ANNUAL REPORT & ACCOUNTS 2017-2018

HEALTH POVERTY ACTION

Contents

Cover image: San children playing outdoors in Namibia. ©Health Poverty Action 2018
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Message from Director and Chair

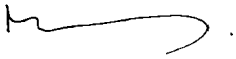
In this time of savage cuts, supporting communities and governments to strengthen livelihoods and the right to health for all has become an emergency. We do this by building long term relationships with communities, and responding to the local problems they face. We don't simply focus on a single issue – instead we have a combined approach. This holistic way of working is not just at the local level – we address the wider political and social issues which are often the root causes of poverty and poor health, such as drug policy, tax and trade, and the funding of health systems.

Sharing in the expertise of Find Your Feet, who we started working closely with over the past year, has helped us enhance our work on all of these complex social determinants of health, whether that be by improving livelihoods through sustainable farming methods, engaging local governance, or supporting communities to set up local lending groups and businesses. We have also shared our expertise in health with Find Your Feet, and our first combined project has seen us expand our work to communities in Malawi, to address some of the challenges they face accessing clean water. Water is not only crucial for growing crops, but it is also important for sanitation, health and hygiene. Supporting communities to improve their access to clean water, toilet facilities, and hygiene practices has been the perfect way to combine the approaches of Health Poverty Action and Find Your Feet.

Together we have been pioneering new approaches to tackle the complex global challenge of mental illness. Mental health is closely linked to poverty, discrimination and overall health and wellbeing, so medical treatment alone is not enough. Whilst mental illnesses are recognised as an urgent health challenge, they are often severely neglected and the people affected are hidden. Funding and resources allocated to mental health are almost non-existent in many health systems around the world; it is a silent epidemic, and those suffering are often not in a position to demand action. In Zimbabwe we are launching a project with Find Your Feet on strengthening services for better mental health, and we have started integrating mental health into our work in Somaliland.

We want to thank all of the donors who continue to support us as we work together with those pursuing change in their own communities, and campaign for policy change to create a more equal world for everyone. **Change is possible, and it is already happening.**

Emma Crewe
Chair of Trustees



Martin Drewry
Director

Strategic report

Charitable objects

Our purpose

Health Poverty Action's charitable purpose is enshrined in its objects 'to preserve and protect the health, through the provision of primary health care, of communities who receive little or no external assistance because of political instability and / or conflict'.

Our vision

A world in which the poorest and most marginalised enjoy their rights to health.

Our mission

We work to strengthen poor and marginalised people in their struggle for health.

Public benefit statement

Health Poverty Action's charitable purpose is carried out for the public benefit in accordance with our vision and mission, promoting a world in which the poorest and most marginalised enjoy their rights to health. The Trustees confirm that they have complied with the duty in Section 17 of the Charities Act 2011 to have due regard to the Charity Commission's general guidance on Charities and Public Benefit.

Objectives and activities

In 2015 we initiated a new Strategic Framework to outline our principles and identify the values that drive our work; a justice-oriented approach, developing strong community roots, creating comprehensive and integrated health systems, and addressing the social determinants of health. It is a living document subject to ongoing informed reflection, and is deliberately not a traditional Strategic Plan. This allows us to be flexible, and to continuously adapt our strategic direction to suit circumstances.

This flexibility has allowed us to develop a strategic partnership with Find Your Feet – an organisation with whom we share many of the same key values, including the importance of a community-led approach. By sharing our expertise we are now working together to create stronger, more holistic health and livelihoods projects that directly benefit the communities we work with.

Health Poverty Action works in partnership with those who have been marginalised and pushed into poverty, supporting them in their struggle for health. We work with communities to help them demand health justice, and to challenge the power imbalances that currently deny them their rights.

We believe health is not just the absence of disease, but a combination of physical, mental and social well-being. We draw strength from the knowledge that we are not alone, but part of a global movement for health justice – the People's Health Movement (PHM). The PHM is today's embodiment of the primary health care movement that achieved groundbreaking success at the UN Alma-Ata Conference in 1978. Such was the power of this moment, that 40 years later the radical vision it set out continues to rally health workers and policymakers worldwide.

The distinct philosophy underlying our work embodies the four key areas of the Alma-Ata principles:

Justice-oriented approach

We believe in health for all, without exclusion. We recognise that development organisations tend to cluster together in the same places, leaving large populations with almost no support at all. We make these most neglected people our highest priority. They may be living in places that are hard to reach because of conflict or political problems, because of geographical remoteness, or because they have been marginalised by stigma and discrimination.

We also recognise that health justice cannot be achieved without social and economic justice. These are inseparable – each being both a cause and a consequence of the other.

The reasons so many are denied their health rights worldwide are not primarily biological factors, but political, social and economic injustices.

This is a global scandal, which results in unnecessary suffering on a massive scale. We challenge unjust power relations at all levels, from practices within the family and community, all the way to regional, national and global policies.

We have a moral duty to speak out, and through our policy work and campaigning, are a progressive voice for change. Not just through our own independent action, but also by exerting influence within and through the development sector as a whole.

Strong community roots

We emphasise the importance of policy makers and service providers being accountable to the communities they serve – and work with communities to make this a reality.

We support communities to actively participate in their own health care – reclaiming power, demanding and monitoring high quality health services, as well as taking community action together to improve their health.

Health care must be decentralised, easily accessible, and culturally appropriate, irrespective of people's ability to pay.

Applying the same principles to ourselves, we strive always to ensure our work is rooted in strong relationships in which we are accountable to those whose rights we serve – seeking not just feedback but genuine dialogue, and reflecting on and challenging our own organisational power dynamics.

Most of the communities we work with have learned through painful experience just how dangerous it can be to trust outsiders. We therefore attach immense importance and respect to the trusting relationships and local understanding we have developed with them over many years. It is these relationships, perhaps more than anything else, that determine the quality and effectiveness of the work we do together.

Relationships such as these take time to develop. We therefore aim to work with communities for the long term to build on our understanding, and improve our effectiveness over time.

Comprehensive and integrated health systems

Tackling one cause of poor health in isolation can give the appearance of improving health by reducing incidence of a particular sickness, but for the world's poorest people this might do little more than change the cause of death. We take a comprehensive and integrated approach that addresses all the key determinants of health, and saves lives.

We help develop comprehensive health systems, providing services that integrate not just within the health sector, but also with the work of other sectors. For example, food distribution can be done through maternal health care centres, to increase uptake of those services and access to other forms of health education.

We never set up parallel structures, but support governments to develop strong, sustainable, accountable and culturally appropriate comprehensive health care.

One element of our integrated approach has proven profoundly effective: strengthening both the supply and demand side of health care at the same time – supporting communities to demand and use high quality services, while simultaneously helping service providers develop the capacity to deliver them.

