspired by us and implementing it at many more clinics."
Internal stakeholder

[22] See for example Johnson, Schellekens et al. (2016). SafeCare: An Innovative Approach for Improving Quality Through Standards, Benchmarking, and Improvement in Low- and Middle- Income Countries.

Q2c. To what extent do the intervention objectives and design respond to the need of governments and the private sector in recipient countries, policies and practices, and why?

High direct relevance

PharmAccess' activities are aimed at holistically strengthening the healthcare sector. This is highly relevant for local governments: the funding and quality of the local healthcare sector is improved and beneficiaries' needs are met. Public stakeholders indeed commend PharmAccess' for how its initiatives contribute to better healthcare, a growing economy and sharing learnings to (in) directly improve the local healthcare sector.

For the relevance of PharmAccess' intervention objectives and design regarding the private sector in recipient countries, this has been evaluated in section Q1a as it corresponds to the Dutch agenda on private sector development. This has been evaluated as high direct relevance.

Some of its stakeholders however express a hesitance around the activities of PharmAccess that focus specifically on the private sector. Some interviewed government officials consider a stronger private sector detrimental to the public healthcare sector, e.g., when the publicly educated physicians are drawn to the private sector. These expressed concerns could be explained by low relevance of these initiatives, by unsuccessful advocacy of PharmAccess to government stakeholders or the fact that the government is right. As stated earlier, an evaluation of the effectiveness of private sector initiatives is beyond the scope of this report.

The flexible approach of PharmAccess contributes to its relevance for local governments: many government stakeholders confirmed that PharmAccess excels in responding to specific needs or "gaps" in the healthcare system. This was most apparent when PharmAccess was able to help public stakeholders to respond to Covid-19 with swift action and advice, as is discussed in the chapter on Effectiveness.

"PharmAccess' approach revolves around testing initiatives in the private sector. Then you have data how to improve care, and how to create value for money. Once you have that, you can share it with government officials. That makes it much easier to channel and actually have an impact. The business-to-government approach should in that way be effective in the long term."
Implementation partner

Demand

Based on the interviews with local government stakeholders, the demand-related activities respond to needs by (regional) governments. The activities focus either on implementing insurance systems to make healthcare more financially accessible or improving these systems (e.g., mapping, identifying and registering indigent population through proxy means testing or digitizing administration through Claim-IT).

Relevance is indeed proven by the fact that these initiatives are done in cooperation with the regional governments and are set up so the local government can scale further. Additionally, PharmAccess often provides highly relevant technical assistance that is highly appreciated by (regional) governments. Due to focus on specific regions for some of the countries, the relevance for national government stakeholders is sometimes less self-evident.

"Establishing the healthcare fund was a real joint action. Part of it was a data-gathering process to establish a database for indigents. This was a lively experience that comfirms my story of the success in implementing together"
Government stakeholder

Supply

The supply-related activities around SafeCare are highly relevant for the government. By registering the quality of the private providers, the government gets an understanding of the quality of service. Increasing the quality of these providers is also of high indirect relevance, if one indeed believes that the public healthcare sector benefits from an improving private sector.

In recent years, SafeCare has also been implemented in more public facilities and 13 (local) governments have incorporated SafeCare standards for their public sector providers (sometimes under white label).[23] This emphasizes the growing relevance of these activities for governments.

"One of the benefits of SafeCare is that it creates an overview of providers and where interventions could be done"
Internal stakeholder

Matching

Many matching activities are conducted in cooperation with private facilities. However, PharmAccess aims to increase transparency and reduce the cost price of high-quality care by collecting and analyzing data from public and private facilities and building digital (transaction) platforms. In addition, it aims to contribute to the ongoing conversation on how to best achieve universal health coverage (UHC) by providing insights in the actual patient pathways especially for groups with above-average care needs. Thus there is direct relevance of matching projects for the local governments. With its focus on creating transparency for a.o. NCD, mother and childcare, tuberculosis and malaria, matching activities structurally contribute to finding innovative ways to radically change and decrease the contributors to the highest burden of disease for these governments.

[23] See Exhibit 26.

Investments

Most investment-related activities are part of the MCF. These are aimed at strengthening the private healthcare sector and financial sector. Thus, the initiatives are not of direct relevance to the governments. However, they do indirectly contribute to the healthcare system and welfare of the country.

To make the impact on the financial sector lasting, training of financial staff is an important part, but both internal and external stakeholders indicate that results are limited because of the high turnover of financial personnel.

"The MCF prevents the clinics taking illegal payments under the table from patients. This helps us to reduce out of pocket for our members. It also helped us to bridge the time to catch up with the claims payment."
Government stakeholder

Research & Advocacy

A large part of advocacy is aimed at sharing the learnings from PharmAccess' initiatives with local governments, thereby increasing the relevance of the other objectives as well. In this way, the activities are highly relevant. PharmAccess also has long-term relationships with many local and national stakeholders in the countries, supporting the health ecosystem as a whole.

PharmAccess has had mixed success with this advocacy; while there are many success stories such as the way in which PharmAccess was able to support governments in its actions around Covid-19, some stakeholders indicate a lack of 'gravitas', prohibiting to improve national policies where it is most relevant.

Government officials also indicate that additional advocacy activities could focus at the larger public, e.g., educational effort to create awareness for the benefits of health insurance. This could further improve its relevance.

Q3. To what extent has PharmAccess' relevance changed due to the Covid-19 pandemic?

Increased relevance

Covid-19 has been an unsolicited reminder of the vulnerability and vital importance of a working healthcare system. Covid-19 changed the world in 2020 and 2021, and will likely have an irreversible ripple effect going forward. Although many things may be different after the pandemic (e.g., in acceptance of digital health), we still see access, quality and financial affordability as the key challenges going forward. We expect that the relevance of the systems approach of PharmAccess and its core activities will therefore either remain the same or further increase. This is discussed in more detail per objective below.

In addition to continuing its existing activities, PharmAccess was able to swiftly and effectively respond to the unfolding of the pandemic, which is further discussed in chapter 4.

Demand

We expect the relevance of demand-related activities to remain as high as it was before Covid-19. The pandemic has further threatened the access to healthcare, and the insurance-related activities contribute to mitigating this effect. The other activities related to, e.g., monitoring and administration will stay as relevant as they were.

Supply

Supply-related activities still have a high relevance to improve the quality of local private healthcare facilities. The relevance of SafeCare was further emphasized by means of the "SafeCare4Covid self-assessment tool", to evaluate the preparedness for Covid-19.

Matching

PharmAccess' activities have become more relevant; we expect that going forward the relevance of effectively using data to battle some of the key disease areas will remain. Additionally, matching activities were expanded with CovidConnect which is a digital app and service that enables individuals to assess their risks for Covid-19 and provides home monitoring and support from remote medical staff to avoid overwhelming hospitals. Although during the first wave high patient numbers did not occur, it was highly relevant as a safety measure during the initial phase of the pandemic. Furthermore, in Kenya the Covid-Dx initiative aided in increasing testing capacity and thus complemented public efforts in this area.

"Costs were maybe [~EUR 20k] for CovidConnect, results were very high, [our country] was very happy with this."
Government stakeholder

Investments

Covid-19 put many private healthcare facilities in a vulnerable spot, with 60% indicating difficulties with paying salaries and 40% having difficulties paying for medical supplies, utilities and rent.[24]

Many banks temporarily stopped providing loans and investors pulled back their investments.[25] Meanwhile, PharmAccess continued to provide cash advances and making capital available to facilities in a time where they needed it the most, thus the relevance of MCF further grew and proved to be vital source of financing.

"PharmAccess was critical, because when most investors were pulling out from Africa during Covid-19, MCF was the only party lending to continue lending during the pandemic."
Implementation partner

[24] See SEO Amsterdam Economics, commissioned by PharmAccess. (2021b). Kwara Community Health Insurance Programme: Macroeconomic impact study.
[25] We could not verify this with external data, but it was confirmed in interviews with internal stakeholders, government stakeholders, international organizations and implementation partners.

Research & Advocacy

PharmAccess responded to Covid-19 not only quickly in terms of its activities on the ground, but also by immediately studying the effects of Covid-19.[26] By placing its observations within a worldwide context, PharmAccess has been able to be a relevant thought leader on Covid-19 in SSA which is exemplified in its early efforts on disseminating information during webinars on best practices and vaccinations.
The advocacy of PharmAccess also was and still is highly relevant in times of Covid-19. Many (public) stakeholders thank PharmAccess for its visibility during Covid-19, to provide them with support, information and advice. PharmAccess was also part of national Covid-working groups, often led by WHO.

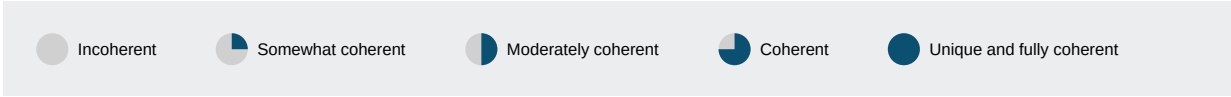
PharmAccess presented on Covid-19 through >40 webinars, pleads on Dutch national radio and television for 'zooming out' and addressing Covid-19 as a worldwide problem, with particular emphasis on Africa.

[26] See for example Adams, Wolday et al. (2021). Scaled testing for COVID-19 needs community involvement and Abraha, Gessesse. (2021). Clinical features and risk factors associated with morbidity and mortality among patients with COVID-19 in northern Ethiopia.

Kenya, 2019, i-PUSH – beneficiary, child and doctor, role of mobile in healthcare

3. Coherence

This chapter addresses ToR research questions 4 to 6 on coherence. Coherence is the compatibility of the intervention with interventions from other organizations or governments and the extent to which the approach or intervention is unique and additional to existing interventions. On this criterium, we use the following marks:



Q4. How coherent is HIF with other Dutch initiatives related to private sector development and health market transformation? To what extent are PharmAccess' activities additional/unique compared to these other Dutch initiatives?

Coherent

To understand the coherence of PharmAccess' activities with other Dutch initiatives related to private sector development and health market transformation, we evaluate its additionality and compatibility with other Dutch initiatives. As the Dutch health market transformation policy goal is primarily focused on SRHR, we evaluate its additionality to other Dutch initiatives on the healthcare market in the broader sense.[27]

Through this lens, we see that PharmAccess' activities are different compared to other Dutch initiatives. Its digital focus, inclusion of the private sector and systems-based approach are not matched by other Dutch initiatives.

In some instances, PharmAccess activities have also been directly compatible with other Dutch initiatives; e.g., there are partnerships with Amref, long-term effective collaborations with Heineken and Philips, the Covid-19 app was developed in collaboration with Luscii and PharmAccess is active in the broader Task Force Health Care. For SHRH specifically there have been collaborations with Aidsfonds, the Amsterdam Dinner Foundation, and ongoing discussions with Rutgers Stichting.

[27] This approach to answering this question has been decided in consultation with MFA as there is currently no Netherlands' agenda on health market transformation

Still, full coherence cannot be ascertained; there are relatively few collaborations with other initiatives via MFA as PharmAccess' focus regions are not focus regions for MFA, and Dutch NGOs often focus more on (specific areas within) the public healthcare sector.[28]

"The PharmAccess approach corresponds to the general private sector approach we take throughout the Dutch programs, such as the agricultural program."
Government stakeholder 1

"Despite limited coherence with other Dutch healthcare initiatives, we see that PharmAccess' approach can be applied to other fields of development aid, such as education and agriculture."
Government stakeholder 2

[28] Observations and conclusions for this research question are primarily based on interviews with national and international partners, which were verified during interviews with national government stakeholders.

Demand

Early demand activities were developed in close collaboration with Dutch multinationals. For example, PharmAccess teamed up with Heineken to offer its local employees access to healthcare by providing insurance. This was at its inception rather unique and it still is. Also Philips has indicated that they involve PharmAccess in its discussions with partners on demand-side financing.

There still is a strong collaboration between PharmAccess and its prior initiative CarePay, which has now spun off as a separate private entity, but still remains a growing Dutch organization.

Hence, there is a full coherence on the demand-side objective.

Supply

The quality improvement interventions by SafeCare are unique and therefore difficult to compare with other Dutch initiatives. There is collaboration with Heineken for 70 clinics in 16 low- and middle-income countries to set up SafeCare on these locations. There could be more such opportunities to team up with other Dutch initiatives to widen the impact of SafeCare.

Matching

Matching activities are relatively unique and additional to activities of other organizations. There has been direct cooperation with other Dutch organizations. Examples are the development of the Covid-19 app with Luscii and the hepatitis C bond with the Achmea Foundation. There is no structural approach to develop comparable initiatives with Dutch partners, the geographical scope of the team is much broader.

Investments

Investments

PharmAccess' investment objective is also rather unique and additional, not only in the Dutch context, but as well in the international field of NGOs. It collaborates here with some Dutch funding partners, such as FMO and Philips. Additionally, it collaborates with the Dutch AMPC International Health Consultants for its support in larger clinics. Hence, there is a high coherence.

Research & Advocacy

Research activities of PharmAccess are performed with a wide range of high-ranked universities and research institutes. Among these research partners, there are a couple of Dutch organizations, e.g., University of Amsterdam, Free University Amsterdam, Amsterdam Institute for Global Health & Development. In collaboration with these Dutch research institutes, impact studies are performed.

PharmAccess is also an active member of collaborations such as the Task Force Health Care and the Dutch Global Health Alliance focus on Covid-19.

There is room for further coherence in more often partnering with MFA to advocate for specific interventions in the countries; many stakeholders indicate this combination of the MFA's 'gravitas' combined with PharmAccess' learnings in the regions could results in a wider impact.

Q5. Coherence with government initiatives in recipient countries

Coherent

Most of PharmAccess' initiatives are highly coherent with government initiatives, especially on the regional level as not all initiatives have reached national level yet. Activities generally fall within two distinct categories:

First, there are activities that are done separate from the governments' own initiatives. Many of PharmAccess' activities to improve quality and investments in the private healthcare sector fall within this category. These activities predominantly complement the governments' own activities, which generally focus on the public healthcare sector. These activities are highly coherent, in particular if one believes that strengthening of the private healthcare sector can go hand in hand with improving the public healthcare sector.[29]

Second, there are activities that are done together with the government. Most demand- and advocacy-focused activities fall within this category. These activities are generally done with governments on a regional level, with governmental institutions or local working groups. PharmAccess has built strong long-term co-creation relationships with these local public stakeholders. Interviewed government officials commend PharmAccess on its effectiveness and flexibility, while being able to maintain the ownership at the government level itself, ensuring a high level of coherence.

On the national government level, coherence is not as self-evident. While MLOs often directly work with the ministers of health and finance, PharmAccess' connections on the national level are not as strong yet but have been increasing over the last years. Some view the focus of PharmAccess on regional levels as a strength, while others see opportunities for more impact.

Especially going forward, a stronger relationship with national governments could be essential to successfully achieve scale. This might require additional investment in advocacy due to the resource-intensive nature of building trust-based and long-term relationships.

"PharmAccess is there when we need it most. It moves out of its comfort zones"
Government stakeholder 1

"PharmAccess' activities align very clearly and coherently with policies and plans of our government. […] It helped us translate the lessons to the national health act and to realize the policies."
Government stakeholder 2

"It is unprecedented that a high-tech financially sophisticated implementer somehow possessed the ability to have relationships of trust with domestic institutions. PharmAccess has literally collaborated on certain things that I have not seen in other systems."
Implementation partner

[29] As mentioned in the Introduction, evaluation of the effectiveness of private sector versus a more publicly financed approach is beyond the scope of this report

Demand

To realize demand-related activities, PharmAccess works together with local governments. It starts pilots together and in successful contexts the government has itself taken ownership to further scale. Kisumu (Kenya) and Kwara State (Nigeria) are some key examples where PharmAccess has been able to work collectively with the government to implement successful schemes. Two government officials and one PharmAccess internal stakeholder have elaborated on some demand-related issues with the national rollout of the iCHF where nationally incoherent choices were made compared to (PharmAccess') original design. Hence, it is inferred that in some cases, coherence on the national government level is moderately coherent.

"With PharmAccess we do not have to get involved with its people in the nitty-gritty of how many euros everything costs. […] I do not know how much the relationship with PA costs in terms of euros. If we have a problem, then we think it through together"
Government stakeholder 1

"Our partnership has gone really well, the universal healthcare program, this really feels like ours"
Government stakeholder 2

Supply

Health providers unanimously indicate that the SafeCare assessment is a unique and valuable addition to government-led accreditation systems. All interviewed stakeholders confirm that SafeCare is more strength-based and helps providers achieve accreditation criteria – especially because SafeCare comes with (technical) assistance and training. Especially many local government stakeholders mentioned that they are currently using SafeCare as the go-to healthcare quality improvement approach. This is also seen in practice as morethan ten (local) governments have now adopted the SafeCare methodology, proving its coherence. Interviewed providers also explained that SafeCare helps them become accredited by national institutions.

"With the help of the improvement through SafeCare the ministry could follow the cold chain and allowed us to provide immunization of babies."
Healthcare provider

Matching

Most matching activities focus on the private healthcare sector with some activities collaborating with (local) public institutions. In that way, there is not always a direct collaboration with local governments, but PharmAccess does complement government efforts. Interviewed government stakeholders described that they found MomCare a very strong initiative to reduce mortality of both mothers and children.

Some matching activities are also in direct alignment with the government, such as the hepatitis C impact bond in Cameroon for public beneficiaries. The reason why PharmAccess does not score full points is due to other matching activities not always having a direct link to other government initiatives such as the digital outpatient care initiative.

Government stakeholder: "MomCare really helped mother-child care to be capably implemented and improved in county hospitals"

"MomCare really helped mother-child care to be capably implemented and improved in county hospitals"
Government stakeholder

Investments

Investment initiatives have a high additionality compared to governments' own initiatives, because they focus on creating a sustainable private sector. From the interviews, this additionality and uniqueness are strongly voiced over by most government officials as well as healthcare providers. However, some public stakeholders believe that private sector financing can be detrimental to the public healthcare facilities and are therefore not fully compatible with their own initiatives.