Social determinants of health

The health sector alone can never deliver health justice. We work not only to strengthen health services but also to tackle the social determinants of health. These include education, water supply, hygiene, violence against women, food security and income generation. Health and poverty are inextricably linked – and we emphasise the need to reduce inequality at all levels.

It is often women and girls who suffer the most when health rights are denied, and we attach high priority to addressing gender inequality. We also recognise the rights of ethnic and cultural minorities, such as indigenous people. People with disabilities often face discrimination on top of the challenges of their disability, and so we also strive to prioritise these people in our work.

When emergencies and humanitarian crises arise, it is important to respond both quickly and appropriately. We build on our local relationships and understanding to provide support in crises, integrating it as far as possible with the longer term development work. We also work with communities and service providers to ensure they are as equipped as possible to deal with emergencies before they happen.

On the ground

We currently work in 18 countries in Africa, Latin America and Asia. All of our programmes aim to improve the health and livelihoods of those we work with and for. Our work on the ground is therefore key to fulfilling our Strategic Framework.

Our projects range from improving sanitation and access to clean water in Malawi, to promoting health messages through radio dramas in Somaliland; from providing maternal health training to communities in Guatemala, to preventing the spread of malaria in Vietnam and Cambodia.

We measure our success in a number of ways, tailoring our approach to each project and community. As you will see from our key highlights on pages 18-19, tracking numbers is very important to measure our impact, whether that is how many children we have vaccinated, or how many ambulances and supplies we have provided. However, it is not the only way of judging impact. Often the best way is to talk with the communities most deeply involved in the projects, and ask how our work together has impacted on their lives. We constantly do this through community meetings, surveys, and direct feedback mechanisms such as comment boxes and feedback phone numbers. This allows us to assess our impact, whilst also adapting and making improvements along the way.

Speaking out

Health for all requires systems and policies that enable it. We campaign and lobby to influence policy both nationally and internationally, to challenge power imbalances and create conditions that support health in the long term. Highlights this year included: several new publications on topics including the root causes of poverty, indigenous women's maternal health and alternative approaches to the current economic system; the launch of key recommendations to create a healthier drug policy; the development of a training course to support national level advocacy; and seeing many of our long term campaign asks adopted as Labour Party policy.

Raising funds

Our restricted project funding is not enough to cover all our organisational costs, and so we need to continually seek to diversify our funding base. Raising unrestricted funds is crucial to supplement our restricted project funding, to increase our impact on the ground as well as invest in developing as an organisation. Our priority has continued to be to explore opportunities to increase our unrestricted funds, through the development of new fundraising campaigns and a shift towards digital fundraising. As the fundraising landscape shifts we have also started to explore non-traditional income generating opportunities, for example social enterprise as an alternative funding model.

Communications

Strong communication is important in all areas of our work. This is especially true when spreading our campaign messages, raising awareness of the challenges different communities face around the world, or raising donations from the public. It is crucial for us to show our supporters the work we are doing, and how their support is helping us achieve change. This year we have worked hard to improve the way we communicate, to ensure we are representing the people we work with around the world in a fair and truthful way. We have also been working hard to demonstrate the important links between all areas of our work – from our projects in different countries, to the policy work we do in the UK. We have been working on a new website, and reaching out to the media to spread our messages.

Reach

This year we continued to make a significant impact. We worked directly with more than 1,900,000 people across 18 countries to support them to improve their health and livelihoods. This includes the immunisation of over 250,000 people, the distribution of over 646,000 contraceptives and family planning services, the provision of nutrition treatment and referrals to over 573,000 people, and the training of over 56,000 people, including health professionals, government officials, and community volunteers.

We also reached a further estimated 1,193,000 people with health messages relating to disease prevention, sanitation and hygiene, nutrition, child health, sexual and reproductive health, healthcare rights and women's rights. This was achieved through various channels, including over 36,000 community awareness sessions, and the distribution of over 16,000 information materials, such as leaflets. We also produced over 350 radio and TV messages, many of which have been broadcast multiple times by various broadcasters.

Our work has also been making an impact on certain areas of policy, such as drugs policy and indigenous women's maternal health, which will result in long term change. Although we still have much further to go before we reach our ultimate goal of health for all, we believe our work this year has taken us further towards this goal.

Achievements, performance and impact

On the ground

Maternal health

In remote areas, women, newborns and children are often the most vulnerable to health problems. Health centres can be difficult to reach, and without alternative forms of transport available to them, women and children sometimes have to walk for days to get there. Even when they reach the facilities, they might find them understaffed or underequipped. Indigenous people can even face discrimination and abuse from health centre staff. These factors discourage mothers from visiting health centres during pregnancy and to give birth, and often they instead rely on traditional birth attendants (TBAs) in the community as their only source of maternal health support.

The position of TBA is passed down through generations of women, and is a highly respected role in the community. However, these women very rarely have access to any health training, leaving them without the skills or tools to identify and treat difficulties in childbirth. Overall, the lack of infrastructure, transport and training means women and newborns are still dying in childbirth.

In Guatemala, TBAs continue to deliver the majority of births where we work. This year we provided 385 TBAs across eight districts with training to improve the early detection of danger signs during pregnancy, and to give them the skills to provide antenatal care and nutritional advice to mothers. The TBAs and community health workers we trained in Namibia now meet with communities, and visit mothers to teach them about maternal health. TBAs also set up Mother-to-Mother clubs, which provide a peer support network, and a place to discuss health and birth plans. As a result, 70% of women in the region can now name three danger signs in pregnancy and 80% have positive attitudes towards maternal health services.

In Sierra Leone we trained TBAs and community health workers on a range of topics, from maternal health to HIV/aids and sexual and reproductive health. Almost 100% of women in the area can now identify at least three danger signs during delivery (compared to 51% at the start of the project). These health workers referred over 12,000 women to health centres for skilled delivery and antenatal care in the last year. In Myanmar we trained 248 TBAs and 187 auxiliary midwives to travel to remote communities to visit mothers, and provide maternal and delivery services in the home. As a result, 4,209 pregnant women received these services from skilled birth attendants this year.

You need to see danger signs, or the mother and baby die. I have seen changes thanks to training – the people now go to health posts. TBAs get support, and TBAs work together and communicate well. If a TBA sees a danger sign, they get the woman to the health post or hospital. Health post staff will come, and together they will convince the family to take the woman to hospital. Both sides are vital in reducing maternal deaths.

Anastacia, a TBA working in Guatemala

In Kenya, as well as working with TBAs, we trained 160 community health workers, enabling them to visit 23,402 mothers in the community and teach them about pregnancy and the benefits of breastfeeding. Together they referred 6,434 mothers for antenatal care, 466 for postnatal care, and provided 6,732 women with personal birth plans.