"Private sector gets the good doctors from public sector and money from private institutions. I want these doctors in the public sector. This is very unfair to more than 50% of the population."
Government stakeholder 1

"A very strong private health sector can work against you if you want to set up a national one."
Government stakeholder 2

Research & Advocacy

Most of the interviewed government stakeholders appreciate PharmAccess' efforts on advocacy, and this has been instrumental to the many long-term relationships it has built, driving the discussed initiatives. While this research & advocacy is considered unique and coherent with government initiatives on content, there are also examples where its efforts were less compatible on process or reach. A reason for this can be that PharmAccess' is simply much smaller compared to many MLOs that have more direct access to national governments. Interviewed government stakeholders also indicated that PharmAccess does not always adhere to the government budget cycles or timelines in order to make its initiatives optimally compatible. Hence, the research & advocacy activities are considered to be moderately coherent to government initiatives in recipient countries.

"If our budget does not allow us to share what we are doing with others, scalability becomes a challenge. Policies become a mega component of our work if we want to be successful."
Internal stakeholder

"At the public sector side everything is a bit slow. PharmAccess is not always able to overcome that, to make a big impact. It can work better with how the systems are set and the processes that must be followed. For example, PharmAccess does not work with the budget cycles of the public sector."
Government stakeholder

Q6. How coherent are PharmAccess' activities with initiatives from Multilateral Development Banks (MDB's), Development Finance Institutions (DFI's) and Global Health Initiatives like World Health Organization (WHO), Global Financing Facility (GFF), etc? To what extent are PharmAccess' activities additional/ unique compared to these initiatives?

Moderately coherent

PharmAccess views itself as a 'disruptor' that does things differently. Indeed, many of the activities that PharmAccess undertakes are unique (within their specific settings). Most distinctive are PharmAccess' systems approach, its focus on the private sector, its flexible working style and its heavy focus on digital.

PharmAccess' role as disruptor is a double-edged sword if it comes to the coherence with existing initiatives: on the one hand, PharmAccess' activities are relatively unique, so it complements the activities of other organizations. On the other hand, PharmAccess strives to work with other parties to successfully scale and therefore a higher level of collaboration could increase coherence. We further explore both sides below.

High level of uniqueness

With its public-private insurance schemes, SME-focused investment fund, and data-driven collaborations with private providers, PharmAccess is a unique player in the development aid landscape. Its activities are a valuable complementary addition to the initiatives of other organizations, that are often narrower in scope, e.g., focus solely on implementation. For some initiatives, PharmAccess has also collaborated with international and local NGOs such as Amref and KMET, and MCF has attracted investments from many international organizations. Moreover, it inspires these organizations, as will be discussed in chapter 5.

"From our side, I believe it complements what we do, also in other aspects of health. Because PharmAccess also supports this and we work together in the same working groups, in terms of coherence it is in order."
International organization 1

"PharmAccess is relatively niche; this is a weakness and a strength. It is niche because it is so small in relation to the large American NGOs. […] PharmAccess dares to go to the private sector, while the multilateral organizations don't dare to talk about business models."
Implementation partner

"We work extremely well with PharmAccess. Especially in Nigeria but also in Kenya and Ghana."
International organization 2

"Question is not if but it is how World Bank and PharmAccess can work together. It will have to go through the country's government itself."
International organization 3

"There are certainly possibilities to work together, but that would have to be on specific modules, we could for instance look how we could implement SafeCare together. You cannot roll out an entire package at once."

International organization 4

Potential for higher compatibility

As far as PharmAccess has been able to scale its initiatives, this is mostly done through governments and local NGOs. A collaboration with larger organizations could be a way towards achieving more impact. These organizations have the size and economic resources to propel an initiative towards greater heights, and the gravitas to have a substantial influence, i.e. to sway convictions on the local and national governments. If such collaboration would be realized, the coherence would be more ensured.

In our discussions with international organizations, several ways emerged in which PharmAccess could realize untapped potential in collaborating with large health organizations:

First, stakeholders indicate that some MLO collaborations require strong local offices. PharmAccess has increased its presence in the regions where it is active, but a next step might help to receive more significant funding and support from MLOs for its activities. At the same time, strengthened offices at some of the MLO strongholds might help increase the mutually enforcing impact on MLO activities. An office (or at least resource capacity) in Washington, Brussels or Geneva will be an investment, but in terms of impact can be worth the price.

"We could not get the Global Fund money, Amref got it. We are not yet considered as a local organization. You need a local board that can make decisions."
Internal stakeholder 1

"There are large opportunities to work with some of the MLOs. But this is also a political field; we might require an office in Washington or Geneva, but this is a serious investment."
Internal stakeholder 2

Second, PharmAccess could be bolder in sharing its impact. It is often considered a 'silent hero' among partners. Also, within PharmAccess the assumption seems to exist that MLOs do not want to work with PharmAccess. While we see how this is based on unfruitful historic experiences and a different way of working, the people we spoke with at these organizations actually indicated a high willingness to find ways to cooperate. Additionally, public and private stakeholders indicated that PharmAccess can be bolder, and they are ready to help PharmAccess get the exposure it desires in the international community.

"[Multilateral] organizations are working on local buy-in, country ownership and doing specific projects for the financing they receive. [That] comes at a cost of delays, inefficiencies and slow adoption of the innovation. There could be some prodding to really shake things up. [They] are doing that and we want to help make some of these innovations more mainstream to show they are working."
Implementation partner 1

"The ministry could showcase the PharmAccess impact much more; it took them a long time to accept that what PharmAccess does is revolutionary."
Implementation partner 2

"PharmAccess' way of innovating might lead one to think it is not coherent. But all the different pieces link. [...] I do not know any international party with which PharmAccess worked that was unhappy. I understand that some of the big organizations might battle to work with PharmAccess because they do not understand them, especially with the private sector things. It could market itselves better. This comes down to resource constraint at the PharmAccess' side. Someone should write reports, keep public relations, then people would understand them better. It took us a while to understand them. Now we got that, now we trust them."
Implementation partner 3

"Sometimes PharmAccess seems to think it can do everything on its own. It might be perceived as know-it-alls."
Government stakeholder

Demand

There is an international consensus that demand-financing health insurances programs are an important stepping stone towards universal health coverage. However, there has been disagreement from other international organizations in the way these schemes should be set up. In prior funding periods, PharmAccess' voluntary private insurance schemes were regarded with some suspicion as these would not be able to reach the lowest incomes in the populations. However, in this funding period PharmAccess only tested and implemented public-based (mandatory) insurance schemes together with local governments. Due to its prior focus, PharmAccess is still regarded by international organizations as in-principle incoherent with its own ways of working. Coherence can be increased in the coming years, if indeed the international organizations are included in PharmAccess' shift in approach and further evidence of its approach reaching also the poorest gets validated or reviewed in literature.

"The insurances that it tries to get people on, are exactly the insurance we try to stop because they do not work."
International organization

Supply

SafeCare has for a long time been unique in providing a strength-based quality assessment system. We see that a higher level of coherence could have been reached if multilateral organizations had directly supported SafeCare, which could have been a catalyst to scaling at public facilities. Also, while it is a success that local partners scale SafeCare, there could have been an opportunity for international organizations to do this for a more coherent approach as one local government mentioned that another international organization is replicating a similar quality framework in the region albeit at a much smaller scale.

PharmAccess collaborates on SafeCare with local NGOs, such as Marie Stopes Ghana, KMET and Doctors for Madagascar

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Matching

Few initiatives from other NGOs seem to resemble the data- and transparency-based initiatives within the Matching category. These initiatives are also often done in isolation compared to initiatives of global institutions, while at the same time two international partners mention that they were unsure whether their organizations could have moved as fast as PharmAccess. There might be opportunities in the future to scale together with international organizations if a closer connection is made.

"MomCare is really an example of what World Bank and others should be doing, providing transparency in financing, gaps in clinical pathways and catastrophic spend. We have conversations, but World Bank is incredibly slow and not innovative."
Private partner

"PharmAccess taught us how to appreciate the data, make it usable for us."
Provider partner

Investments

MCF is unique in terms of private healthcare sector financing, combining this with technical support as exacerbated by most interviewed stakeholders from local governments and multilateral organizations. It is thereby highly coherent, because it makes a considerable contribution to existing organizations and projects. By now, alternative funds have been initiated but with less success as of yet. There has been direct collaboration with various development financing institutions, with mixed success. One multilateral organization stakeholder mentioned that MCF is working against multilateral organizations' purpose as it mobilizes money into the private sector rather than the public sector.

"MCF is complementary to what else we see on the equity side. It is filling a gap."
Private partner

Research & Advocacy

While PharmAccess has unique initiatives, this is not always translated to a substantial role in research and advocacy between the global institutions.

PharmAccess has seats on various public working groups together with global health institutions (e.g., WHO-led workgroup in Kenya). As these institutions are often very close to where the decisions are made, an increased presence could benefit both the coherence and the effectiveness of the activities.

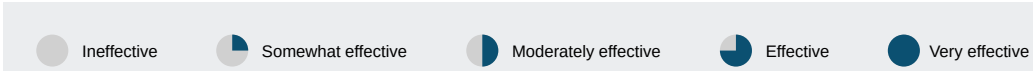
For research, we do not see full coherence, as this would mean to match global health institutions in terms of reach. These organizations generally publish in larger and more impactful papers. If PharmAccess would match this or conduct research together in a higher capacity with international organizations, that would further influence the thinking and doing of the largest development aid organizations.

"I think PharmAccess does a lot more than people know about in terms of advocacy. However, there is room for improvement. The old traditional partners e.g., WHO, World Bank, they are very much government-to-government type organizations, which PharmAccess is not quite. This is a point that the Dutch government might need to look at."
Implementation partner

Kenya, 2021, MomCare – nurse and expectant mother during an antenatal health check-up

4. Effectiveness

This chapter addresses ToR research questions 7 and 8 on effectiveness. Effectiveness is the extent to which interventions have achieved or are expected to achieve the pre-defined objectives. On this criterium, we use the following marks:



Data analyses presented in this chapter are based on PharmAccess' own data if not otherwise stated.

Q7. How effective has HIF been in achieving or progressing towards its objectives?

Q7a. How effective has HIF been in achieving or progressing towards the five objectives stated in its Theory of Change, and why?

Effective

It is not easy to do justice to the extent to which PharmAccess has been effective in improving healthcare sectors in the countries it is active. Government stakeholders and healthcare providers explained how PharmAccess' actions have had an effect on millions of lives, through making healthcare more financially accessible, improved quality of care, providing vital loans and supporting governments to take charge in effective interventions. With an organization of ~197 FTE, that is not a small achievement.

Many stakeholders acknowledge that the counties in which PharmAccess has been most active, would not have been the same without it. Many also emphasized that PharmAccess successfully applies holistic system thinking and enables private markets to improve health care systems in the complex and continuously changing context of SSA. There is a possibility for them to gather and share more evidence of this impact. In the section below, we gather and discuss a number of facts that speak to the reach and impact that PharmAccess has been able to achieve across its five strategic objectives. The results below are primarily based on the impacts of the more mature initiatives, as data of the newer initiatives is not available yet.

"If you have done something that is working, and now want to scale and people want to adopt it, that speaks to effectiveness. It speaks to the relevance for the needs and the health of the country."
Government stakeholder 1

"PharmAccess lacks a number-driven culture."
Implementation partner

"PharmAccess has had striking power on county level that never would have been possible on the country level. That is an enormous added value"
Government stakeholder 2

Demand

PharmAccess has been very effective in (co)developing health insurance schemes and innovating healthcare payment models. As shown in exhibit 7, its efforts have contributed to reaching millions of inhabitants of the countries it is active in. To further analyze the actual effectiveness, we focus on the program for which most data is available, the Kwara State Health Insurance Program:

In Nigeria, PharmAccess started a pilot in Kwara State in 2007. It was renewed in 2020 after the passing of the health insurance law in November 2017 and has with its success inspired 33 other Nigerian states to adopt health insurance legislation. This pilot has been heavily studied and showcased strong impact in reducing the healthcare coverage cost per capita:

"The Kwara State health insurance program has demonstrated that State-based health insurance schemes can deliver a decent basic healthcare coverage at US $28 per person per year compared to WHO benchmark of US $60 and Nigeria's total health expenditure per capita of US $115."
Amsterdam Institute for Global Health and Development (2017)

The findings show a 53% lower basic healthcare coverage cost ($28) compared to the WHO benchmark ($60), which if realized at full scale could provide a cost-effective way of providing insurance coverage.[30]

There is evidence that out-of-pocket spending and the number of catastrophic health events decreased by 52% and 65% respectively. The health insurance pilot also seems to have prompted a significant behaviour change in relation to health care access, as utilization of care increased by 200%. Lastly, a macro-economic impact study from SEO[31] found that the Kwara health insurance scheme also increased domestic production by an additional $10.1 mln per annum; the average annual investment into the Kwara Community Health Insurance Programme (KCHIP) equaled $3.2 mln per annum.

However, the evidence does suggest that healthcare access for the uninsured population decreased during the pilot, suggesting a "crowding out" of other sources of (informal) funding. This is a problem as enrolment in some initiatives is relatively limited. It stresses the importance of full UHC.

Stakeholders report that increased enrolment would help ensure that all beneficiaries' needs are met, avoiding a dichotomy between those insured and non-insured. PharmAccess might want to invest in education around insurance to increase the numbers enrolling in the scheme. Furthermore, there should be a clear objective set during the design phase of the health insurance scheme to avoid crowding out the lowest income groups.

"Using propensity score matching the author finds that for the insured the program increased healthcare utilization and reduced out-of-pocket (OOP) expenditure. These improvements seem largely driven by the insurance. However, among the uninsured in the area with upgraded facilities, formal healthcare utilization decreased, informal healthcare utilization increased and OOP expenditures went up. These results suggest crowding-out of the uninsured from formal care facilities, which is problematic given that 67 percent of the sample did not take up the insurance in the initial two years of implementation"
Amsterdam Institute for Global Health and Development (2017)

[30] Amsterdam Institute of Global Health and Development (2017). Access to Better Healthcare in Africa: New findings from research on PharmAccess Group supported programs.
[31] (SEO Amsterdam Economics. (2021). Kwara Community Health Insurance Programme: Macroeconomic impact study

Exhibit 7 - Impact of demand objective

PharmAccess has shown that increasing financial access to healthcare is viable, with full potential requiring wider adoption

Demand: Develop private pre-payment mechanisms, risk pooling structures, and mobilize resources for organized demand

Case example of impact
No impact assessment available

Output		Outcome		Impact proxy: economic, social or health outcome
Country	**Potential reach**	**Population reached[7]**	**Initiatives**	**Case Example: Kwara State Health Insurance Scheme**
Kenya	1.3 mln (Kisumu)	0.2 mln (13% Kisumu, 37% of all poor households[8])	Kisumu Marwa Health Scheme	
	4.5 mln (4 counties)	2.8 mln (62%)[1]	M-TIBA (UHC through PAF)	
Nigeria[2]	3.2 mln	26k (1%)	Kwara State Health Insurance Scheme	
	12 mln	0.3 mln (3%)	Lagos State Health Scheme	
Tanzania	53 mln[3]	1.6 mln (3%)	NiCHF	
	1.5 mln	0.15 mln (10%)	Zanzibar[4]	
Ghana	31 mln[5]	16 mln (53%)	NHIA digitization & data support[6]	

Impact KPIs	KPI Results
(A) Cost of insurance coverage per person per year	**$28** (WHO benchmark: $60, Nigerian per capita health expenditure: $115)
(B) Reduction in out-of-pocket expenditure	**-52%**
(C) Reduction of people incurring catastrophic spending	**-65%**
(D) Increase in utilization of care	**+200%**
(E) Inspired adoption by other Nigerian states	**33 out of 36 (92%)**
(F) Domestic production increase through KCHIP	**$10.1 mln p.a.[9]** (production factor = 3.1[10])

For the non-insured, the study found increased out-of-pocket expenditures. and some evidence of possible crowding out of the non-insured, hence reiterating the importance of UHC

1. Additional 130k people covered by I-PUSH, Muranga'a, Kakamega and Afya/Gertrudes schemes
2. Also TA to Adamawa state
3. Based on informal sector
4. Ongoing enrolment
5. NHIS covers 16.3 mln people in Ghana]
6. Digitization through e-claims with additional data support and analysis
7. Enrolments schemes include health plan (NiCHF, Marwa) and registrations measure interest in schemes in development (Zanzibar)
8. Ambition to cover 90k poor households
9. Average annual investment into KCHIP equals $3.2 mln
10. Production factor is calculated as [domestic production increase] / [investment]

Source: Short and longer-term impacts of health insurance on catastrophic health expenditures in Nigeria (PA, 2020), World Bank, SEO (2021)

Supply

Concerning Supply (quality), PharmAccess' main activities evaluated here are related to SafeCare and its sub-initiatives. In 2016, SafeCare was already an existing product that found moderate success. One of its drawbacks was the significant cost-per-assessment, making it a less scalable and effective business model. For that reason, PharmAccess has adapted SafeCare into four separate models over the period 2016-2021:

1. Quality Platform, a digital platform for providers
2. SafeCare accreditation for recognizing facilities, catering to more public facilities
3. SafeCare self-assessment tools for beneficiaries to self-assess and reduce transaction costs
4. SafeCare licensing with the purpose of scaling and providing quality assessments.

In this section we will evaluate the assessments performed to understand how effective these have been in reaching facilities and helping clinics improve the quality of services they provide (Exhibit 8).

PharmAccess has conducted 5,959 SafeCare assessments in the period 2016-2021 (71% of 2011-2021 total). Furthermore, there are 4,410 unique healthcare facilities that are part of the SafeCare program.