In very remote and nomadic communities, it is crucial to provide transport options to enable women to actually reach the health facilities they are being referred to. In Ethiopia we work with nomadic pastoralists living in South Omo and Dollo Ado. Nomadic pastoralists make up about 12% of the country's population, and their remote and mobile locations mean their needs are often neglected by government and other development partners. We provided mobile outreach clinics for 4,223 pastoralist community members living in remote areas. Our ambulance service there has been utilised by 942 mothers and children. As a result of these services, births assisted by skilled birth attendants rose to 59% (from 45% last year), and the percentage of pregnant women attending at least four antenatal check-ups rose to 37% (from 19%).

In Kenya the two ambulances we provided allowed 192 emergency obstetric cases to be referred during the year. In Namibia we provided four donkey cart ambulances, which bring mothers from the most remote areas in order to reach the clinics. We also provided 45 community health workers with mobile phones, credit, and small solar panels for charging, so they are able to call for an ambulance in emergencies.

Donkey cart ambulances in Namibia are essential to transport pregnant women living in remote villages to the clinic for check-ups, and to birth waiting homes so they can be close to the clinic when they are near their due date.

Maria is nine months pregnant, and lives in a remote village in Namibia, a day's walk from the nearest clinic. With her due date fast approaching, she is staying in a birth waiting home close to the clinic so she can access medical care as soon as she needs it.

If it were not for the ambulance that was sent, my life would have been at risk because of the complication I got during my delivery. I am very grateful to the organisations for the support they have given me, and the support they give our health facilities and staff.

Nuria, a 26 year old mother living in Hareri village, Kenya.

Birth waiting homes have also played a key part in mothers' access to maternal health facilities, allowing women to stay comfortably near to the health centre when they are waiting to give birth. In Namibia we provided four birth waiting homes, and 90% of expectant mothers now give birth at health facilities, compared to just 40% at the start of the project. In Sierra Leone, 943 women used our 28 birth waiting homes last year, with priority going to women with high risk of complications, or those who lived particularly far away from the health centres.

In Nicaragua 80% of pregnant women in the areas where we work stayed in birth waiting homes before delivery. For the remaining number who could not access these services, we provided 82 TBAs with

delivery kits and training to ensure home births are safe. This resulted in maternal deaths in the region where we work falling from 7 per 100,000 in 2016/17, to 2 per 100,000 this year.

It is also crucial that the health centres have the right staff, skills and medical equipment to provide appropriate care to women when they arrive. In Guatemala we are working with the Ministry of Health to provide training and supplies to staff, and to ensure the facilities are welcoming and culturally appropriate to indigenous women when they arrive. In Somaliland we provide support to government health facilities in order to strengthen the services provided. 11,456 women delivered at health facilities supported by Health Poverty Action this year, and 2,112 of those were able to reach the health facility thanks to our ambulance service.

Access to quality healthcare

Improving access to healthcare is a priority in every area of our work. It often requires a range of different approaches that are adapted to the context of where we are working. One way in which we do this is to strengthen existing health systems by providing training, medical supplies and equipment to local health centres. Where these health centres are sparse, or difficult for populations to access, we provide outreach health services and ambulance services to transport people to health facilities.

In Somaliland we supported over 50 health facilities with equipment, medical supplies and staff salaries. We provided outreach health services targeting those living in remote areas, or those unable to visit health facilities due to their financial situation. More than 200,000 people received healthcare at these outpatient departments this year. We also supported 26 mobile health and nutrition teams to visit almost 150 villages giving nutritional advice and treatment.

To ensure there was enough blood available in the blood bank where we work in Sierra Leone, we organised several blood bank collection drives across the five chiefdoms we work in; 240 units of blood were donated and stored in the blood bank.

An important part of our work is providing training to health centre staff to ensure they have the medical skills to diagnose and treat patients. In Ethiopia we supported an integrated supervision programme, where senior health professionals provide on the job training and mentoring to grassroots health workers. In addition, we gave staff training to 257 government health staff in family planning, counselling and life-saving skills.

We have done similar work training staff in Kenya, where we strengthened the Continuous Medical Education programme at the Sub County Referral Hospitals by helping them put together an annual training timetable, improving the skills and knowledge of healthcare staff at the hospitals. We also hired an experienced nurse and midwife to train and mentor other staff; 44 nurses who were mentored are now able to confidently provide a quality standard of care.

In Guatemala this year we trained 352 Ministry of Health staff on the guidelines to culturally appropriate care to ensure health services are accessible to indigenous groups. They also received training on violence against women, differentiated services for children and adolescents, and how to work effectively with TBAs. We have also remodelled health facilities to make them more culturally friendly – for example by providing appropriate gowns, and painting the walls in warm, traditional colours to create the culturally appropriate ambiance preferred by indigenous women.

Where it is needed, we facilitate the links between government and communities to ensure health needs are being met. This year in Sierra Leone we organised three ambulance management committee meetings with representatives from communities, hospitals and the government. The purpose of the committee is to coordinate and oversee the referral system in the district of Bombali, to ensure the efficient running of the three ambulances stationed in the project area.

Health Poverty Action Health Facilitator, Carmen, demonstrates the culturally appropriate delivery robe that is provided to indigenous women visiting the health centre to give birth in Guatemala. Behind her the walls are painted a bright, warm colour to ensure the room is welcoming to indigenous women.

In Guatemala we are supporting Health Commissions in six municipalities, and Community Health Commissions in seven communities. With the help of user satisfaction surveys, these commissions are helping to resolve issues and complaints with health authorities, such as mistreatment, opening hours, lack of infrastructure and lack of basic medicines. Local and district government are beginning to respond. For example, the local government agreed to supply water to the health centre in the municipality of Cabricán. The health facilities have even responded to requests to increase their opening hours, with many now providing weekend services.

Health knowledge and behaviour change

We work with community health volunteers, and develop local committees to provide health training and awareness sessions. The aim is to educate communities about hygiene and disease prevention, whilst also raising awareness of symptoms and warning signs. We use these education sessions to not only build awareness of health itself, but also to build awareness of health rights, and the health facilities available to communities to create demand.

In Myanmar we conducted a range of different education sessions in communities on topics such as nutrition, disease prevention, family planning, harm reduction and sexual and reproductive health. These sessions not only targeted the general population, but were also brought to high risk groups such as adolescents, migrant workers, sex workers and prisoners. In the conflict affected areas of Kachin State, we also organised 731 sessions on hygiene and health in communities and camps for displaced people. In addition, we arranged training sessions for village health committees and teachers on how to deliver participatory health knowledge workshops in communities and schools. 594 school teachers trained to be sexual and reproductive health educators in schools.

In Namibia we trained 30 teachers across six schools to enable them to teach children about sexual and reproductive health issues. We also worked with 14 tuberculosis (TB) field promoters in Namibia, who held 3,832 TB sensitisation sessions to teach communities about the warning signs and symptoms of TB.