Exhibit 8 - Impact of supply objective

PharmAccess has proved improving quality of care is possible, with full potential requiring wider adoption or through licensing

Supply: Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers

Case example of impact
No impact assessment available

Output		Outcome		Impact proxy: economic, social or health outcome
Country	**Facilities per country**	**Facilities reached by PAF[2]**	**Initiatives**	**Case Example: SafeCare (all countries)**
Kenya	4,437 private[1]	1,287 private (29%) 177 public (4%)	SafeCare	
	4,878 public	360 private (8% of all private), 12 public	SafeCare Licensing (KMET)	
Nigeria	3,360 private	589 private (18%) 373 public (2%)	SafeCare	
	17,755 public	35 (1% of all private)	SafeCare Licensing (Pathfinder, Heineken)	
Tanzania	1,898 private	775 private (41%) 182 public (4%)	SafeCare	
	5,173 public	765 (40% of all private)	SafeCare Licensing (CSSC, APHFTA)	
Ghana	1,427 private	602 private (42%) 26 public (1%)	SafeCare	
	1,960 public	458 (32% of all private)	SafeCare Licensing (CHAG, Marie Stopes)	

Impact KPIs	KPI Results
(A) # patient visits to quality score improved centers (2020)	**3.3 mln** (of which 2 mln low-income patients)
(B) % of facilities with improved SafeCare score	**81%**
(C) # of SafeCare quality standards & stepwise certification & regulations co-developers	**17**
(D) (Local) governments inspired to adopt quality standards	**13**
(E) License partners	**10 with a reach of 1,619 facilities**

While SafeCare model is effective in improving the structural and managerial quality of health facilities, no strong evidence was found for improving clinical quality of care. A new study is investigating longer-term effects.

1. Private includes faith-based facilities
2. Total of 4,410 facilities reached by PAF but displayed numbers exclude on-target country facilities and NGO/uncaptured facilities (399 facilities)

Supply (continued)

The amount of healthcare facilities reached in the four target countries is sizeable: the SafeCare program has impacted between 18%-42% of the private facilities in these countries (Exhibit 8). This translates into 34.2 million patient visits to SafeCare centers (in 2016-2021) of which 13.6 million patients benefitted from a quality-improved clinic. Not all clinics have been able to improve their SafeCare assessment scores, and it is also possible for clinics to have a worse score on their subsequent assessment. However, 81% of facilities on average improve their SafeCare score upon their next assessment visit, indicating the program has a strong and pragmatic approach to helping these facilities improve.

PharmAccess has been able to catalyze a paradigm shift, evidenced by their inspiration of local or national governments to adopt step-wise quality standards and their co-development of tailored SafeCare standards with other institutions and governments. In total, there are 13 local or national governments that have adopted similar care quality standards and 17 parties with which PharmAccess has been co-developing a customized SafeCare-based approach.[32]

SafeCare licensing, a new model since 2019, is designed to reach more beneficiaries while decreasing the reliance on available PharmAccess funding for these assessments. In the past two years, PharmAccess has onboarded ten license partners in a number of countries (including India, Afghanistan and Madagascar). These license partners in turn can reach 1,653 healthcare facilities.

In summary, SafeCare is increasing its reach of facilities and beneficiaries and improving its models over time to best fit the need of the clinics. However, we should also examine health outcomes of the interventions and review whether the program impacts the actual quality of care patients receive.

[32] See Exhibit 26.

The London School of Hygiene and Tropical Science and Ifakara Health Institute (2020) tested this with a randomized control trial. They found that the structural and managerial quality of health facilities significantly improved in the intervention group compared to the control group, as measured by SafeCare assessment scores increasing. However, their findings did not provide significant evidence that the use of SafeCare by a care facility improved its clinical quality of care over time.

Therefore, the only proof of clinical improvement relies on anecdotal evidence: in in-depth interviews, clinic owners and beneficiaries explained to us how patients benefit from reduced waiting times, access to more health services and a smoother patient journey.

PharmAccess' research department is currently conducting more research in the field of clinical care improvement through the SafeCare program.

"[Our findings] suggests that the SafeCare model was effective in improving the structural and managerial quality of health facilities, as measured by the SafeCare score. However, our findings suggest that SafeCare was not effective in improving clinical quality of care."
PharmAccess, London School of Hygiene & Tropical Medicine & Ifakara Health Institute (2020)

Matching

PharmAccess' has since 2016 started a range of new initiatives that it fits within its "matching" objective. These mostly focus on data and digital, such as MomCare, Remote Care Ghana, Hepatitis C Impact Bond, Connected Diagnostics. An overview of these activities is provided in section Q7d.

Most of the matching initiatives are in an early phase of development and the effectiveness cannot yet be properly assessed. Therefore, the section below will focus on the effectiveness of the two main initiatives for which effectiveness can be evaluated: MomCare and NCD Model (Exhibit 9).

— More than 40,000 mothers have delivered their babies with a MomCare bundle in Kenya and Tanzania, consisting of ANC, delivery, and PNC. We identified the regions in which there are active MomCare facilities: MomCare reached 11% of expected pregnant mothers in Kenya and 27% of expected pregnant mothers in Tanzania on sub-county level. As part of MomCare, the percentage of well-managed journeys is measured through the reporting of mothers directly as well as clinician reported data. MomCare has shown to help increase the percentage of well-managed journeys by 22% from baseline to endline. In terms of actual care quality improvement, a study found that there was a 24% increase in skilled deliveries (or clinics active in the MomCare program for at least 1.5 years).

There is also evidence that the population with controlled NCD-disease increased because of NCD-related matching activities. Their NCD disease management model has prompted a 20% increase in compliance to NCD treatment compared to benchmark (Oti et al., 2016) and even a 24% uptick compared to the benchmark in the percentage of people with controlled NCD after a 1-year follow up.

Exhibit 9 - Impact of matching objective

PharmAccess' digital solutions showcase impact on health outcomes, with full potential requiring wider adoption and time

Matching: Improve efficiency, effectiveness, and transparency to better match demand and supply of healthcare transactions

Case example of impact
No impact assessment available

Output | **Outcome** | **Impact proxy: economic, social or health outcome**

Country	Potential reach p.a.	Cumulative reach (2016-2021)	Initiatives
Kenya	256k exp. births p.a. (4 counties[6])	31 clinics 23,198 mothers (11%)[4]	MomCare (2016)
	260k malaria cases[8] (Kisumu)	11,689 febrile patients[1]	Connected Diagnostics
	4-5 mln HT&D	1,627 patients	NCD Model (2018)
Nigeria	N/A	500k people screened[2]	MATS tuberculosis screening
Tanzania	24k expected births p.a. (2 counties[7])	40 clinics 17,318 mothers (27%)[5]	MomCare (2019)
Ghana	N/A	140 patients	Remote Care (2021)

Case Example: MomCare

Impact KPIs	KPI Results
A % increase in skilled deliveries (1.5 years of participation)	**+24%**
B % increase in well-managed journeys	**+22%**
C Average care costs of a MomCare bundle[3]	**€64** (rural KE) **€144** (urban KE)
D Maternal death rate	**9.2x** lower vs. KE average[9]
E Neonatal death rate	**3.4x** lower vs. KE average[9]
F Mothers below poverty line	**4,327**
G Teenage mothers	**6,798**

Case Example: NCD Model

A % increase in patient compliance to treatment	**+20%** (vs. benchmark[10])
B % patients with controlled disease at 1-year follow up	**57% (+24% vs. benchmark)**

1. Positivity rate is 18.1% (2,119 cases)
2. Positivity rate is 0.2% (1,106 cases) |
3. Rural KE cost receives an additional reimbursement from Linda Mama and urban KE cost receives an additional reimbursement from NHIF
4. Based on 11,970 mothers enrolled in 2020
5. Based on 6,439 mothers enrolled in 2020
6. Active areas in Kisumu, Kakamega (only East, South and Mumias East), Nairobi (only Njiru, Mathare, Kasarani), Vihiga sub-county
7. Active areas are Babati in Manyara and
8. Moshi in Kilimanjaro
9. 20% prev. rate in Kisumu (K-MoH) | 9. Kenyan average based on Unicef data and MomCare data from PharmAccess
10. Study from Oti et al. (2016)

Source: Van Duijn et al. (2021), Kenyan Ministry of Health, Oti et al. (2016)

Investments

For the Supply – Investments objective, the core activity reviewed will be the Medical Credit Fund (MCF) and its successor MCF II (Exhibit 10).

MCF has been able to provide loans to ~16% of all private facilities in Kenya, Nigeria and Tanzania and even ~26% of all private facilities in Ghana. Its total disbursement volume is above $139 mln across all countries including Liberia and Uganda. Evidence indicates that investments into facilities have grown because of the activities PharmAccess undertakes. Covid-19 further increased its relevance, as the MCF helped carry facilities through the crisis while there was a gap in financing: most investors pulled out of the African continent, but the MCF decided to assist and aid facilities at a time when they most needed it.

Multiple stakeholders have raised the notion that PharmAccess was the first of its kind, mobilizing capital towards the healthcare sector. Traditionally, healthcare was regarded as a bad investment opportunity due to the high (reputational) risk and lack of moral collateral for a bank. Hence, besides actually mobilizing the capital, PharmAccess was able to accomplish a paradigm shift, indicated by growing numbers of financial partners. Some of the banks, such as NMB Tanzania, have been very successful. In addition, PharmAccess has encouraged a shift towards digital with initiatives like digital lending pilots and the highly successful Cash Advance platform in Kenya. Its way of working is testament to the agility of the organization and it's ability to jump on opportunities that arise.

There is evidence that MCF has increased the number of outpatient visits by 20% as well as the number of inpatient admissions. Per month, almost 400 thousand patients benefit from clinics that have received an MCF loan. In the period 2016-2021, there were 95 million patient visits to clinics that received an MCF loan. Of these facilities, 80% were able to increase their SafeCare score by being able use funds to improve their own services and care. If we assume there is

no "crowding out" of other unfunded facilities, access to care is seen to be improved, with attendance volume increasing as results of the funds. But increase in quality of care is uncertain: the loans are connected to SafeCare activities, which has not yet been proven to improve clinical outcomes for the beneficiaries. Based on anecdotal evidence from beneficiaries, they do enjoy better patient experiences when comparing visits before and after MCF loans; often with new health services (e.g., a baby warmer). Lastly, many financial institutions worry that the repayment rates will be worse for healthcare loan takers; MCF has proven that this is not the case with high repayment rates of 93% during Covid-19 and 96% before Covid-19.

PharmAccess, as pioneer in the field, has bought digital technology into its own initiatives, including running several digital lending pilots. One very successful pilot is Cash Advance which has offers smaller loans through mobile advances without requiring collateral. Beneficiary clinics have been highly positive, finding it easy to use, quick, increases transparency, and, most importantly, makes financial capital accessible to the average clinic. This presents a solution to the challenges in MCF's initial years around working with banks in financially unstable contexts and committing to investing more into healthcare. It is of particular note that Cash Advance reduces waiting times for loans – most loan approvals take between four hours and a full day, whereas most traditional bank loans take five days up to even two months, especially with complex collateral like land. With conservative bounds (1 full day for Cash Advance and 5 days for a traditional bank loan), this would mean a reduction in waiting time of at least 80%.

Exhibit 10 - Impact of investments objective[33]

PharmAccess has accelerated improvement of care through mobilizing capital, with full potential requiring partnerships

Investments: Mobilize capital into the private health sector

Case example of impact
No impact assessment available

Output		Outcome		Impact proxy: economic, social or health outcome
Country	**Total facilities**	**Facilities reached**	**Initiatives**	**Case Example: Medical Credit Fund (all countries)**
Kenya	4,437 private[1]	688 facilities (16%) 4,289 loans, $91M	MCF	
	4,878 public	337 facilities (8%) 3,370 loans, $48M	Cash Advance	
Nigeria	3,360 private	589 private (18%) 373 public (2%)	MCF	
	17,755 public			
Tanzania	1,898 private	295 facilities (16%) 364 loans, $6M	MCF	
	5,173 public			
Ghana	1,427 private	365 facilities (26%) 830 loans, $23M)	MCF	
	1,960 public	23 facilities ($250K, 15% ordered out of 150 CHAG providers)	Med4All	

Impact KPIs	KPI Results
(A) # patients served through beneficiary clinics (2020)	**24m** (with 13m low-income patients, 12m female patients, 5m child patients)
(B) % facilities that improved SafeCare score after loan provision	**80%**
(C) Repayment rate	**93%** (96% pre-COVID)
(D) Financial partners	**18** (37% risk-sharing for outstanding portfolio)
(E) Female entrepreneurs supported	**396 (21%)**
(F) % increase in outpatient visits for MCF clinics p.a.	**+20%**
(F) **Cash Advance:** Approval time for bank loan through digital	4h– 1d (vs. 5d – 2m) (at least 80% decrease)

1. Private includes faith-based facilities
2. Med4All is a volume bundling solution through pooled procurement and digital supply chain in collaboration with CHAG

Source: The healthcare system in Kenya, Nigeria, Ghana, Tanzania (PharmAccess)

"Outpatient visits have increased by 20 per cent per annum across the MCF clinics in our study, from an average baseline of 7,255 outpatient visits to over 14,000 outpatients per year currently. Meanwhile, inpatient admissions have grown from an average of 450 per clinic in the baseline year to a current average of 871 inpatient admissions per year."
CDC Group (2020)

[33] CDC Investment Works. (2020). What is the impact of improved access to finance for healthcare facilities in Kenya?

Research & Advocacy

PharmAccess has been able to build an impressive network of partners, local government members and other stakeholders. In this way it has been able to advocate for its innovations, being a driver for the positive results described above. Many involved governmental stakeholders indicate that PharmAccess is a strong and supportive advocate in its network, especially on the regional level. Outside of these regions and at other organizations, stakeholders sometimes describe PharmAccess as a "silent hero".

Considering its 2.5 FTE strong Research department, it was able to publish almost 200 publications in the period 2016-2021. One pitfall is that, to some extent, PharmAccess expects its results to speak for themselves, but these are not always self-evident or hard-hitting facts. Many stakeholders indicate that it could document its successes and learnings better while pooling the right fact base to convince potential partners and loudest critics. Evidence of its systems-level approach could especially help bring its role as advocate to the next level, in particular when translated to groundbreaking whitepapers and research publications. We also see opportunities for further collaboration with academic partners.

"Influence of PharmAccess 5-7 years ago was very small, but now everyone knows them. Because it engages all partners together, which has catapulted it to a level of influence like global players"
Government partner

"I understand that some of the big organizations might battle to work with PharmAccess because they do not understand them. It could market itself better. Its PR could be better. […] Part of the challenge is that it does not have bench-strength to unpack all its data"
Implementation partner

"PharmAccess could document its learnings better to help us and others"
Government stakeholder

"We should embed research from the start of an initiative, but do not have enough resources or maybe we do not prioritize this enough"
Internal stakeholder

Q7b. How effective has HIF been in reaching low-income groups and health care providers servicing those groups?

Indirect relevance

PharmAccess' ToC does not solely focus on the low-income groups. It believes that by developing long-term sustainable models, it can lift the healthcare sector of a country as a whole. Notably, for the period 2016-2021 the agreements PharmAccess made with MFA did not include the focus of reaching the poorest, although it might be implied in the formulation of "Making inclusive health markets work". As requested by the ToR, we will evaluate this by looking at the reach of PharmAccess' interventions among low-income groups. Furthermore, below we also evaluate the number of women and children reached. Note that data is often not readily available for all initiatives in this analysis, so a selection has been made to serve as a simplified illustration of PharmAccess' reach.

The definitions used for very low-income, low-income, middle-income and high-income groups are provided in exhibit 11.[34]

"If healthcare would be completely free, that would be the best for the lowest incomes. In practice that is not possible for the countries. The interventions of PharmAccess make sure that patients can be treated better, more effectively and with enough funding. At least this makes improvement possible."
Government stakeholder

Exhibit 11
Definitions of income groups

Very low income LSM 1-2 social class E	Low income LSM 3-5, social class 0	Middle income LSM 6-8 social class C2	High Income LSM 9 and above, social class CI and above
Livelihood: Subsistence farming, live stock and/or money from relatives	Livelihood: Small parcel of agricultural land or small businesses, often irregular income	Livelihood: Breadwinner's salary	Livelihood: Breadwinner(s) has/have permanent/fulltime employment
Housing: Traditional or simple structures, commonly without water or electricity	Housing: Houses made of cement bricks, metal and/or wood, some with blair toilet or pit latrine. Few have electricity	Housing: Modern materials such as bricks, with electricity. Possibly tap water and (inside/outside) flush toilet	Housing: Minimally brick houses with inside flush toilet and running tap water. Possibly domestic staff.
Education: Formal education is rare, usually illiterate	Education: From limited literacy to a household head with (some) secondary level education	Education: Chief wage earner had completed secondary level education	Education: Household members have minimally secondary education
Possession: Radio, bicycle, wheel barrow, paraffin stove	Possessions: Small piece of land for a few goats and chickens, or a few crops	Possessions: TV, radio. Some have a refrigerator, CD/video player	Possessions: Vehicle, internet and email, possible, domestic staff

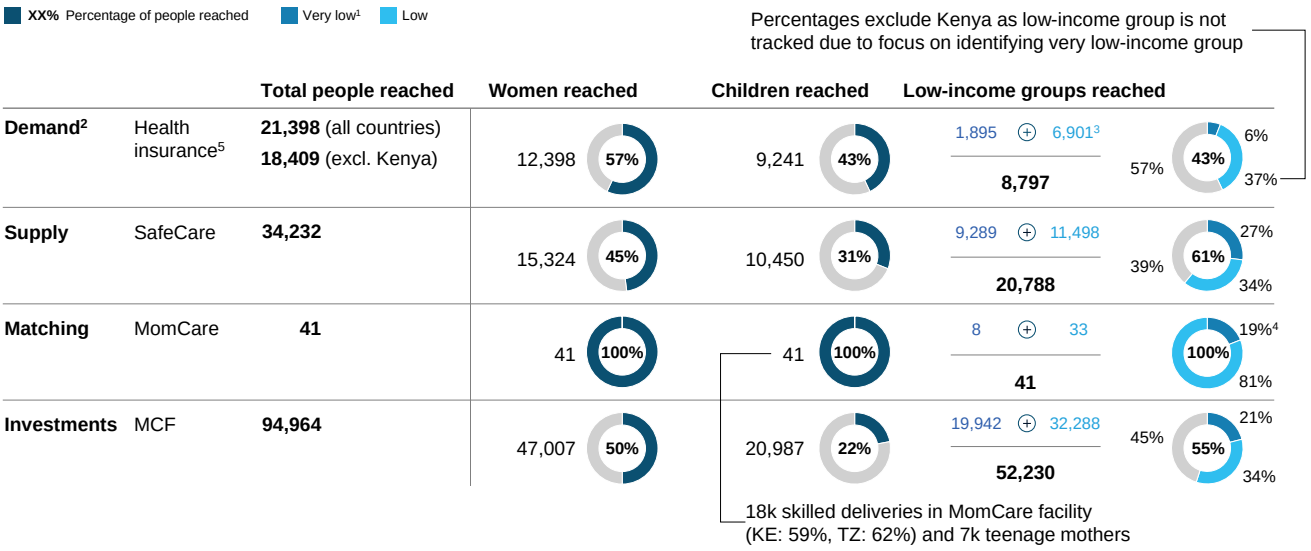
Source: PharmAccess

[34] Data on income groups has been provided by PharmAccess. This was not available for all initiatives and geographical areas and so we could not verify in all cases whether the right definition was applied. Hence, this might lead to a selection bias or respectively an over- or underestimation of the effect

Exhibit 12 - Social impact of initiatives

The social impact of PharmAccess-supported programs is significant despite not being a criterion during 2016-2021

People reached (x1000) in the period 2016-2021



1. For demand and matching: very low-income refers to the international standard for below poverty line of income less than $1.9 per day, for supply and investments there is another clinic-specific definition (see appendix)
2. For demand, the split between very low-income and low-income is not always available
3. For Ghana limited socio-economic data available so categorized indigents as 'very low-income' and informal sector as 'low-income' which implies that the low-income group does not exclusively contain low-income Ghanaians. For Tanzania, the split between very low-income and low-income is not provided by the NiCHF, hence, they are categorized as 'low-income' indicating an underrepresentation of the very low-income group
4. Only known for Kenya (hence 19% only reflects Kenya)
5. For Ghana and Tanzania, due to 2019 data available, the percentages for women/children/low-income groups are extrapolated to 2021 figures

Demand

An often-heard criticism on PharmAccess concerns its work on insurance-schemes. Supposedly the insurance schemes are not effective to provide healthcare coverage for low-income groups. This stems from its initial projects which focused on implementing a private voluntary insurance. Indeed, the lowest incomes do not seem to subscribe to such voluntary system, and private health insurance can limit parity.

However, PharmAccess also learned from these experiences, and has over the last few years turned its focus towards mandatory and state-owned health insurance programs. In Kisumu for instance, it works together with the government for a co-funded mandatory insurance scheme (50% donor, 50% government). Insurance for the lowest incomes is subsidized. In Kwara, it is helping the local government to transition its scheme into a mandatory insurance. All in all, for its efforts in Ghana, Kenya and Nigeria, data analysis shows that of all insurance enrollees on PharmAccess-supported programs, 6% are from very low-income groups and 37% are from the informal sector group (as an estimate for low-income) (Exhibit 12).

While many arguments against PharmAccess' demand-financing insurance schemes are not relevant for its current activities, we cannot completely settle that debate here. Further proof is required to show that indeed the lowest incomes are successfully reached and their access to healthcare sustainably improved. The current numbers do already provide some indications that indeed the lowest incomes are reached:

— In Nigeria, the Kwara State Health Insurance program includes now 88% of indigents (defined as below poverty line - $1.9 per day). The Lagos State Health Scheme (LASHMA) consisted of 50% indigents that received health coverage.

— In Kenya, in the 4 UHC counties (Kirinyaga, Kisumu, Machakos, Nyeri) 27% of the total lives covered were from low-income groups. Since March 2021, Kisumu county in collaboration with PharmAccess launched the Marwa Health Scheme where first the

indigent households were identified using a PharmAccess tool (proxy means testing) in collaboration with the Kenyan Ministry of Health. After identifying these 90k households, the scheme is targeted to provide these indigent households with health insurance schemes subsidized by the county. Currently more than 45k households are already covered with the ambition to further cover all 90k households. The ambition is to include the entire Kisumu County population in this scheme, with free access for the lowest incomes.

— In Ghana, the NHIS is supported by PharmAccess with data support and technical assistance. Of all insurance-covered people, 6% are considered from very low-income groups and 34% are from the informal sector group.

In Tanzania, the same analysis cannot be performed due to the governments running their own national health insurance schemes and hence, data for impact analysis is not directly available.

During interviews, there were contradicting opinions with most PharmAccess partners stressing the fact that low-income groups are being reached while some multilateral organizations were convinced that PharmAccess only reaches the low-to-middle class and not the lowest income groups. However, some of these beliefs were found to be related to PharmAccess' old insurance schemes. A selection of these quotes can be found below. At the same time, quantitative analysis showcases that PharmAccess' demand activities reach ~6% of very low- income group and another ~37% of the low-income group.

"A health insurance theme that is based on the following principle: each to ability, each to its needs"
Government stakeholder

"PharmAccess definitely reaches the lowest income groups. As an example, Kwara is one of the poorest states in Nigeria. The work it did there directly addresses the needs of the poor and showcased that the program could work in any other state."
International organization 1

"I have looked for proof that the insurance schemes work, but have not found it. […] The negative spillover of its voluntary health systems is that you subtract means from the system where it is needed the most"
International organization 2

Supply

The private clinics that PharmAccess targets are usually in the most rural and poor neighborhoods of their countries. These often lack information and quality standards to strengthen their provision of care. Hence, they miss certain hygiene procedures, access to certain healthcare services (e.g., x-ray services or maternity room) and thus also score low on SafeCare assessments. Among private facilities, these are also the facilities that are most likely to receive more low-income beneficiaries. In the period 2016-2021, 9 million very low-income (27%) and 11.5 million low-income (34%) patients have visited a healthcare facility in the SafeCare program. With more than 60% of patients helped being from very low-income to low-income population groups, SafeCare does target healthcare providers that service disadvantaged groups in society.

Matching

For matching, the initiatives that are most relevant due to data availability are MomCare. For MomCare, out of the 41k mothers helped in Kenya and Tanzania, more than 8 thousand live below poverty line (19% with income below $1.9 per day). The other 33k pregnant women (81%) also come from low-income groups. In addition, the MomCare initiative also fully caters to maternal and child health, further increasing the social impact of the initiative. In this light, PharmAccess does undertake initiatives that make lasting impact on low-income, disadvantaged women in (rural) SSA countries.

Other initiatives do not specifically cater to the most deprived groups in society (e.g., Covid Connect, MATS tuberculosis screening tool, NCD model). However, as these diseases are most prevalent amongst low-income groups, it can be expected that there will be a skew towards helping these groups. Towards the future, there is more potential to reach the lowest income groups using the digitally-enabled matching platforms to increase transparency of healthcare services and to reduce transaction costs, so low-income groups are able to leverage more financially accessible and trustworthy healthcare services.

Investments

The Medical Credit Fund has been founded to be able to help mobilize investments into the healthcare sector so healthcare facilities could improve their quality of care, especially in rural areas. These rural areas in Kenya, Nigeria, Ghana, Tanzania and also Liberia and Uganda often also have a high percentage of low-income inhabitants.

Out of the 95 million patient visits (2016-2021) to MCF beneficiary clinics, 55% of the patients come from very low-income to low-income groups.

"To the point that PharmAccess is assisting hospitals, it is assisting the common man. Poorest of the poor will find access to health. Create infrastructure for us, so we give access to the lowest. We serve even other countries."
Healthcare provider

"To guarantee sustainability you need a working business model. If you have that as a focus, it is very difficult to adhere to the policy "leave no one behind". You see that activities are often not focused on the poorest of the poor."
Government stakeholder

Research & Advocacy

PharmAccess and its partners have published a number of articles about effects on the poor, particularly on social protection through risk pooling and avoidance of catastrophic expenditures. As we cannot measure the effect of these activities on reaching low-income groups and health care providers servicing those groups, we refrain from scoring this dimension.

Q7c. To what extent (and how) have innovative financing mechanisms, technological innovations and public-private partnership played a role in reaching the objectives?

Fully effective

Nearly all interviewed stakeholders agreed that innovation is one of the key strengths of PharmAccess. The majority of its activities include highly innovative elements. In exhibit 13, the innovations in financing mechanisms, technology and public-private partnerships are summarized. Below, we summarize to what extend and how these innovations have played a role in the reaching the objectives:

Innovative financing mechanisms

Innovative financing mechanisms are at the core of PharmAccess' activities related to demand and investment. Traditionally, financing in the SSA regions is based on out-of-pocket payments or volatile government budgets. PharmAccess implements financing mechanisms based on pooling and incentivizes quality-improvement and sustainable investment. In that way, its financing innovation contributes to a shift to a trust- and quality-based healthcare system.

Some of PharmAccess' matching activities also incorporate innovative financing mechanisms. Its innovations with value-based payments and the hepatitis C impact bond focus on outcome-based payment.

"All our digital health investments built upon on what PharmAccess built with the digital wallet."
Implementation partner

"I always expect PharmAccess to be on the forefront of innovation"
Government stakeholder

Technological innovations

Almost every PharmAccess activity includes a technological innovation. Many are focused on the mobile phone. The penetration of mobile phones in SSA has grown rapidly and is in 2019 at 77% with 816 mln SIM connections and at 45% with 477 mln unique mobile subscribers.[35] PharmAccess has taken this as opportunity to transform the mobile device into a wallet, register, assessor, health check, monitor and more. All interviewed stakeholder consider these innovations as truly groundbreaking, for which the spin-off CarePay is a key proof.

"PharmAccess has much more impact than the long route that governments take. It is really disruptive with its digital innovations."
Government stakeholder 1

"Without PharmAccess, I would be unaware of the power of digital technology"
Government stakeholder 2

[35] See GSMA (2020). The Mobile Economy Sub-Saharan Africa 2020.

Public-private partnerships

PharmAccess is active in both the public and private sector. A selection of activities also bridges this divide:

- Most demand-related programs bring together public and private healthcare providers; the insurance schemes in Lagos State, Kwara State and iCHF in Tanzania are all public private partnerships
- In Delta State, public primary health centers were revitalized and managed by private organizations
- M-TIBA was developed together with Safaricom
- PharmAccess supported local government in Kenya in cooperating with private testing and vaccination initiatives

PharmAccess also is a strong advocator for public-private cooperation. Many of its activities include some form of public private collaboration, sometimes in explicit partnerships. Some stakeholders indicated that PharmAccess could take an even more prominent role to make long-term connections between the private and public sectors because of its involvement with both.

"PharmAccess has a very significant reach. […] It could try to make a stronger bridge for the private and public. […] A lot of problems are because of a lack of trust between private and public; if PharmAccess could do more to facilitate, taking on more to bring it together, stick out its neck, it could build a bridge"
Government stakeholder

"PharmAccess is able to show private, public and government sector how to collaborate together."
Implementation partner

"PA unique selling point is using unique private partnerships to help the public financing for UHC"
International organization

Exhibit 13

Innovations per initiative

Objective	Activity	Innovative financing mechanisms	Technological/ digital innovations	Public private partnerships & collaborations[1]
Demand	Health Insurance Kisumu	✓	✓	✓
	Kakamega Scheme	✓		✓
	Health Insurance Lagos State (Lashma scheme)	✓		✓
	Health Insurance Kwara	✓	✓	✓
	Health Insurance Adamawa	✓		✓
	Health Insurance Zanzibar	✓	✓	✓
	National iCHF	✓		✓
	National Health Insurance Agency (data analytics)	✓	✓	✓
	Claim-IT		✓	
	I-PUSH	✓	✓	✓
	M-TIBA wallet	✓	✓	✓
	Afya Credit - Health loan	✓	✓	
	Take Care Africa		✓	
	Health remittances	✓	✓	
Supply	**SafeCare quality standards & methodology**	If requirement for MCF investments	✓	✓
	• Tailored quality assurance and capacity building	If requirement for MCF investments		✓
	• SafeCare licensing (SafeCare steps)			
	• SafeCare accreditation			
	• SafeCare self-assessment tools — SafeCare4COVID		✓	✓
			✓	✓
	Quality Platform		✓	✓
	Women360			
Matching	CarePay (exited 2017)	✓	✓	✓
	Value Based Payments • Momcare • NCD model (e.g. Digital outpatient care)	✓	✓	✓
	Connected Diagnostics	✓	✓	✓
	COVID Connect (has transitioned into Digital outpatient Care in Ghana)		✓	
	Hep C Impact Bond	✓		✓
	MATS TB screening		✓	✓
	Samburu/Lamu health system support		✓	✓
	ICHOM MNCH pilot		✓	
	Chain of Trust (CoT)		✓	
Investments	**Medical Credit Fund 1+2**	✓	✓	Delta State project
	Partner loans • Direct (term) loans • Syndicated loans	✓		
	Digital loans (Cash Advance, digital lending pilots)	✓	✓	
	Med4ALL	✓	✓	✓

1. As public private partnerships we define the activities which bring together public and private stakeholders within one initiative; for some initiatives this is in a formal partnership, in other instances the initiative brings these two sectors closer together, such as the SafeCare standard that helps government overview the quality of the private facilities in the country

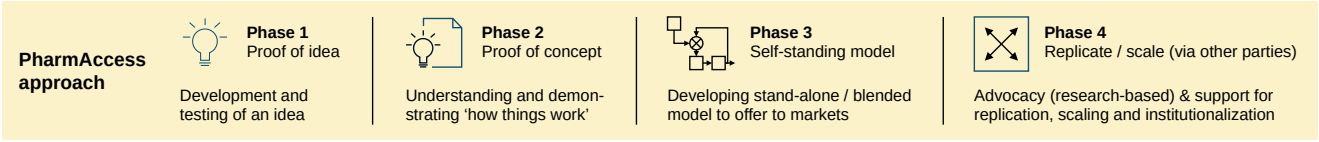
Q7d. To what extent has HIF been able to scale up and/or replicate its innovations?

Moderately coherent

PharmAccess identifies itself as a catalyst for change. It does not strive to be the NGO with the largest reach from its own activities; it wants to change whole systems by showing what is possible and thereby inspiring others. Still, some path to scale is required to realize this ambition. In its ToC, PharmAccess distinguishes four phases within its activities as can be seen in exhibit 14.

Exhibit 14

PharmAccess phasing approach



For each of the five objectives, we evaluate PharmAccess' activities in light of these four phases later in this section. Below, we first share several overall observations on the way PharmAccess has been able to scale up its innovations.

Diversity in pathways to scale

We believe there are four distinct ways in which PharmAccess' initiatives could reach its full impact:

1. Scaling through PharmAccess' own activities
2. Scaling or replication by governments
3. Scaling or replication by other organizations
4. Scaling by spinning off the initiative

PharmAccess has been able to apply a context-sensitive mix of these types of scaling up. In this way, it has achieved the reach that was presented earlier in this chapter. An overview of how this scale was achieved per objective will be provided later in this section.

Interviewed stakeholders especially address the potential of PharmAccess' activities to reach scale because of their digital nature. With economies of scale, it can drive down the price of improved healthcare with its breakthroughs, as has been successfully done with M-TIBA/ CarePay, Cash Advance and SafeCare self-assessments.

Opportunities to scale more effectively

The results in this evaluation are primarily based on the impacts of and stakeholders' experiences with PharmAccess' well-known successes and more mature initiatives. The current pipeline of other projects doesn't yet have a fact base showing impact or potential as convincing as these existing initiatives. We see an opportunity for PharmAccess to further increase and scale its impact in its target regions and, indirectly, in other regions, by leveraging its experience, successes, and partnership with MFA.

PharmAccess has achieved scale beyond the pilot phase for a number of cornerstone interventions. The current pipeline of other projects doesn't yet have a fact base showing impact or potential as convincing as these existing initiatives. We see an opportunity for PharmAccess that could help to scale more effectively:

— Always have scale in mind. We recognize that it will not always be possible at inception which scaling model is most appropriate. However, we believe that there should always be running hypothesis of how to scale, which can be adapted accordingly. Especially because this might require cooperation with specific partners or governments from an early stage.

— Adjust stage-gating based on (potential implementation and/or scaling) partners. Different partners will require different things in order to (help) scale PharmAccess' activities. Whereas a private partner could take an initiative to the next stage after a proof of concept, a government might require a multi-year cocreated and evaluated pilot. PharmAccess can in earlier stages determine which strategy is most appropriate, including a hypothesis of the "take-off moment" in which scaling will be done by partners. Together, a stage-gate process can be set to ensure mutual success.

— Consistently consider opportunity costs. We have heard from many stakeholders how PharmAccess' adjusts its activities to a specific context. Partners appreciate this, but herein also lies a pitfall as its activities are sometimes too context specific. Sometimes, PharmAccess might have to forego an opportunity to help in a specific situation, because in the larger scheme another activity could lead to more scale. A fact-driven way for decision making can help this process.

— Leverage the gravitas of the Dutch Ministry. PharmAccess is known as a "humble hero"; punching above its weight in terms of impact, but sometimes drowned out in the noise of the Anglo-Saxon countries. PharmAccess has an opportunity to increase the clarity and reach of its message. However, many indicate that the ministry could play a larger role. If the international community understand the effect of PharmAccess' activities, a larger scope of impact could be reached.

If this mindset had been applied more consistently, initiatives might not have been started, or might have ended earlier or been scaled more successful.