Together with government partners, we conducted an awareness and education campaign in Laos called 'Together towards a malaria-free Laos in 2030' across all 10 districts of Champasak province. This included a range of awareness raising events, such as football tournaments, marathons, and stands and information booths at traditional festivals. A total of 3,217 people were reached through these events. 10 secondary schools also organised peer educators

Members of a school gender club in Sierra Leone gather to learn about sexual and reproductive health, and to openly discuss their questions and concerns.

Our radio show in Somaliland combines drama and interviews with local people in order to explore sensitive cultural and health issues, such as FGM, rape and respecting women. Mohamed has been an actor in the radio show since October 2013. He is 23 years old, and is also a Medical student at Hargeisa University.

"The majority of my friends were scared to talk about these issues. Now after hearing our messages through the radio show they want to talk about the issues, and I encourage them."

Ayan has been performing with the radio show since 2003. She used to play a victim of FGM in the drama, but now she plays a doctor. Ayan has seen the impacts of the radio show in her own community.

"My friend has lots of daughters, and after listening to the radio show and learning about the health risks of FGM, she decided not to have her daughters circumcised."

The actors say the success of the show is due to Somaliland being an oral society.

to help provide health education, and raise awareness of how to prevent malaria infection amongst children and youth. A total of 4,007 students and their teachers actively participated in these peer education sessions.

In Kenya we are supporting a bi-monthly health education community theatre show run by a women's group in the community. In Kenya and Ethiopia we have also used community conversation forums to conduct 'dialogue days' and encourage discussion of health issues and harmful traditional practices, such as Female Genital Mutilation (FGM). These awareness activities are encouraging healthier behaviours, increasing the uptake of health services and resulting in greater community participation – particularly by women.

In Sierra Leone we supported 20 gender clubs in schools which hold weekly sessions to discuss sexual and reproductive health topics among adolescents. We trained 40 teachers to facilitate the clubs, and to increase their knowledge about sexual and reproductive health, teenage pregnancy, and the importance of visiting health facilities.

In Rwanda we are using a range of methods, from school and community clubs to radio chat show broadcasts, to promote family planning, and raise awareness of the availability of condoms and other contraceptives.

In Namibia we organised 30 minute radio slots twice per week to broadcast health messages. San traditional leaders, community health workers and TBAs spoke during the radio slots, and reached around 8,000 listeners at a time. In Sierra Leone we produced and broadcasted 48 radio discussions, which went out weekly. These covered a range of topics, from child marriage and sexually transmitted infections, to puberty and contraception. In Somaliland we broadcast 102 episodes of a radio drama, which again explored a range of health issues to raise awareness and health knowledge. We also had 32 television spots on national television to raise awareness of the same issues.

Food and nutrition

In the conflict affected areas of the Kachin and Shan States in Myanmar there are a high number of displaced people. We provided over 11,000 people living in camps with food to meet their nutritional needs. We also provided nutrition services to pregnant women and children in the camps and hard to reach areas; each quarter we monitored the growth of around 2,700 children under two years old. We have provided 7,000 children with vitamin A supplements, and we gave micronutrient supplements to over 1,500 pregnant and lactating women.

In Somaliland there are high rates of malnutrition, particularly among pregnant and lactating women, and children under five years old. This has been exacerbated by the ongoing drought in the country, and the large numbers of internally displaced people, who are particularly vulnerable. We sent outreach teams to over 200 villages in nine districts of the Sahil, Sanaag, Maroodi-jeh and Togdheer regions of Somaliland, and screened 198,000 children under five years old for malnutrition. 16,200 children with severe malnutrition and over 50,000 children with moderate acute malnutrition were enrolled on the nutrition programme, and provided with treatments involving food blends and nutritional supplements.

To help tackle the problem further, we trained 75 staff in how to manage acute malnutrition, and 51 staff in infant and young child feeding. These staff then taught community health workers, enabling them to go in to the communities to support parents and other caregivers in how to best feed their young children.

In Guatemala we promoted the importance of maternal nutrition by working directly with TBAs, community leaders and mothers. We also participated in municipal level 'Nutrition Round Tables', which bring together members of Municipal Health Commissions, Ministry of Agriculture and Ministry of Health and Nutrition. Through these meetings we help to monitor and report cases of malnutrition. For example, in Cerro, in the municipality of Cabrican, we worked through the Municipal Health Commission to take action in the case of a four month old twin who weighed just six pounds. We facilitated community action to raise funds for the mother, ensuring she received the food required to ensure her baby's survival and growth. We organised similar collections for malnourished children in the community and local government through fundraising marches and sporting events.

In Laos following our work with 408 families to improve their nutrition, food security and livelihoods, we conducted a follow up nutrition study to

The drought in Somaliland has left many families with less food and resources, causing malnourishment, and an increased vulnerability to disease. "We used to have 300 goats and sheep. Now we only have 90 left because of the drought."

Hawa's youngest child, Hamse, is just two and a half years old, and has been diagnosed with anaemia, pneumonia and severe malnutrition.

"When I brought the baby in to Berbera hospital they immediately sent blood samples off for a lab investigation. Hamse was then given a blood transfusion, and nutritious milk to make him stronger. If this service was not here, my baby would have died. His condition was very serious – he had to be on an oxygen drip for 5 days. When I first arrived, I was very worried and scared, but the staff were brilliant. They acted quickly, and put lots of extra effort in to ensuring me he would be ok. Now he is recovering."

Chibwana village in Malawi used to have no toilets and no hand washing facilities. People were forced to use the local forest to go to the toilet, and germs and disease spread easily, making people unwell.

Together with Find Your Feet we provided training for the community in Chibwana village about health and sanitation, and worked with them to build toilets and handwashing facilities for every household.

The village has 60 households and 59 of them now have a toilet. The final one is also under construction. Owen (pictured), a farmer in the village, has noticed a big change:

"There used to be a bush around the village which was used for open defecation. There were many water borne diseases. Through the training we learnt that open defecation was not good. The village asked how to address the challenge and were told a complete set latrine (pit latrine, drop hole cover and hand washing facilities). Since we started to construct the pit latrines we can see a change in terms of the number of people attending the health clinic."

understand if the community had any further needs. As a result, we supported additional activities in the community, such as working with model households to promote peer-to-peer learning, and building the capacity of the three trained village veterinary workers to provide veterinary services in the community. As a result of all of the activities in this project, all of the households have established new livelihood activities, from raising and breeding livestock, such as goats and ducks, to planting and selling bananas, or setting up their own small grocery shops. Some have even set up their own motorbike repair shops, or rice mills, and the total income generated from these livelihood activities is more than $16,000 (USD). Households have therefore experienced a reduction in food shortages, with the number of 'hungry months' decreasing by over half, from 6.8 months to 3.3 months per year.

In Kenya we gave demonstrations with the Ministry of Agriculture and Livestock to communities, to teach them how to set up gardens by planting fast growing nutritious vegetables, and how to cook nutritious and balanced meals using these and locally available ingredients. On top of this, our outreach health teams supplied 21,786 children with vitamin A supplements.

Water and sanitation

In many of the most remote places where we work, access to clean water, and lack of toilet facilities are some of the biggest health challenges faced by communities. As well as the physical lack of facilities, there is often little opportunity for education about these issues. This means much of our work focuses on providing information and education sessions, so communities can use their own knowledge to make improvements to hygiene.

Where we work in Laos, most households get their water from rivers, unprotected springs or open wells. There was only one sanitary toilet across 25 villages. We worked with government partners to conduct awareness sessions and nutrition screening for children under five. Together with the community we constructed 50 new toilets, with priority going to households headed by single women, or anyone with a disability. We also constructed 10 new wells, three gravity fed water systems, and two boreholes.

In partnership with Find Your Feet in Malawi, we trained staff, governments and communities in the

links between water, sanitation and health. Together with communities, we facilitated the rehabilitation of 21 boreholes, the construction of three new shallow wells, and 1,445 improved toilets, with 1,992 hand washing facilities. The new and improved water sources have particularly improved the lives of women and girls, who are frequently responsible for collecting water, and often have to walk far to find it.

To ensure these water sources are maintained we supported the creation of 21 water point committees, and trained 194 of their members on borehole maintenance. Together, these water point committees are responsible for maintaining 54 water points. The improved quality of water is helping to reduce disease by providing safe and clean drinking water, and this has meant children and adults have spent less time off from school and work due to sickness. 30 community members were also trained in the different types of compost toilet, and how to use this sanitised compost in agriculture – once again supporting families with sustainable agricultural technologies which enable them to grow more food.

In Somaliland we rehabilitated 21 water, sanitation and hygiene facilities for 21 health centres, and provided a further 19 health facilities with toilets. In Kenya we supported health facilities without running water by providing water containers for hand washing.

Raising awareness about the importance of hygiene is a core part of our work in Myanmar, both in schools and in communities. We are working with Village Health Committees to improve community hygiene, and to engage people in the community in activities to improve sanitation and hygiene in the village. This year we collaborated with 16 villages in Shan State to build new toilet facilities, and improve water and sanitation facilities. This has benefitted 2,908 people from 497 families.

In Nicaragua we worked with Water Aid to improve water, sanitation and hygiene particularly in relation to maternal health. It is an innovative approach to link these two areas of work, by training TBAs and communities on the importance of sanitation and hygiene in relation to delivery of babies to prevent infections. We taught teachers and students the importance of hand washing, and hygiene during periods. We also carried out an awareness raising campaign in 22 communities on safe water, disinfection methods, and the importance of keeping toilets in good condition, reaching almost 2,000 people. We worked with 26 women's groups to provide workshops on water, sanitation and hygiene, and have supported community health committees to present demands for better facilities to municipal and regional authorities.

Disease prevention

Much of our disease prevention work starts at the most primary level with vaccinating young children, but is supported by our health education and community awareness work. In Somaliland primary prevention is a key part of tackling disease, and this year we vaccinated more than 18,500 children under one year. We also trained 28 members of staff on communications skills to help them run community awareness activities, and ran 1,150 meetings in the community on how to prevent common diseases such as diarrhoea.

In Myanmar we continue to work closely with the government to deliver essential immunisation programmes to ethnic minority groups in the remote and hard to reach regions of Kachin and Shan State. This year we immunised over 152,000 children under 15 years old against Japanese Encephalitis.

As part of our disease prevention work we also specifically tackle diseases which are spreading at a high rate in certain areas, such as drug-resistant malaria in Cambodia, and drug-resistant TB in Namibia. Cambodia is the epicentre of drug-resistant malaria, and cases are rising in both Cambodia, and neighbouring Vietnam and Laos. We work with communities deep in the remote forest and border areas of these countries through mobile outreach teams. These teams provide diagnosis and treatment services for malaria, and provide information on the prevention of the disease. We also station trained village malaria workers in these remote communities to provide training, knowledge and support to local people. In Laos this year we established 48 malaria posts in remote border regions, and trained 98 malaria post volunteers to staff these posts and provide information, testing and treatment.

> ***The malaria post increased the villagers' access to malaria health services by making it more convenient for villagers and forest-goers to seek out malaria testing and get the correct treatment without having to make a trip to the hospital, which is often difficult to access due to both the distance, and financial costs of travelling so far.***
>
> **Keodune,** malaria post volunteer, Champasak District, Laos.

Forest survival kits are distributed to malaria post volunteers in Nondeng Nuea village in Laos.

This year, 2,778 malaria cases were referred to health centres or village malaria workers in Cambodia and Vietnam. To keep a record of these cases, we trained village malaria workers in Cambodia in mapping techniques so they could record malaria incidents in their communities. Our staff in Vietnam also used detailed geo-spatial data in the border regions where there are a high number of endemic malaria cases. This data collection allowed outreach workers and village malaria workers to instantly map and track malaria cases using a mobile phone app. This is providing near real-time case reporting, and detailed geo-location of individual cases, and what household they are from. This helps to identify areas with high rates of malaria transmission, allowing us to target them in our efforts to prevent and control the spread of malaria.


Health Centre worker, Dieu Nam, uses a smartphone app to record cases of malaria in the community in remote areas of Vietnam.

We also work to prevent malaria in Sierra Leone, where we trained 325 community health workers to conduct rapid malaria testing in communities, and refer cases to health facilities. We particularly targeted the most vulnerable groups, such as pregnant women, teenage mothers, and children under five years old in hard to reach areas. We supported health facilities, and their staff to improve the management of malaria cases by providing training and guidelines on malaria testing, case referrals and record keeping. We also selected 130 staff at these health facilities to provide support and resources, such as medication, to the community health workers.

In Myanmar we continue to work with the National Malaria Programme and National TB Programme. We gave training and support to community health workers and health facility staff, and arranged community education sessions to raise awareness of the diseases. We distributed 122,315 long-lasting insecticidal nets to at-risk populations, and identified 3,588 people with suspected malaria who were then referred to receive anti-malarial treatment. Community health workers referred 1,515 suspected cases of TB to the health facilities. This community screening and referral system has helped to improve the timely diagnosis and treatment of people with TB in very remote villages.

TB is a disease we are working to combat across several countries, especially in areas where drug resistant strains of the disease are becoming prevalent. It is important to prevent the spread of the disease, but also to ensure people complete their course of medication to lower the risk of drug resistant strains developing. Our work with communities in Cambodia resulted in 5,832 people suspected of having TB being tested, 43 cases being clinically diagnosed and confirmed, and 243 cases being cured through completed treatment. 92 health centres received 276 staff supervision visits to improve TB case registration processes and accurate data collection.