"What it can do better: to determine per initiative when it lets it go as NGO, and spin it off as social enterprise with which they can cooperate. It is difficult if PharmAccess does not want to let it go."
Implementation partner 1

"I like everything PharmAccess does but there is a huge risk of losing sight of the larger vision"
Implementation partner 2

"We should really start ticking what works and what does not"
Internal stakeholder

"Maybe it should focus on scaling specific solutions. Its sub components are valuable, but "we roll out the entire package" is not how a government works."
International organization

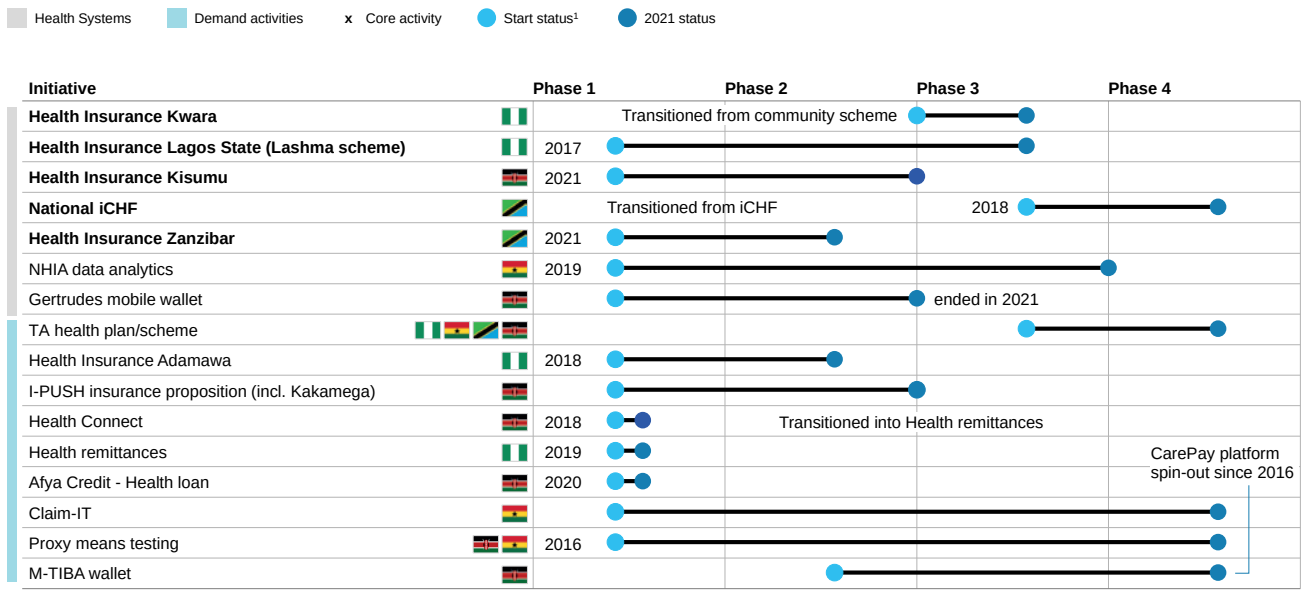
Demand

Demand-related activities are not straightforward to scale. These are very context-specific and require adaption to the specific needs of the local governments and beneficiaries, in addition to coherence with the existing mechanisms.

This context-specificity is reflected phase-overview in exhibit 15: for the different countries and regions within, different activities have been started. Some have reached serious scale such as Claim-IT and M-TIBA (4+ million users), while others have not surpassed the pilot phase. Everything combined, we see a healthy mix of initiatives. This is also represented in the 222% growth in the total number of enrollees from 2016 until 2020, as represented in Exhibit 16.

Exhibit 15 - Phasing of demand initiatives

Shift towards maturity in demand with large part of core initiatives as self standing model or in scaling mode



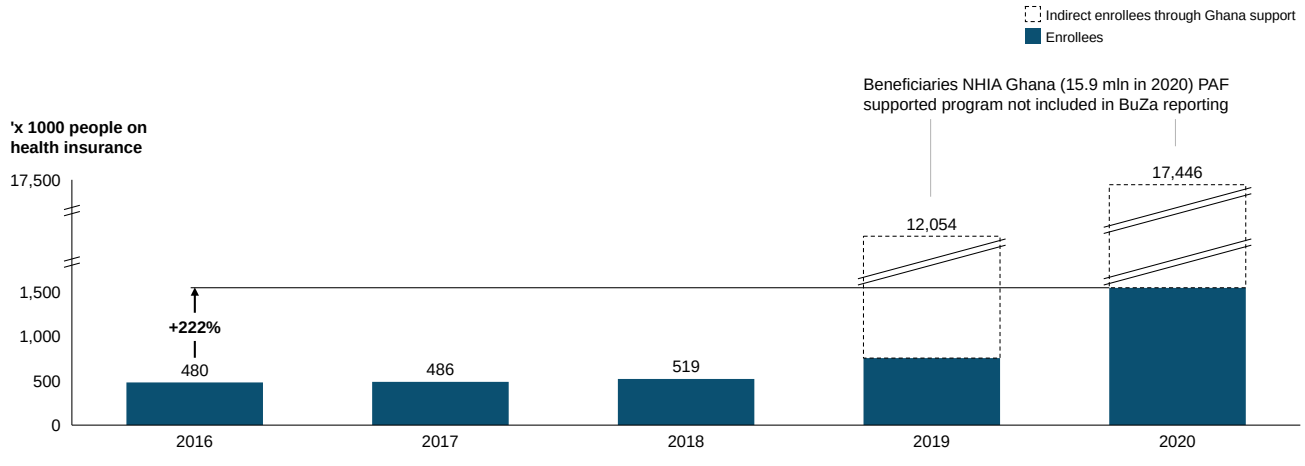
1. If no start date is explicitly mentioned, then the light blue circle indicates the 2016 status

Exhibit 16 - Growth of demand initiatives

Health insurance schemes: Growth 2016-2021

Cumulative number of enrollees in PAF supported programs; x 1,000 people on health insurance

Demand: Develop private pre-payment mechanisms, risk pooling structures, and mobilize resources for organized demand



Source: PharmAccess

Supply

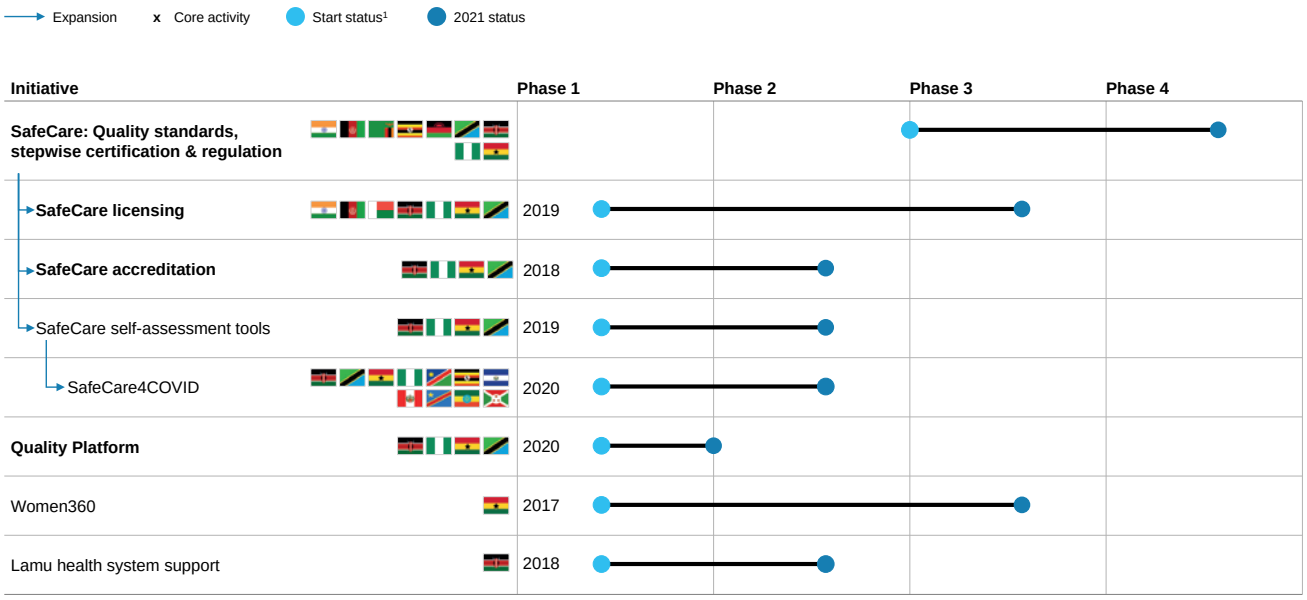
SafeCare is a primary example of an initiative with which PharmAccess has achieved scale largely because on its own efforts (Exhibit 17). More than 4,000 assessments have been performed, reaching over 5 million visitors monthly (Exhibit 18). After achieving substantial scale, PharmAccess has also started to license its SafeCare knowledge through other parties, both private organizations and local governments. As these other parties further increase SafeCare's reach, PharmAccess focuses on further innovating the approach, with self-assessment and digitization.

While most provider organizations are exuberant about the impact SafeCare has on their facilities, some indicate that PharmAccess could provide a clearer scaling model, e.g., to allow organizations to make their own adjustments to the method. Some even argue for an open-source model, which could indeed be a key to further scaling if effectively used.

"For scaling it would help if PharmAccess would have a more clear and transparent model. There is no clear plan for scaling SafeCare, and we miss transparency there. Part of the challenge: we understand that it has the branding for SafeCare and are hosting the database."
Healthcare provider

Exhibit 17 - Phasing of supply initiatives

After successfully building out the SafeCare label, now also expanding on different SafeCare models



1. If no start date is explicitly mentioned, then the light blue circle indicates the 2016 status

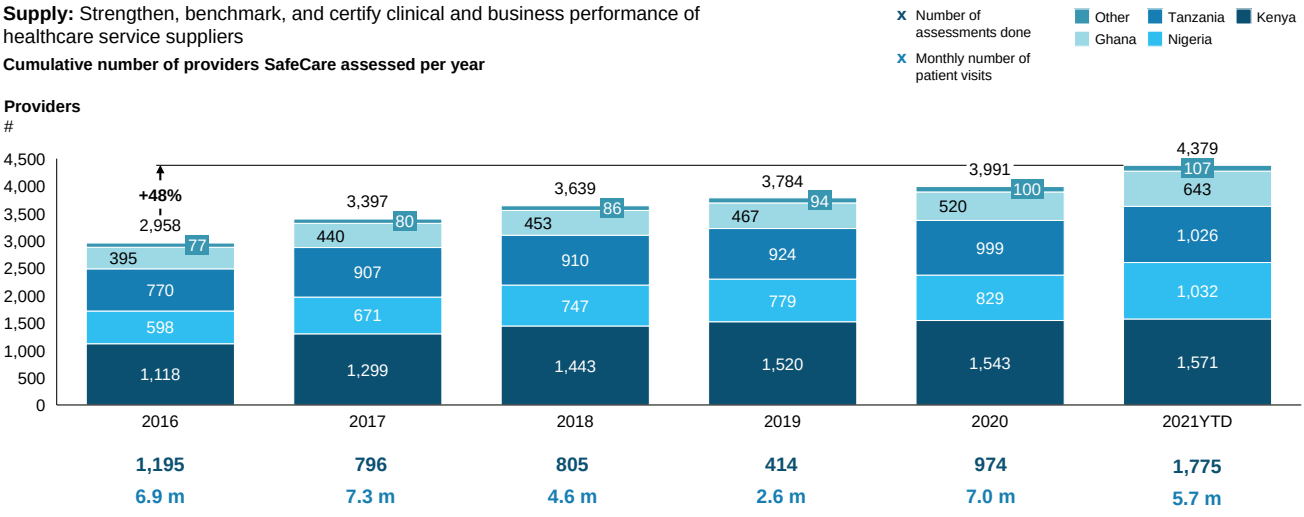
Exhibit 18 - Growth of supply initiatives

SafeCare: Growth 2016-2021

Number of providers in SafeCare program

Supply: Strengthen, benchmark, and certify clinical and business performance of healthcare service suppliers

Cumulative number of providers SafeCare assessed per year



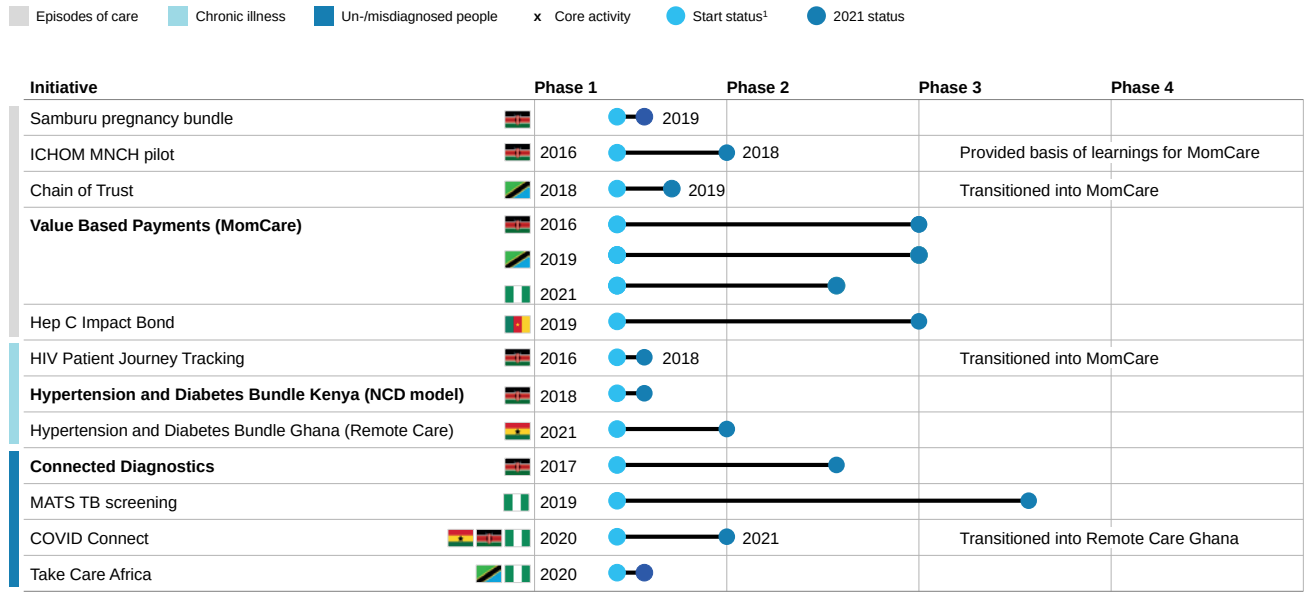
Source: SafeCare Dashboard

Matching

PharmAccess' matching activities are diverse. The majority has been started in 2018 or later and is currently in the proof of concept phase, transitioning to a self-standing model (Exhibit 19). The coming years will be essential for PharmAccess to prove it is able to scale these initiatives. The digital models and collaborations with (private) partners are promising.

Exhibit 19 - Phasing of matching initiatives

Matching activities focused on more value of care for 3 groups with above-average care needs



1. If no start date is explicitly mentioned, then the light blue circle indicates the 2016 status

Not part of this evaluation period is CarePay. The spin-off of this intervention as separate organization is a large success and a good example of scaling. The scoring of the matching activities focuses however on the other initiatives.

"MomCare is getting to a tipping point where with the technology we can scale it quite quickly. This is a strong endorsement that its ability to scale is there."
Implementation partner

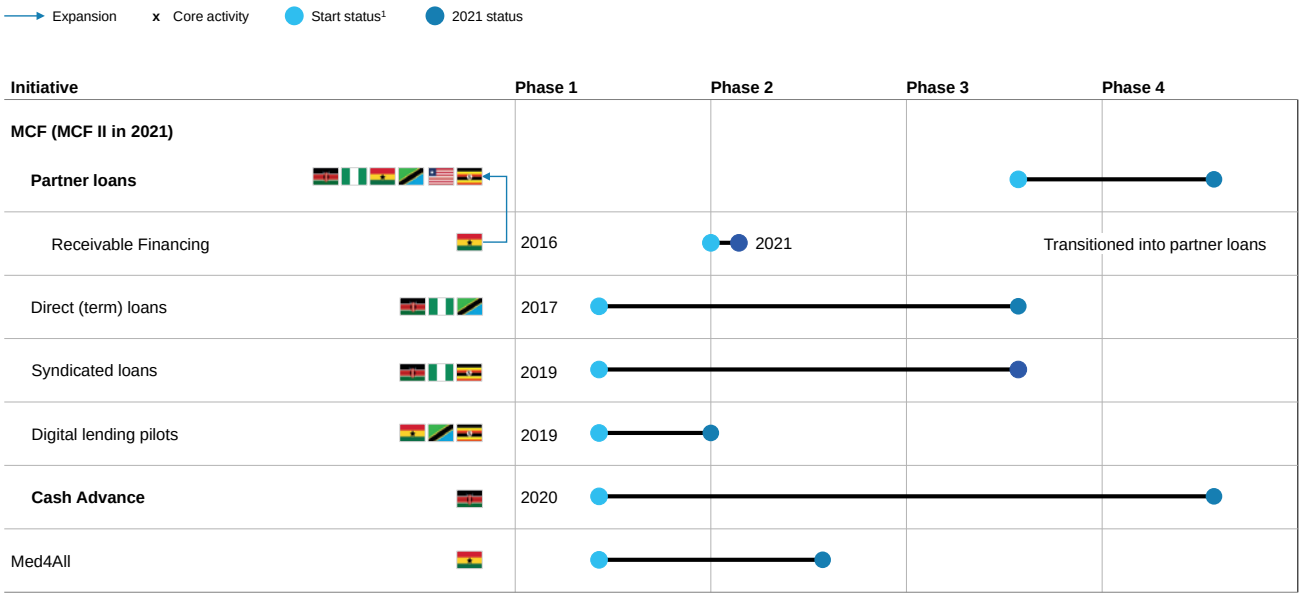
"Scale is only really possible with the digital applications"
International organization

Investments

MCF has been successful in scaling (Exhibit 20). Perhaps not as successful as initially envisioned, as scaling through local banks proved to be harder than expected. However, it speaks to PharmAccess' resilience that it has found models with which it still has been able to realize an increasing volume, as shown in exhibit 21. With MCF2 commencing and MCF inspiring other starting funds, this seems to be an ever expanding positive contribution in a growing number of local healthcare landscapes.