In Namibia we worked with indigenous communities in Tsumkwe to raise awareness about TB prevention and care in order to reduce the infection rate. We trained five new outreach workers, bringing the total to 14. Together they conducted 3,832 TB awareness and health education sessions this year. We also symptom-screened 826 community members, and referred 641 of those to health centres for TB examinations.

In Guatemala we are working with TBAs, teachers, students and their parents to improve understanding of HIV transmission. TBAs now actively promote the importance of HIV testing amongst their patients, and teachers are integrating the learning into sex education at schools.

Women's rights

In many of the areas where we work, patriarchal practices are still dominant. This results in the oppression of women in already poor and marginalised areas. This power imbalance means the health, education and economic status of women is most heavily impacted. We believe that for a society to truly be healthy, and prosperous, all members of that society must have equal rights.

In Myanmar we are working to ensure women's voices are listened to and valued in the community. We have made sure that women make up at least a third of the village health committee and community health committee members, and are encouraging community discussions on the importance of including women in household decision making. We have also helped to establish 94 women's groups, where women have the chance to meet, discuss the challenges and health problems they face, and come up with solutions together. We have trained 232 members of these groups to organise the meetings, and facilitate the discussions.

This year we trained 448 Women's Association members in Myanmar to become community health agents. This has helped us to work more closely with women from ethnic minority communities, and spread health knowledge further. We also trained 50 female volunteers to deliver awareness sessions in the community about sexual and gender based violence. This training has equipped them to identify cases of gender based violence in the community, and provide referral and follow up support.

In Kenya we have been using our successful model of community conversations to address the harmful traditional practice of female genital mutilation (FGM).

Traditional birth attendants attend training in Guatemala.

Women, men, traditional circumcisers (who perform FGM on girls) and religious leaders have all been involved in these conversations. 1,316 people who participated in the forums have declared that they will not cut their daughters in the future. 47 religious leaders and 89 circumcisers also declared they would stop the practice, preventing an estimated 700 girls from undergoing FGM per annum.

By training TBAs and young people in Guatemala about violence against women, we have seen a huge increase in cases being reported. Young women now know that violence and sexual harassment in any form are legally punishable, and understand they no longer need to accept it. In Cerro, Cabricán, our survey showed there was a 65% increase in knowledge on how to report violence. We also ran a series of self-care workshops for TBAs, allowing them a space to reflect on the challenges they face as women in a patriarchal society, and encouraging them to challenge the self-blame stigmas they had assumed.

In Guatemala we also trained teachers on the laws around statutory rape, resulting in a 363% increase in awareness of their obligation to report pregnancies of children under 14 years old. All health districts in the Quetzaltenango Department now receive notifications from teachers of under 14s who are pregnant. We also trained Community Mayors in their role in tackling violence against women, and their responsibility to report crimes within the legal framework, rather than just informally mediate between couples.

In Rwanda we trained 24 youth champions from schools and community clubs in sexual and gender based violence, and sexual and reproductive health. These youth champions used this training to hold their own awareness raising sessions in the community. We also trained 24 men from the communities to support women in responding to sexual and gender based violence, and to be advocates to prevent such violence occurring in the community. To raise further awareness of the issues, 26 radio chat shows were aired. These shows also talked about the services available in the community, and the rights people have.

In Somaliland we also raised awareness of women's rights through our regular radio show, and through outreach visits to communities. Topics we have covered include sexual and gender based violence and FGM.

We are also working hard in Kenya to prevent and eradicate the practice of FGM. Each month we broadcasted an hour long interactive radio show focusing on reducing harmful traditional practices. In response we received 72 calls and 564 text message responses, which were then discussed, answered and clarified on air. We estimate that 60,000 people were reached with these shows.

Odette is a counsellor at Nyagisozi one-stop centre in Rwanda. She supports around 10 survivors of sexual and gender-based violence on a weekly basis. She has a good reputation in her community and is trusted and respected thanks to her work with families in the community.

In Guatemala we brought together the Ministry of Health, civil society networks and others to record a series of discussion programmes for radio on a number of issues, including violence against women and children. This was broadcast on local radio, and has since been used as a resource by the Ministry of Health, schools, and Municipal Women's offices to stimulate group discussion on difficult topics.

In Rwanda we have established five centres to provide support for survivors of sexual and gender based violence. These centres provide a safe place for survivors to take refuge, and provide counselling and referrals to other services. This year the centres received 469 cases; 80% were resolved by the centre itself, whilst 20% were referred to other service providers, such as the police, local authorities and the courts.

We work with the Nidia White Association in Nicaragua to provide a shelter home for girls who are survivors of sexual violence; 111 girls received services at the shelter this year. We also work together to train men in the community about preventing violence against women. 16 men were trained initially, and they went on to train a further 190 men in the community. We also provided legal support to 521 women and adolescents and counselling to 32 women and children. As a result of our awareness raising work, the number of survivors reporting cases of violence against them has risen by 10%.

We continue to support the only shelter home in Somaliland for women escaping sexual and gender based violence. This year we provided 39 women with accommodation and services at the shelter home, 51 women with counselling services, and 17 women were referred to the legal aid service.

Nasteexo, 18 years old, sits in bed with her baby at the shelter home in Somaliland. She is a survivor of rape, and is receiving accommodation, food and counselling to support her.

Improving youth livelihoods

As well as working on rights for girls and women in Rwanda, we are working with both 359 girls and 309 boys to provide them with work readiness training and employability skills. We trained 400 students on work readiness, and being your own boss, and 362 young people in different trades such as hairdressing, carpentry, welding, tailoring and painting. As a result of this training, 314 young people who took part in the programme have now found jobs, and 21 have set up their own businesses, becoming self employed.

The training Alphonse (pictured) attended helped him to set up his own small farming business and buy a sewing machine with the proceeds. He has now started a second business making clothing.

Key highlights

Key beneficiary figures from 2017/18

Guatemala

385 TBAs from across eight health districts attended training on danger signs in pregnancy, and violence against women

Nicaragua

80% of pregnant women in the area stayed at birth waiting homes before delivery

Sierra Leone

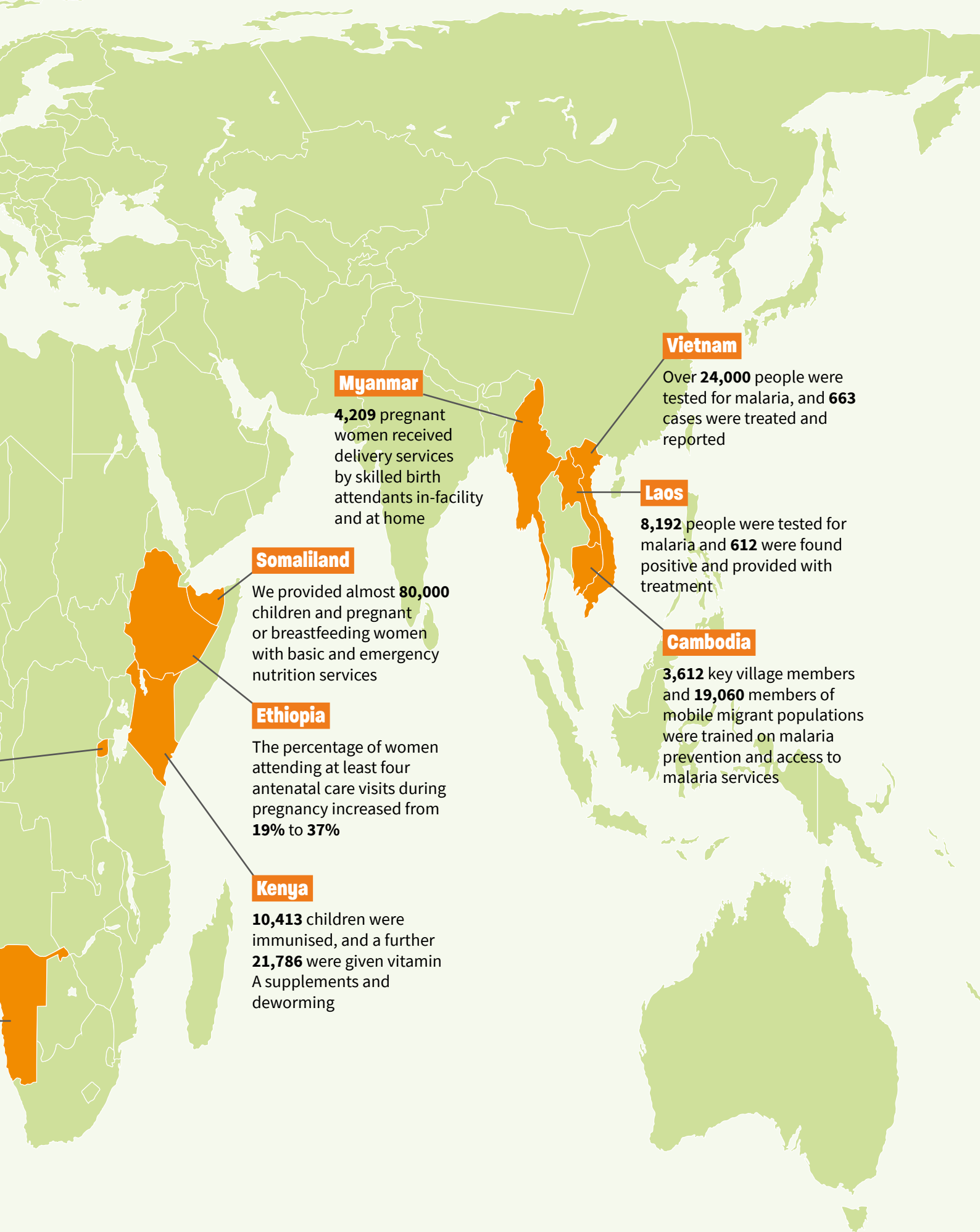
48 radio discussion programmes were produced and one broadcasted each week to spread health messages

Rwanda

Five one stop centres were established, and supported **469** survivors of sexual and gender based violence

Namibia

More than **90%** of expecting mothers delivered at health facilities



Vietnam

Over **24,000** people were tested for malaria, and **663** cases were treated and reported

Myanmar

4,209 pregnant women received delivery services by skilled birth attendants in-facility and at home

Laos

8,192 people were tested for malaria and **612** were found positive and provided with treatment

Somaliland

We provided almost **80,000** children and pregnant or breastfeeding women with basic and emergency nutrition services

Cambodia

3,612 key village members and **19,060** members of mobile migrant populations were trained on malaria prevention and access to malaria services

Ethiopia

The percentage of women attending at least four antenatal care visits during pregnancy increased from **19%** to **37%**

Kenya

10,413 children were immunised, and a further **21,786** were given vitamin A supplements and deworming

Speaking out

We campaign and lobby to influence policy both nationally and internationally to challenge power imbalances and create conditions that support health in the long term.

The root causes of poor health

We have driven forward approaches that challenge the root causes of poor health and map out alternative approaches for healthier lives.

Our report and video showcasing alternatives from around the world was launched at an event with the Shadow Secretary of State for Health. We held a popular event on 'Reclaiming Internationalism' and developed and published ten key policy ideas for the next government, with other members of the Progressive Development Forum.

Our Head of Policy and Campaigns was also approached in a personal capacity to sit on a prestigious Labour Party Taskforce, advising the Shadow Secretary of State for International Development on the Labour Party's approach to international development. We are delighted that many of the issues Health Poverty Action has been campaigning on for many years have now become Labour Party policy. We also supported the One Day Without Us Campaign to celebrate the contribution of migrants to the UK and spoke at numerous conferences, events and workshops.

Our work on illicit drug policy continues to lead the way in the sector. In the last year we developed and published six key recommendations to create a healthier drug policy. These were endorsed by a range of other organisations. We also co-authored a report looking at how to better measure the impacts of drug policy in line with the Sustainable Development Goals (the new UN framework for tackling global poverty) and presented this at its launch at the International Peace Institute, and contributed a chapter to Global Health Watch (the alternative World Health Report).

Strong and culturally appropriate health systems

We continue to advocate for culturally appropriate health services and for progress to be monitored using adequate data. We worked with Minority Rights Group to produce a factsheet on Indigenous Women's Maternal health highlighting the dearth of data for these groups. It was published by UNFPA, UNICEF and UN Women and launched at the UN Permanent Forum on Indigenous Issues in New York. We are now working with UN bodies to implement the recommendations in the factsheet. We also strengthened advocacy in our country programme teams by organising a successful training for the Country Directors of our Africa Programmmes with our allies in the People's Health Movement. This has created a firm basis on which to amplify advocacy in our country programmes to make health services more accessible for the people they serve.

Fundraising

Events

We continue to be amazed by our London Marathon team who, in 2017, raised over £60k – more than ever before! We are so grateful to have such a great group of people dedicating their time, energy and imagination to raise funds (as well as run 26.2 miles!) for our work. Thank you to everyone for taking part in runs and other sporting fundraisers throughout the year.

The brilliant students of St Swithun's on their Health Heroes day.

Community

Thank you also to all the super schools who have got their pupils involved in our fun School Stomp or Health Heroes initiatives throughout the year. A special thanks to the pupils of St Swithun's Junior School who raised an extraordinary £3.3k by taking part in Health Heroes, as well as raising vital awareness about the inequalities in health rights around the world. We were also delighted to have almost 100 incredible choirs singing for us at train and tube stations across London, raising more than £14k.