Exhibit 20 - Phasing of investing initiatives

MCF has proved to be a self standing model and is ready for further scaling (MCF2)



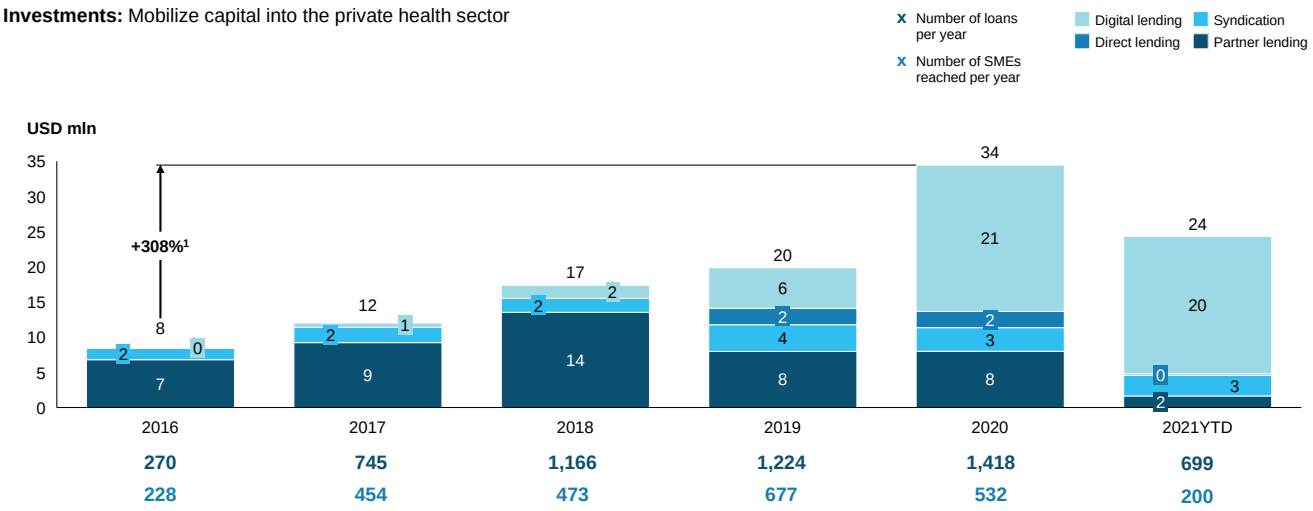
1. If no start date is explicitly mentioned, then the light blue circle indicates the 2016 status

Exhibit 21 - Growth of investing initiatives

Investing: Disbursed volume of MCF has grown with 300+% in the period 2016-2020

Disbursed volume per year; USD mln

Investments: Mobilize capital into the private health sector



1. Based on last available full year

Research & Advocacy Not applicable

Q8. How has HIF responded to changing contexts in general – e.g., political change, technological progress, emerging partnerships, as well as to specific changes like Covid-19?

Fully effective

The context of which PharmAccess' activities is one of continuous change. In 2016-2021 there was economic growth, often multiple election cycles, further technological process. Then, Covid-19 struck and impacted everything.

If there is one thing that stands out from the interviews of stakeholders over this period, it is the adaptability of PharmAccess. Its approach is not set in stone, which allows it to adapt and respond where most urgent. We recognize MFA's "program funding" an important enabler for PharmAccess' agility.

We distinguish two elements of a response to changing contexts: robustness and resilience. Below, we discuss PharmAccess' activities in light of these elements.

Robustness: To which extend can PharmAccess' activities be successful independent of changes in context?

Two of PharmAccess' activities have proven to be successful in a high variation of settings: SafeCare, used in seven countries and MCF, used in six countries. The other initiatives require more customization for the specific context, which makes complete robustness unrealistic; demand-related activities for instance require cooperation with governments and other parties and are thus dependent on the willingness of the incumbent.

To mitigate the impact of contextual changes, PharmAccess has built very successful long-term cocreation programs such as Kwara. It has often been able to deliver over multiple election cycles. Still, there have been some setbacks due to political changes. For example, in Tanzania the planned national roll-out of SafeCare was reconsidered by the new government because they implemented their own label, and iCHF was adjusted by the government without the help of PharmAccess, resulting in suboptimal outcomes. In these instances, we believe there is an opportunity for more advocacy with governments to collectively build robust impact.

Resilience: To what extend is HIF able to adapt its activities based on changes in context to remain successful, and potentially deploy new activities based on these changes?

For the "core activities", PharmAccess has shown a high ability to adapt to changes in context. For instance: After the government adjustment of National iCHF, PharmAccess was able to adjust its focus to the Zanzibar region, where it has been able to scale SafeCare together with the government.

The most striking case in point to the resilience of PharmAccess is how swift, effective and context-sensitive it responded to the Covid-19 pandemic. Many of its core activities were adjusted to keep or enhanced its value within the new context, e.g.,

— SafeCare was extended with a mobile SafeCare4Covid assessment, to assess the readiness for Covid-19

— Covid-Connect was launched, a digital app and service to enable individuals to assess their risks for Covid-19 and provides home monitoring and support from remote medical staff

— Covid-Dx was launched, a project that uses Connected Diagnostics to build a replicable public-private partnership model for addressing Covid-19. Covid-Dx was subsequently adopted by Kisumu DoH as its County-wide Covid-intelligence dashboard.

— Workshops and training on both academic understanding of the virus, and practical ways to handle it locally

In addition to concrete activities, the local teams acted as advisors to the local governments. Many of the interviewed public stakeholders commended the teams and country managers for the way it brought in the most relevant knowledge on Covid-19 and advised concrete ways to mitigate its impact. Also bespoke solutions were developed, such as to help government set up private-owned testing facilities in Kenya.

These activities have also enhanced PharmAccess' visibility for (public) stakeholders. In our interviews, some even mentioned this response as the primary example of PharmAccess' success. This exposure can be an asset of PharmAccess going forward.

Below, we will focus on the response to Covid-19 for each of the objectives to highlight PharmAccess' adaptability.

"If initiatives fail, PharmAccess adapts them to make them work"
Implementation partner

"PharmAccess is very agile and nimble compared to other organizations"
Government stakeholder

Demand

While the demand financing insurance schemes have been an important backbone of PharmAccess quickly after its inception, these schemes have seen many changes. Its schemes have seen failures and successes, and it is able to learn from this, most recently focusing more on mandatory insurance than voluntary schemes. It speaks to PharmAccess' resilience that it keeps looking for new opportunities to systematically strengthen healthcare systems, whether that is in new regions, with new collaborations or with new types of programs.

Supply

For local healthcare providers, SafeCare has played an important role in mitigating the wider spreading of Covid-19. It has swiftly provided providers and communities with desinfection gel, face masks, (rapid) diagnostic tests, protective clothing, virus transport media and data entry tablets. Moreover, SafeCare quickly launched the SafeCare4Covid self-assessment tool for preparedness on Covid-19-prevention, which has been used by more than 600 facilities.

"PharmAccess was very handy. It came to our facility to provide protocols how to handle Covid-19. One came to check the washing units, whether they were in the right place and with materials to sensitize communities."
Healthcare provider

Matching

Together with a.o. Achmea, PharmAccess launched the CovidConnect app in March 2020, a digital app and service that enables individuals to assess their risks for Covid-19 and provides home monitoring and support from remote medical staff. It was rolled out in Ghana, Nigeria, and Kenya. As was already mentioned, also Covid-Dx was launched in Kenya, using Connected Diagnostics to increase testing capacity of local facilities and linking these to public efforts.

PharmAccess further showed it resourcefulness by later transforming the CovidConnect app into a self-monitoring app for hypertension and diabetes.

"PharmAccess was the only one that directly proposed to do a project around Covid-19, with monitoring and handouts for providers, to help the local government with implementing a method to mitigate and use the app of Lucii"
Implementation partner

"PharmAccess has a very high adaptability. It was able to turn the Corona app into an app for hypertension and diabetes for very low costs"
Government stakeholder

Investments

The MCF has proven to be highly resilient during the Covid-19-pandemic. Not only was it in many contexts the only fund that kept providing loans in the initial phase, it also adjusted its range to provide more mobile direct cash advances, to be able to directly assist the most vulnerable providers.

In its evaluation, SEO Amsterdam Economics (2021c) has not been able to prove a significant effect on performance of the served providers yet. However, we deem it likely that MCF's loans will prove to sustain many providers throughout the challenging period of Covid-19 that is still ongoing in 2021, and provide them with a chance to rebuild after the pandemic.

"The technical assistance program got a focus on Covid-19, facilities were able to apply and get funding quite quickly. MCF was one of the key benefactors to the countries from fund perspective. It was very effective of putting together technical assistance providers. It could see the effects early on and was key."
Implementation partner 1

"PharmAccess was critical, because when most investors were pulling out from Africa during Covid-19, MCF was the only party lending into Covid-19"
Implementation partner 2

Research & Advocacy

PharmAccess has proven to be highly adaptable in its research and advocacy:

In its research, it has directly started or commissioned a multitude of studies on the effects of the pandemic and translated this to the implications for worldwide health care policies. We have counted more than 40 Covid-19 related webinars and more than 10 Covid-19 related media expressions (publications, reports, new papers articles).

In terms of advocacy, many public stakeholders indicate that the PharmAccess' teams were more visible than ever, providing expert insight into the national situation and supporting with critical interventions for both providers and the government itself, such as Covid-19 call centers in Kisumu.

"The embassy had very regularly contact with PharmAccess during Covid-19. It told us about the situation in the country and were very close to the experts, this was very helpful."
"It has a good ownership together with the Ghana government, specifically for Covid-19"
Government stakeholder

Ghana, 2017, patient and nurse at a maternity clinic

5. Other observations

As requested by the ToR, the evaluation has focused on three criteria: Relevance, Coherence and Effectiveness. These are part of the set of evaluation criteria formulated by the OECD DAC Network on Development Evaluation (OECD, 2019). This set also contains three other potential evaluation criteria: Efficiency, Impact and Sustainability. We believe that these other three criteria are helpful to add additional perspectives on the main research question. Hence, we have addressed these elements during the evaluation of PharmAccess' activities. The level of depth is lower than for the other criteria and therefore we limit ourselves here to providing high-level observations.

Efficiency - how well resources being used?

PharmAccess does not keep a complete register of all resources being used for each of its objectives. Therefore, it is not possible to investigate the efficiency of resources on a detailed level. Based on the available data of HIF budget, we below provide a number of high-level observations based on the development of the expenditure for three PharmAccess core activities in the timeframe 2016-2021. Please note that this analysis disregards funding from other sources on these objectives.

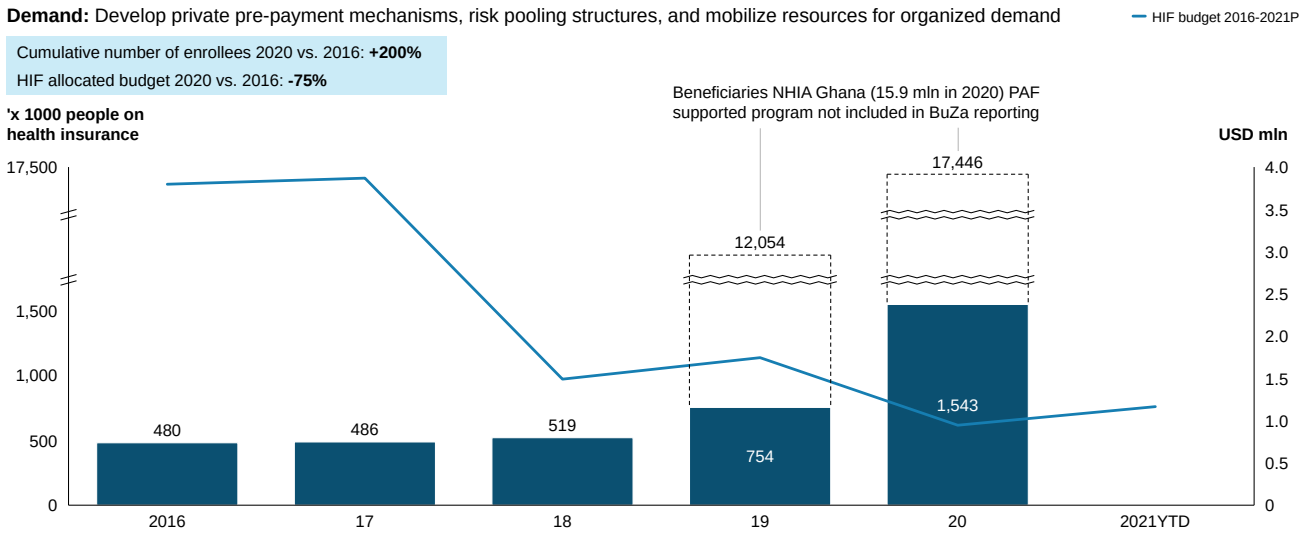
Observations on evolution of reach vs costs

For demand-financing insurance schemes, we see that the number of enrollees has grown with 200+%, while PharmAccess' expenditures on this dimension have decreased with 75% (Exhibit 22). This is an important development, as it implies that with less financial HIF resources more people can be reached. If this evolution can be continued, the feasibility of further scaling increases as well as leading up to a more independent, self-financed healthcare sector in Africa.

Exhibit 22 - Allocated HIF-budget and reach for demand objective

Demand: Enrollee growth of 200+% has been realized in 2016-2020 with 75% lower HIF allocated budget

Cumulative number of enrollees in PAF supported programs (x 1,000 people on health insurance versus HIF budget allocation to demand objective



Source: PharmAccess

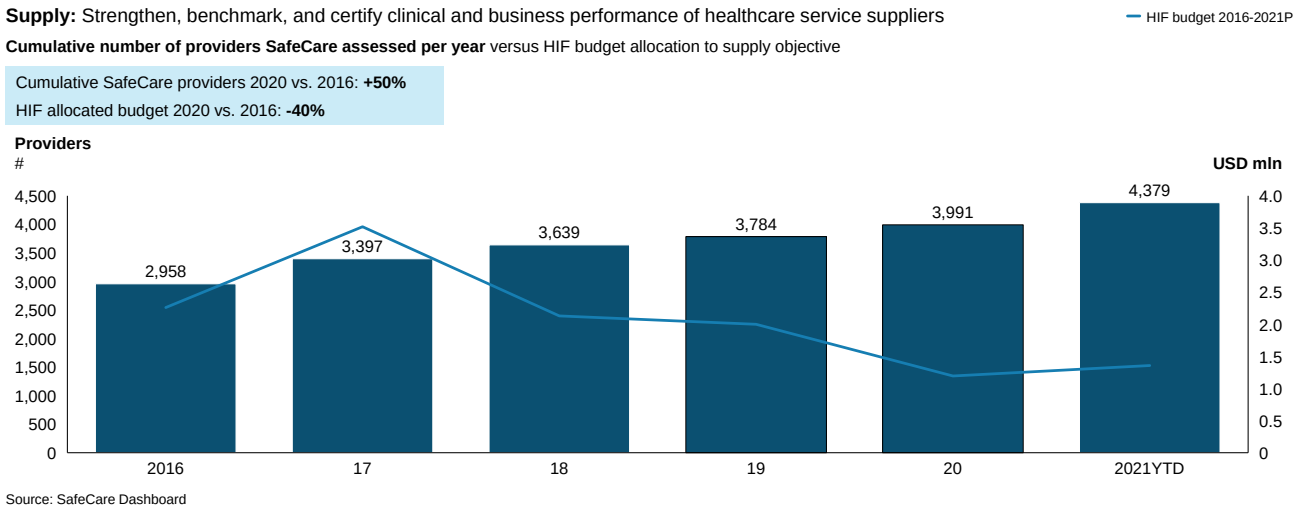
SafeCare was initially scaled by PharmAccess' own efforts. More recently, scaling is mostly done through private and public partners, and licensing models are developed, resulting in 50% more enrolled healthcare providers. This can be seen in a steady decline of the costs over the recent years by 40% (Exhibit 23). By further leveraging digital tools, a further decrease of cost per provider can enable an even larger set of governments or providers to incorporate SafeCare quality improvements.

MCF's total volume has grown: the total disbursed amount went up with 300+% in the period 2016-2020. In the same period, PharmAccess' costs have grown by 78%. This can be explained by continuous innovation efforts at MCF's side, resulting in MCF2 launched in 2021 (Exhibit 24). The 2020 costs contain a one-off effect caused by the bankruptcy of two partner banks in 2019. Bringing down the costs over time can help create a positive business case incorporating even more facilities.

Exhibit 23 - Allocated HIF-budget and reach for supply objective

Supply: SafeCare provider growth of 50% has been realized in 2016-2021P with 40% lower HIF allocated budget

Cumulative number of providers in SafeCare program versus HIF budget allocation to supply objective

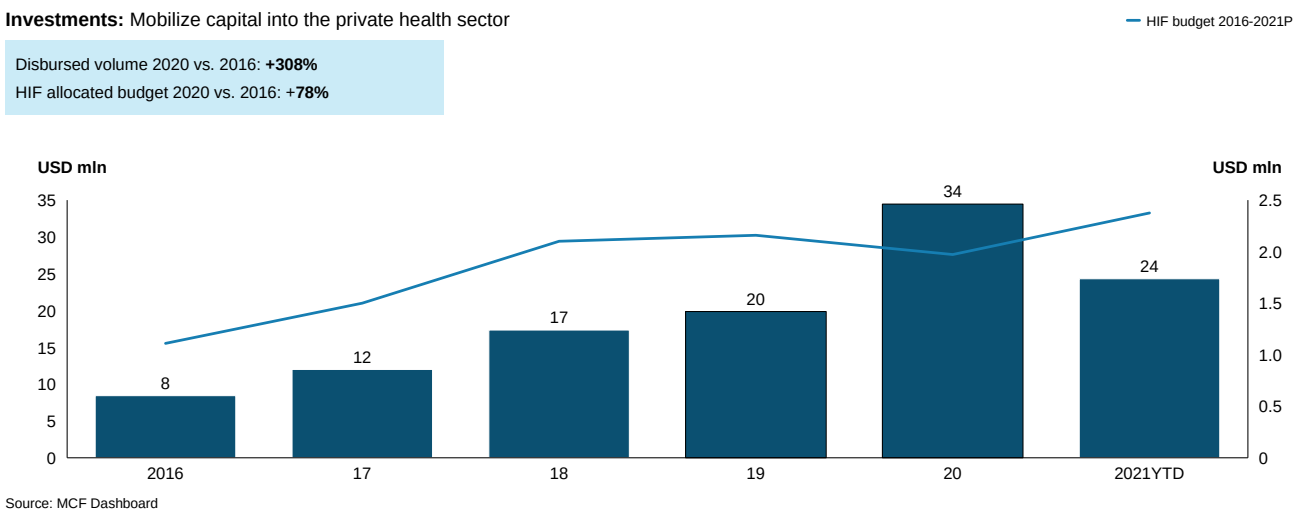


Source: SafeCare Dashboard

Exhibit 24 - Allocated HIF-budget and reach for investing objective

MCF: MCF disbursement growth of 308% has been realized in 2020 vs. 2020 with 78% higher HIF allocated budget

Disbursed volume per year; USD mln versus HIF budget allocation to investments objective



Source: MCF Dashboard

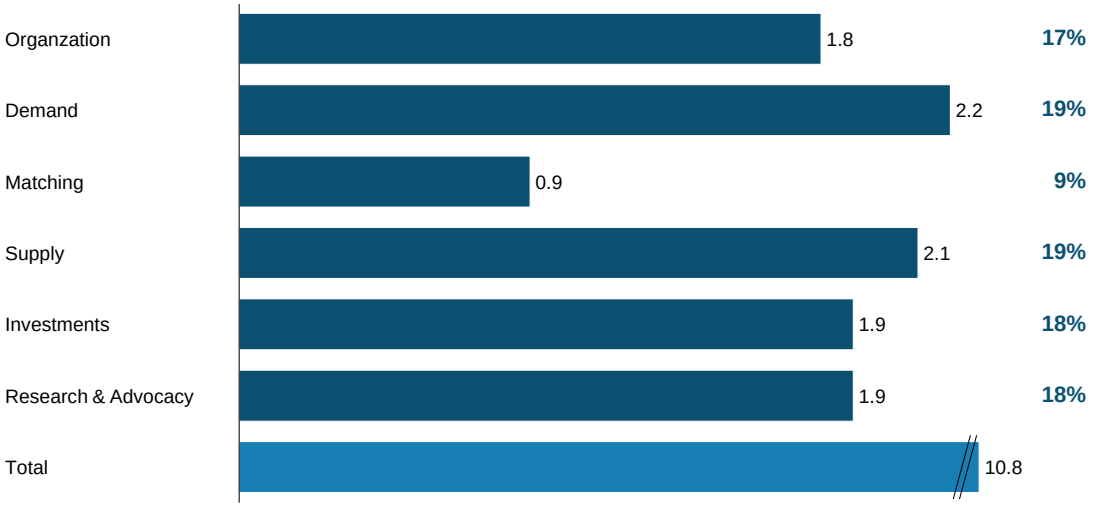
Overall observations

The organizational costs of PharmAccess amount to an average of 17% (EUR ~1,8M) of total expenditure (Exhibit 25). PharmAccess' spends 18% of its budget (~EUR 1,9M) on research and advocacy, of which about two-thirds on advocacy. This is a relatively modest amount if we put this in perspective of the essential role that collaboration and partnerships have in increasing PharmAccess' impact. As described in the chapter on Effectiveness, cooperation with local governments and partners is a key requirement for success on a larger scale. Therefore, a higher investment or at least higher level of attention to in advocacy and partnering could be a larger "lever" to more impact than investments in individual interventions (i.e. resulting in a higher level of efficiency).

The total HIF budget is EUR ~10 mln per year, complemented by EUR 10-15 mln of other donors. We recommend a closer monitoring of the expenditure per activity because the difference between scaled-up activities and innovations are significant. Current cumulative HIF-leverage is reported by PharmAccess to be 4.4x. PharmAccess leverage per initiative (own funding versus third party funding) would be an interesting metric to show how PharmAccess creates opportunities to attract more financing. This enables backward-looking to understand faster which activities might be relatively expensive for its impact, and forward-looking to help stage-gating and faster decision making.

Exhibit 25 - Allocation of HIF-budget to the different objectives
Average expenditure 2016-2020

EUR million



Impact - what difference does the intervention make?

Sustainable Development Goals Impact

OECD formulates impact as to "identify the social, environmental and economic effects of the intervention that are longer term or broader in scope than those already captured under the effectiveness criterion".

The chapter on Effectiveness already addressed the effects of PharmAccess' activities for various stakeholders. We concluded that most activities were able to effectively contribute to PharmAccess' objectives.

In this section we discuss observations concerning the impact of PharmAccess on the Sustainable Development Goals that it has encompassed in its ToC.

SDG1 No Poverty: PharmAccess' activities are able to reach a portion of the indigent population as was shown in the chapter of effectiveness. Good health is a foundation on which to build — a life, a community, an economy. Thereby an indirect impact is made to reduce poverty.

SDG3 Good health and well-being: PharmAccess' activities directly contribute to SDG objectives such as reducing maternal deaths and fighting communicable diseases. In addition, the insurance schemes decrease the proportion of population who direct a large share of household expenditure towards health. However, stakeholders describe some skepticism regarding the extent to which activities also contribute to the overall goal of universal health coverage; as private sector activities may especially reach lower-middle income in relatively developed countries, "leave no one behind" might not always be realized. Additional data gathering or research could help PharmAccess to convince others of its contribution.

"Its assumption is that the private sector can fill a gap in inequalities. The question is whether PharmAccess can show this. If it reaches two million people, is that really a systematic contribution to SDG3, this is currently not measured"
Health organization

SDG5 Gender equality: It is unclear how PharmAccess' activities contribute to gender equality, aside from an overall contribution to the health of a population. In its ToC it argues that it contributes to equal rights to financial services and promote empowerment of women through technology. There might be an indirect effect through the autonomy that access through the mobile phone can provide, but an argument for a larger effect is not made within its ToC. Creating the analysis to underpin this argument of use of PharmAccess tool by different gender groups might be a topic for future research.

SDG8 Decent work and economic growth: All PharmAccess activities can have some impact on work and economic growth within its respective regions, as these promote a functioning (private) healthcare sector. However, only for Demand-related initiatives a significant effect has as (of yet) been found. SEO Amsterdam Economics (2021b) developed an input-output model for the demand-related activities for the KCHIS program in Kwara, Nigeria. This estimated a significant macro-economic leverage effect of the activities, implying a significant contribution to this SDG.

"The average annual investment into the KCHIP – consisting of the subsidized premia and the facility upgrades – was 491 million naira (USD 3.19 million) during 2007-2016. This investment into the healthcare sector has brought about an average annual production increase of 1552 million Naira (USD 8.73 million) supporting 690 jobs. In terms of economic multipliers, the production multiplier of the programme is 2.47 (1.20 for the health sector alone and 1.27 for the linked sectors). This means that each dollar spent by the programme generated an estimated 2.47 dollar in increase domestic production of goods and services."
SEO Amsterdam Economics (2021b)

SDG9 Industry, innovation and infrastructure: PharmAccess' investment-activities contribute directly to this SDG (predominantly MCF). It does this by increasing access to financial services; CDC (2020) found that 67% of the studied MCF-supported clinics reported no sources of finance other than MCF.[36] On average MCF funding made up more than 80 per cent of their total financing. Additionally, an overall contribution to innovation is made as many PharmAccess' activities incorporate innovations, as described in section Q7c.

SDG10 Reduced inequalities: Some of PharmAccess' activities have made an indirect contribution to reducing inequalities. Registering the indigent population in Kisumu can for instance help realize more inclusive policies and execution. However, PharmAccess' ToC does not show how it contributes to wider universal social, economic and political inclusion, nor do the available data.

SDG17 Partnerships for the goals: PharmAccess makes a significant contribution to this goal, by partnering up with local financial organizations and governments as well as bringing together private and public organizations into formal and informal public-private partnerships. Interviewed stakeholders indicate this contribution could be enhanced by enabling more knowledge exchange between the different regions and countries.

"PharmAccess has a footprint in other countries – it could facilitate some kind of network between those that are working with it. It is in a unique position to facilitate peer-to-peer learning in Sub-Saharan Africa."
Government stakeholder

[36] CDC Investment Works. (2020). What is the impact of improved access to finance for healthcare facilities in Kenya?

Capturing full impact

Besides direct impact of PharmAccess initiatives, we observe impact by inspiration and advocacy. In order to acknowledge all PharmAccess' impact on healthcare in target countries (and beyond), introducing an impact measurement framework with three levels can be considered:

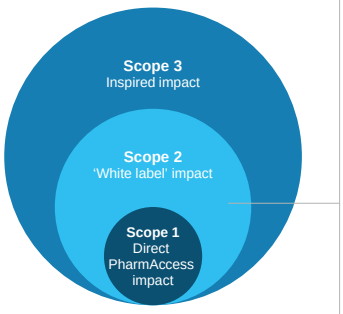
1. PharmAccess's direct impact;
2. White label impact: impact generated through support or co-development by PharmAccess;
3. Inspired impact: impact through PharmAccess' role in catalyzing a paradigm shift, e.g., other parties mimicking PharmAccess or following in its footsteps.

Exhibits 26 and 27 provide an overview of the impact of PharmAccess beyond the core scope of its activities – this is known to a limited extent but is important to remain relevant.

Exhibit 26 - Scope 2 impact

PharmAccess creates further impact

Overview of White Label Impact since inception of PharmAccess[1]



Scope 2: White Label Impact
Impact generated through supporting or co-developing initiatives outside of PharmAccess' direct scope

Demand
- Supported Kwara, Adamawa and Lagos State (Nigeria) and Kisumu (Kenya) in formulating health laws, including support for the parliamentary committees and other relevant players including governor, health commissioner (Health insurance laws in Kenya & Nigeria)
- Based on the NCU Health Plan (developed Apr 2011 for 4 districts in Kilimanjaro region), PharmAccess was requested to support the local government with regional iCHF development in Oct 2014; subsequently adopted to national Tanzanian health insurance in Sept 2018 (NiCHF)

Supply
- Nationwide quality rating system and tools based on safecare methodology (NHIS Nigeria) and helped build the eHEFAMAA electronic portal to facilitate licensing and monitoring of health providers in Lagos State (HEFAMAA)
- Adapted and adopted the SafeCare standards and methodology, and help build the national Afghanistan Accreditation Agency ANHAO (AFIAT program, Afghanistan)
- Adapted and adopted SafeCare approach (Doctors for Madagaskar quality improvement for Madagaskar)
- Adapted and adopted the SafeCare standards and methodology (Zanzibar MoH)
- Supported in building licensing system for healthcare facilities in Kenya (Joint Health Inspection Checklist)
- Supported Kenya Quality Model for Health to help build a national framework for quality for Kenya with recognition for SafeCare approach (KQMH)

Matching
- Spin-off CarePay

Investment
- Set up Investment Fund for Health in Africa, a private equity fund to increase investment (IFHA)
- Banks have taken over financing of some of MCF customers, which means MCF has increased the credit-readiness of clients (Refinancing by Sidian, Equity and Coop Bank in Kenya and IFC financed one MCF customer in Ghana for expansion)

Research & Advocacy
- Established the Joep Lange Institute was to promote the digital health agenda (JLI)
- Involved in policy development and implementation that led to the establishment of the Health Facilities Regulatory Agency Ghana (HEFRA Ghana)

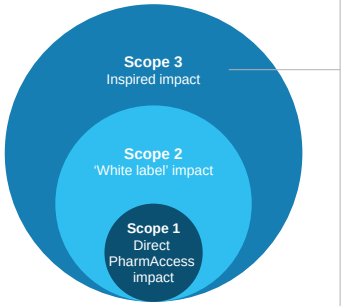
Other
- Facilitated the service availability mapping (census) of community pharmacies and PPMVs in 2 states and through other consortia which has now been replicated in 20 Nigerian States (Pharmacy Council Nigeria)
- Continued support to the strengthening of private sector organizations (private health care federations in Ghana, Nigeria and East Africa)
- Helped Delta State implement the Access to Finance Initiative, where nonfunctional public primary care centers in rural areas of Delta State are refurbished, managed and operated by private health care providers through a unique PPP with MCF providing loans for refurbishment (Delta State Nigeria)
- Data modeling and integration of NHIA's and National Identification Authority's data system for informed decision making on insurance operations and better enrollment (NHIA Ghana)

1. This impact goes beyond the evaluation for the period 2016-2021 specifically, as some of the white label impact examples have required multiple years to take effect

Exhibit 27 - Scope 3 impact

PharmAccess aims to catalyze impact through a paradigm shift and by inspiring others

Overview of Inspired Impact since inception of PharmAccess[1]



Scope 3: Inspired Impact
Impact that might be catalyzed by the paradigm shift caused by PharmAccess but not directly attributable

Demand
- Health insurance policy in 33 Nigerian States: Kwara program provided a proof of concept which led to the NHIS passing policies that facilitated the implementation of State Health Insurance Scheme, subsequently this has led 33 out of 36 States passing a legislation for the implementation of mandatory health insurance schemes

Supply
- Self-Regulatory Quality Improvement System (SQIS) in Uganda: Uganda MoH's now-mandatory SQIS inspired by SafeCare approach
- Big Results Now in Tanzania: Using the experience of the SafeCare standards and methodology to inspire the development of a quality program within Big Results Now Tanzania
- Quality methodology in India: Use SafeCare learnings to improve Manyata quality methodology

Matching
- Transformational potential of digital and mobile (money) for health sector: While there has been slow traction in leveraging the transformational nature of the digital revolution in the development community, PharmAccess has early on advocated the leapfrogging opportunities that digital transformation brings to development including efficiency and transparency

Investments
- Rise of blended funds: MCF has resulted in interest and developments in blended funds and seen as exemplary (Rise of blended funds)
- Private equity & debt funds: Increasing interest in investing in private entities in the health sector since MCF/IFHA have been founded and which has further been strengthened by the COVID pandemic
- Increased interest of banks in financing healthcare businesses: NMB in Tanzania, Polaris Bank in Nigeria, Equity Bank in Kenya with the latter even running their own clinics

Other
- Adoption private sector in health development programming & public policies: While collaboration with the private sector was frowned upon in 2006 when PharmAccess started, PharmAccess has contributed to a growing body of evidence suggesting that the private sector serves a large proportion of the poor; the trickling down of funding to automatically arrive in facilities is a flawed concept and the private sector is largely ignored by policy- and decision makers on all levels
- Adoption of government driven social health insurance schemes protecting the poor: When we started in 2006 with public private health insurance in Nigeria there was virtually no social insurance in SSA and very limited political will. Currently financial protection from catastrophic health care expenditure (social health insurance) has become one of the key topics in the debate around Universal Health Coverage around SSA

1. This impact goes beyond the evaluation for the period 2016-2021 specifically, as some of the white label impact examples have required multiple years to take effect

Sustainability - will the benefits last?

Creating sustainable solutions in healthcare is not easy: economic and social circumstances change, governments change, there can be conflicting commercial incentives, and many solutions require the support of specific capabilities.

Most PharmAccess activities include some type of capacity building and technical assistance, both on provider and government level: providers create internal SafeCare improvement teams, government administration systems are improved for demand-related schemes, and providers systems can be coupled with M-TIBA. This promotes sustainability. Additionally, PharmAccess' own adaptability as described in the effectiveness chapter will be important going forward.

Thus, PharmAccess has brought some of the critical enablers in place. Now, the next steps in its scaling approach will show whether it is able to create sustainability: can governments successfully sustain the insurance schemes; will SafeCare also motivate change when assessors are trained by various new partners, and will the data-driven changes in care pathways through MomCare last?

Increased advocacy additionally can help sustain the impact of PharmAccess activities. The more PharmAccess can prove that its methodology is better than others, the harder it will be to get replaced.

6. Conclusion

Based on the answers to the eight ToR sub-questions a conclusion and answer to main research question emerges: To what extent has HIF progressed towards making inclusive health markets work?

PharmAccess' activities are considered innovative and groundbreaking: from adopting digital solutions to applying holistic system thinking and enabling the private market to improve health care systems in SSA. PharmAccess seeks to realize change by taking deliberate risks, advocating and implementing initiatives tailored to a complex and continuously changing local context characterized by a fast-growing population, quickly increasing levels of diseases, limited funding and governments of varying qualities. Interventions are executed across five cohesive objectives – demand, supply, matching, investing and research & advocacy. PharmAccess' essential claim is that these interventions collectively improve healthcare on a system-level; the whole of these activities is greater than the sum of its parts.

Its efforts have resulted in a number of well-known successes within the framework it proposes, in particular SafeCare, MCF and spin-off CarePay. More importantly, it has challenged the status quo and catalyzed change. Examples of change include the introduction of loans/ investments into SSA healthcare (combined with advisory services); establishment of quality standards to improve rather than approve/close a facility; embedding digital to connect healthcare parties and "leapfrog" healthcare systems to a next level. Interventions across the objectives are relevant for local stakeholders (government, healthcare providers and patients) and, to a certain extent, the MFA.

The results in this evaluation are primarily based on the impacts of and stakeholders' experiences with the aforementioned well-known successes. The current pipeline of other projects doesn't yet have a fact base showing impact or potential as convincing as these existing initiatives.

In addition, the evidence of impact is often scattered or not available in structured format. It is a challenge to investigate beyond the anecdotal positive feedback that is available.

From our analysis, we tend to confirm that PharmAccess's approach realizes its ambition about inclusivity. It reaches the very low income groups particularly through quality (9 mln very low income beneficiaries, 27% of total beneficiaries) and investment interventions (20 mln beneficiaries, 21%).[37]

For implementation, PharmAccess uses an approach based on long-term relationships with (local) governments and health organizations in SSA. Local stakeholders are supported across different dimensions based on its approach involving both the public and private sector. This approach is much appreciated by local stakeholders and has proven to be an effective way to embed in existing systems. PharmAccess is commended for listening to local needs and for seeking to work together as a partner on a solution, instead of "pushing" its own agenda as other international aid has been described. This approach results in a high level of coherence with local initiatives, but also with initiatives of other Dutch or international partners.

To bring target countries to a next level, a systematic view per country could be the North Star; envisioning how each intervention would contribute to an inclusive health market. However, this view or a plan on involvement of implementation stakeholders is not available. PharmAcccess should develop a view on how far each intervention should be developed before it can be handed over to or replicated by another partner, in order avoid too many small-scale and scattered initiatives. The challenging local context makes it hard to plan these elements. However, we believe that a more focused way of working – one that shows how its holistic approach works in a community – would be extremely effective in revealing the real impact of its work. A more structured approach with has scale in mind, even

[37] Refer to definitions provided in Exhibit 11

in early phases of initiative development, a process funnel with clear Go / No-go criteria, and early involvement of scaling partners could help PharmAccess to achieve this focus.

We understand that potential future collaboration with MFA might involve other departments with different focus areas, and this in turn may result in a need for more collaboration with scaling partners, such as MLOs, national governments and local implementation partners. In such a situation PharmAccess would benefit from gathering more data about how its activities lead to inclusive health markets at a larger scale. This data would help PharmAccess to prove its beliefs are supported by evidence, convince critics and MLOs about its way of working, and refute possible side effects (e.g., that a private-sector approach excludes the poorest people). Its impact on inclusiveness (e.g., how many women and children are reached, its impact on poorest people) can then be structurally reported. If it manages to achieve this, PharmAccess will be better able to leverage large scaling partners and so achieve a much larger impact of its initiatives.

7. Recommendations

This evaluation proposes six recommendations to further improve the impact of PharmAccess. The first three relate to PharmAccess' strategy, while the latter three touch on the way it operates:

1. Decide on strategic role
To optimize its impact as a small player in a crowded field, PharmAccess could decide which strategic role it wants to play and the maturity level it aspires to support. Potential roles could be:

— Incubator of innovations: Deliver a proof-of-concept and provide a first, informed estimation of potential impact and effectiveness of an innovation. Hand this proof-of-concept over to another party for further development and scaling. PharmAccess can remain involved as advisor. As the innovation has not yet proved to be successful at a larger scale, the development or scaling party should have risk appetite that is able to deal with the uncertainty of future success.

— Catalyst of innovations: Go further than the proof-of-concept and pilot the innovation at a larger scale to develop a self-standing model. In this context, the proof of impact and effectiveness is more substantiated by the data gathered during the (large) pilot. The solution is either handed over to a scaling partner or kept in the organization and licensed to other partners. In this situation, PharmAccess can also remain involved as advisor. The risk appetite of the scaling partner is lower than in the 'incubator of innovations' role.

— Implementer of innovations: In this role, PharmAccess scales and implements the solution in a local context itself. It is likely that this will happen in close collaboration with the (local) government and requires long-term involvement. This role implies a stronger focus, as more (financial) resources are required to be active in these activities.

We believe 'Catalyst of innovations' is closest to PharmAccess' current role based on most activities.

2. Prioritize initiatives
PharmAccess could clearly prioritize which initiatives and geographic areas to focus on, primarily based on scaling potential, and then work consistently on those. Right now, PharmAccess' agenda and geographical scope seem to be stretched given its available resources. This pressure is likely to further increase as the future involvement of other MFA departments may lead to expansion or shift of this scope. By prioritizing, PharmAccess can extend its impact in specific areas of focus.

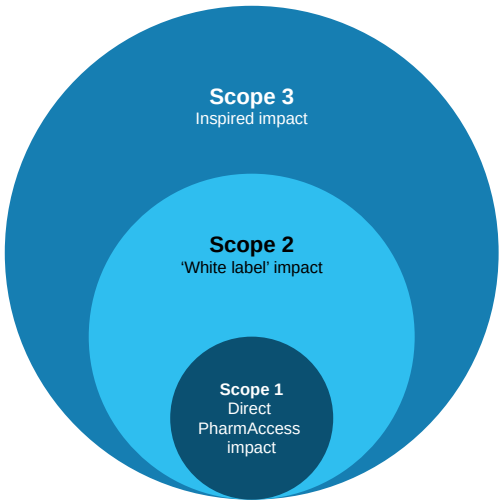
3. Prepare for engaging scaling partners
PharmAccess could use its expertise to engage scaling partners that can support PharmAccess' initiatives to have greater impact, e.g., Multilateral Organizations (MLO), national governments and local implementation partners. These scaling partners would need to be involved in early phases of an innovation, to ensure full alignment, to prove the initiative works also vis-à-vis their objectives, and to comply with various funding guidelines. Typically, these larger scaling partners have a sharp focus on impact and performance. Knowing PharmAccess has presented itself to MLOs and other large organizations in the past, PharmAccess could consider improving its quantitative performance management as this will increase the likelihood of successful partnership.

4. Improve (quantitative) performance management
This action would support organizational leadership to focus on activities that are aligned with the strategy and priorities. Performance management can be used to support strategic discussions with the advisory board and external fund providers, including the MFA. A greater focus in this area would also allow scaling partners to be engaged based on structured impact figures.

A culture of performance management would be enhanced by implementing a clear stage-gating process for all initiatives and projects. This impact can be measured across:

1. PharmAccess's direct impact;
2. 'White label' impact: impact generated through support or co-development by PharmAccess;
3. Inspired impact: impact through PharmAccess' role in catalyzing a paradigm shift, e.g., other parties mimicking PharmAccess or following in its footsteps (Exhibit 28).

Exhibit 28
Proposed impact measurement framework at 3 levels



5. Be bold on impact underpinned by data and promote it
External communication could be more fact-based and data-driven, enabling PharmAccess to build a stronger public profile. This would allow it to strengthen its advocacy role at both government and MLO level. This might require an evaluation of the current staffing of 2.5 FTE in the research department and current research partners to determine whether this setup is sufficient to realize a bolder ambition.

6. Invest in a concise "why, what, how"
A refined and crisper description of activities, core beliefs and methodology would build PharmAccess' profile as innovative change maker of healthcare in SSA and beyond. Together with more structured collection of data on impact, this action will help other parties to better understand what PharmAccess stands for and may facilitate the creation of new partnerships.

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List of abbreviations

DAC	Development Assistance Committee
DDE	Directie Duurzame Economische Ontwikkeling (Sustainable Economic Development Department)
DSO	Directie Sociale Ontwikkeling (Social Development Department)
FTE	Full Time Equivalent
IFC	International Finance Corporation
MCF	Medical Credit Fund
MFA	Ministry of Foreign Affairs
MLO	Multilateral Organization
NGO	Non-Governmental Organisation
MSME	Micro, Small & Medium Enterprises
OECD	Organisation for Economic Co-operation and Development
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
ToC	Theory of Change
ToR	Terms of Reference
UHC	Universal Health Coverage
WHO	World Health Organization

Intervention overview

Exhibit 29

Demand

Initiative	Description	Self-reported start year	Country
Data analytics	National Health Insurance Authority Ghana (NHIA). PharmAccess provides technical assistance to make the NHIA a data-driven insurer and knowledge institute that capitalizes on the potential of digitalization to create value out of its data. We assist with the analysis of three years of claims data to provide insights and generate policy briefs and research publications for management decision-making. Such data analysis provides insights into enrollment and coverage of different segments of population, including e.g. women and pregnant teenagers, a key requirement to address gender equality.	2019	
	Provision of dashboards & additional analytics into registration & utilization of care for multiple counties. For example the Kisumu Marwa dashboards support the Kisumu County government in strategic decision making. Healthcare utilization data at empanelled clinics and hospitals is collected through M-TIBA and the data analyzed and shared with the County Government and NHIF through an online dashboard. The automated dashboard covers the full process from registration to medical utilisation and financial claims management.	2018	
Claim-IT	Digital application that allows easy generation and submission of claims that are valid per the NHIS validation protocols and replace paper claims. We have supported the design, roll-out and training of providers of the app at 500 healthcare providers and continue supporting further roll out.	2016	
TA health plan/scheme	Technical advisor for national and local governments (see all "grey Systems") on the road to UHC. Technical Assistance is provided in relation to: • Governance & structures • Financial models & risk management • Scheme design & operations • Data analytics • Management & control • Technology These TA activities are provided within/for multiple schemes, at various levels of maturation. In addition to the schemes mentioned under "systems", work was also done for Ogun state (see below).	2007	
	TA for Ogun State. PharmAccess supported Ogun State in the design of the Araya Community based Health Insurance Scheme (CBHIS) and in scale up of the scheme, while addressing impediments that restrict the provision of quality healthcare through the implementation of a quality improvement program and by creating access to finance for the healthcare providers participating in the program.	2018	
Afya Credit - Health loan	We aim to develop and test digital loans to lower-middle income Kenyans for payment of NHIF premium payments and OOP costs at the moments they lack financial liquidity, that can be scaled through partners.	2020	
Proxy means testing	Develop algorithm to assess socio-economic status. To support the efficient identification and targeting of specific populations, and in the absence of alternatives such as taxation records, proxy means test (PMT) models determine individual household wealth status. Currently, these models are good (reliability of >80%) at determining household poverty, but they need refinement to enable further segmentation of the informal sector. PharmAccess develops PMT models with governments in Kenya, Nigeria, and Tanzania, among other focusing on combining these models with other population-based approaches to increase efficiency and scalability. In addition we advocate the adoption (e.g., by government departments, insurers) of PMT models as ways of targeting subsidies to indigents.	2020	
Health remittances	Explore the feasibility and appetite for a peer-to-peer platform to channel remittances from the diaspora to (social) health insurance. This activity was developed in follow up to Health Connect.	2018	
I-PUSH	I-Push is funded by the NPL and implemented by Amref and PharmAccess and aims to improve access to quality healthcare for low-income women of reproductive age through demand side financing and by enabling access to quality healthcare in Kenya (Nairobi and Kakamega), using mobile technology and data. Elements of the program include: Inclusive financing, including development and testing of different co-payment propositions. Using behavioral intervention techniques to encourage low-income women to save up to 50 percent of their NHIF premium (in their M-TIBA wallets). Quality of Care; quality improvement of selected health care facilities using SafeCare. Socio-economic mapping to identify the most vulnerable low-income women that are not able to pay for social health insurance and need premium subsidy. Sensitization of the Nairobi and Kakamega county governments on how these elements can support their UHC agenda.	2016	
M-TIBA wallet	Developed in partnership with technology company CarePay and telecommunications company Safaricom, the digital health wallet is the principle enabler of healthcare financing, particularly health insurance, at scale. It connects payers, such as insurers, donors, governments, public and private healthcare providers and individual users so that they can transact with each other in real-time. With real-time connection, time to settle an insurance claim is reduced from an average of 3 months to 48 hours. Users can save and receive money and benefits for healthcare in their wallets, healthcare providers can use the system to bill for healthcare services and receive payments, and payers can use it to track healthcare utilization and expenditures in real-time. First launched in Kenya as M-TIBA the platform is now supporting the enrolment of populations in states in Nigeria. Since then M-Tiba is used a a platform in various interventions with various purposes. Among other the platform was used for; 1) Health savings product on M-Tiba (called Bonus Top-up). 2) Gertrude's Smiles program with NHIF Supa Cover on M-TIBA. 3) iPUSH: program for women of reproductive age and their families using NHIF Supa Cover and M-TIBA for administrative purposes. 4) UHC Kenya; M-TIBA was used for the mass enrollment of the population of four UHC counties in Kenya. 5) Kisumu Marwa Solidarity Scheme.	2015	
Gertrudes mobile wallet (vertical/horizontal integration)	Gertrude's Children's Hospital (GCH) is the leading pediatric facility in East Africa. Since 2010, the hospital runs two outreach clinics in the informal settlement areas of Githogoro and Mathare in Nairobi. Together with the main hospital's Comprehensive Care Centre (CCC) these clinics provide subsidized primary care services (incl. HIV/Aids treatment) to low income participants. In 2015, M-TIBA was trialed with Gertrude's Children's Hospitals Sunshine program for 2500 HIV patients, recording visits, diagnoses, treatments and costs. This was followed by the Smiles program in 2016 with five Gertrude's outreach clinics with a total of 70.000 users in informal settlements in Nairobi. The program was designed to demonstrate how primary care (horizontal funding) can be seamlessly combined with specific benefits for HIV, MNCH, TB, Malaria and Hepatitis B (vertical funding) in individual health wallets on M-TIBA. In 2017, the partners Getrude's and Pharmaccess tested the NHIF Supa Cover as an alternative financing model for the current defined benefits package. In addition, the partners wished to test the use of M-TIBA with Supa Cover to collect and analyze outpatient utilization data. The program came to be known as NHIF Smiles.	2015	
Health Connect	HealthConnect operates a peer-to-peer donation platform supporting low- income Kenyan families with premium payments for health insurance.	2018	

Exhibit 30

Supply

Initiative	Description	Self-reported start year	Country
SafeCare licensing	Licensing of SafeCare to expand reach through public and private partners.	2019	
SafeCare accreditation	To bridge the existing gap in affordable accreditation in emerging markets and the growing demand for accreditation SafeCareis in the process of establishing itself as a globally recognized accreditation body.	2018	
SafeCare self-assessment tools	Empower healthcare providers (and medicine shops) to improve their quality with practical actionable information and provide data to organizations to use for informed decision making. Integrating the self-assessments as an incentivizing first step in SafeCare Steps, with which efficient affordable quality support can be given to a big group of facilities, including the MCF cash advance facilities.	2019	
SafeCare steps	The SafeCare standards and stepwise methodology previously branded as generic 'SafeCare' has been segmented and part has been rebranded as 'SafeCare Steps' to allow for a clear distinction with the newly developed SafeCare accreditation label. In 2019 the SafeCare assessment tool has been fully digitized.	2010	
Tailored quality assurance and capacity building	Further scale, using a modular approach for tailored quality assurance & capacity building of government partners in SSA and Asia , including India and Afghanistan, the use of standards-based Quality Improvement/ Quality Assurance approaches.		
Quality Platform	Use data to create value for health care providers and for other stakeholders. For providers, the quality platform provides interactive benchmarking and continuous quality improvement tools such as access to protocols, training modules and a chat box to drive better quality performance. For stakeholders, the platform provides up to date information on scale, scope and quality of care to stimulate data driven decision making, resource allocation, investments and contracting.	2020/2021	
SafeCare4COVID --> see SC self-assement tools	The SafeCare4Covid mobile app was developed during the onset of the pandemic and 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.	2020	
Women360	Demonstrate viable business in delivering high quality maternal and child health service at affordable prices through a data- and digital driven hub and spoke franchise model	2017-check will follow	

Exhibit 31

Matching

Initiative	Description	Self-reported start year	Country
MCF/MCF2: partner/syndicated loans	Partner loans are loans under financial partnerships, where the (bank) partner is the lender of record and MCF provides support and shares the credit risk through guarantees or co-funding. In syndications, MCF is lender of record and has a direct relationship with the borrower. The MCF loan is matched by an identical loan from another organisation (bank or NBFI) and both loans are bound by an inter-creditor agreement.	Partner loans 2011, Syndicated loans 2016	
MCF/MCF2: direct (term) loans	Direct term loans are (non-digital) loans where MCF is the lender of record. Loans are usually larger and with longer tenures than digital loans.	2019	
MCF/MCF2: Cash Advance	In 2017, MCF, together with CarePay, launched MCF Cash Advance, a 3-6 months loan product based on mobile money cashflows in healthcare facilities. In 2018, MCF expanded MCF Cash Advance to provide a specific loan (24-36 months) to finance medical equipment purchasing.	2016/2017	
MCF/MCF2: digital lending pilots	Following the success of the Cash Advance product in Kenya, MCF is testing similar digital products in other geographic areas.	2020	
Med4All	Ensure that quality medicines are available to healthcare providers at affordable prices through the establishment of a self-sustaining business model. 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.	2019	
Receivable Financing - integrated initialy into partner lending and to be transitioned to digital lending	This is a self-liquidating loan, whereby MCF provides an advance on the NHIS claim to the clinic at a discount. The interest is accrued on the loan account of a maximum period of 9 months and paid down as claims payments from the NHIS are made.	2016	

Exhibit 32

Investments

Initiative	Description	Self-reported start year	Country
MCF/MCF2: partner/syndicated loans	Partner loans are loans under financial partnerships, where the (bank) partner is the lender of record and MCF provides support and shares the credit risk through guarantees or co-funding. In syndications, MCF is lender of record and has a direct relationship with the borrower. The MCF loan is matched by an identical loan from another organisation (bank or NBFI) and both loans are bound by an inter-creditor agreement.	Partner loans 2011, Syndicated loans 2016	
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Receivable Financing - integrated initialy into partner lending and to be transitioned to digital lending	This is a self-liquidating loan, whereby MCF provides an advance on the NHIS claim to the clinic at a discount. The interest is accrued on the loan account of a maximum period of 9 months and paid down as claims payments from the NHIS are made.	2016