Partnerships

Following a successful pilot last year, we grew our new 'As One' campaign – a doctor-led initiative to show solidarity with primary health care professionals in the communities where we work. We are delighted to have formed so many strong partnerships for the campaign, with our As One Ambassadors supporting us to shape the initiative and new partners such as NB Medical helping us grow its reach.

Supporters

The generosity of our supporters is crucial in enabling us to stay focused on establishing and maintaining effective, high-quality programmes in the world's poorest communities. We are especially thankful to everyone who has continued to support us with a regular gift, and those who generously increased this or made additional donations to our appeals during the year. We have spent a lot of our year focused on improving our communications and ensuring we have the systems in place to keep our supporters up-to-date with our work. As ever, we will strive to meet the highest standards of fundraising practice and keep our supporters close to the heart of our work.

The wonderful Parklife choir singing for us at Archway station in December 2017.

Trusts and Foundations

Overall we raised almost £300k from Trusts and Foundations towards our work around the world, including match funding and bespoke projects. We were grateful once again to Emerging Markets Benefits Limited for choosing us as the beneficiary of their annual Charity Ball, and were very sorry that this marked their 'Last Dance' after more than 22 years of support totalling an incredible £1.3million towards our work.

We also started to develop relationships with larger funders who we look forward to working with in the year ahead. Our main priority has been to secure funding for key country programmes, including our maternal health work in Ethiopia. We would like to thank all of our generous supporters, including The Allan and Nesta Ferguson Charitable Trust, The Beatrice Laing Trust and The Waterloo Foundation.

Communications

Messaging

In all of our messaging, we aim to accurately represent the work we do, and the people we work with around the world. We want to show how poverty is created on a structural level, whilst representing the personal stories of those we work with in an honest and human way. The complexity of our work and messaging can make communicating in a simple and positive way quite challenging. This year we worked to strengthen our organisational voice using values and frames theory, which helped us think about the language we use, and how that language can effectively evoke and represent the values of the organisation. This has been an incredibly helpful process, teaching us to communicate clearly in a way that honestly represents our organisational values, and helping us to develop a new communications strategy for the organisation.

Digital

Our following on social media continues to grow, with over 7,000 followers on Twitter and over 3,700 likes on Facebook. We have started to grow our use of Facebook advertising to increase our reach and grow our profile.

Our current website has served us for over 10 years, and so this year we made the decision to develop a new website. As evermore fundraising and communications rely on digital platforms, it is important for us to ensure our website accurately presents the work of Health Poverty Action, and is an easy to use tool for supporters wanting to campaign, volunteer, donate or fundraise with us. We look forward to sharing the new platform with you in the coming year.

Storytelling

This year we developed a storytelling and photography training workshop for our UK staff. We have now started to roll out this training to our in country staff, and have already delivered it to our Kenya office, and both our offices in Somaliland. This training aims to help us share the incredible stories of the people we work with around the world, the challenges they face, and how we are working together to create change.

Media

Getting our campaigns and views into the media is another key way in which are raising our profile. In the past year we have been proactive in seeking media opportunities in order to raise awareness about the causes of poverty, and promote our campaigns and work. We had staff training on pitching to the media to gain coverage, and have had coverage in several big newspapers this year. Early in the year we had over 15 pieces of news coverage of our joint Honest Accounts report with Global Justice Now and other partners, including a piece the Independent, the Guardian and Aljazeera. We also published our own article in the New Internationalist, and were interviewed on Radio France Internationale. We have also had pieces in the Guardian on the tobacco industry and its trade deals with the Global South, and highlighting the challenging narratives around poverty and inequality in the development sector.

Financial review

Overview

During 2017-18, we maintained our financial strategy of investing in our in-country programmes. Our income during the reporting period was £19,169,688, which is the second highest that it has ever been and an increase of 19.47% on the previous year (£16,045,101). We are extremely grateful to all our donors for their generosity in helping us achieve this.

Income

Our income base includes income from institutional and individual donors.

The income from charitable activities of £18,742,472, up from £15,523,886 in 2016-17, comes primarily from grants from international institutions, governments, trusts and foundations and represents 98% of the overall organisation income. Of the £176,425 contribution from trusts and foundations, £138,700 was provided as match for institutional-funded projects, and the remainder was raised in support of our programmes. The remaining 2% of our income comes from unrestricted fundraising income – donations which include all types of income that are in substance gifts made on a voluntary basis. This includes all individual giving, community fundraising, legacies and some trust income. For further detail please refer to Note 2 of the accounts.

There was a decrease in unrestricted fundraising income of £93,999, compared to 2016-17. This was partly due to the realignment of our fundraising strategy, in light of our partnership with Find Your Feet and the resulting change in priorities. At the same time we saw the expected decline in the number of individual supporters, without new donors coming on board during the year as we developed new campaigns in line with Fundraising Regulations and GDPR. We also secured less income from trusts and foundations than in 2016-17, based on changes to funding criteria and cycles, and some expected grants not coming through until after the financial year end. These grants, however, should see an improvement in income in this area in 2018-19.

Charitable activities

Our commitment and investment in developing our in-country programmes work saw the charitable expenditure increase by £546,823, 3.18% more than the previous year. Whilst this is a remarkable achievement, we expect the expenditure figure in 2018-19 to increase as project activities take place, for which income was received late 2017-18.

Risks, uncertainties and mitigation

The Board has adopted a formal Risk Policy, and the Trustees and management have identified risks and ranked these by likelihood and impact. Key risks are regularly reviewed and monitored by senior managers as part of ongoing risk management throughout the year, while the Trustees review the major risks that face the organisation on at least an annual basis and more often if needed. The Board has established systems and clear reporting mechanisms to monitor, manage and mitigate the exposure to risk.

For 2018-19 we have identified five major risk areas which would have direct impact on unrestricted reserves:

- Over-dependence on restricted funds
- Exchange rate risk
- Compliance risk
- Brexit and impact on EC funding
- Financial risks

The main risk area for HPA remains its dependence on restricted funds. In 2017-18, 98% of HPA's income came from institutional donors and other restricted funding donors while 2% came from unrestricted sources. While there has been a 19.47% increase income during the financial year, the post Brexit environment challenges us to explore other income generating sources. For this reason the Board of Trustees have been discussing developing business plans in order to generate a higher level of unrestricted funds that would support HPA in its charitable activities in the medium and long term.

Exchange rate risk: The volatility of the exchange rate presents another risk that will need to be mitigated with an exchange rate policy. Exchange rate fluctuations elevate pressure on our unrestricted reserves in the event of losses. In 2016-17, we recorded a gain of £259,211 and in 2017-18 a loss of £112,258. As an INGO operating in countries with various currencies the risk management of currencies will prove vital in the uncertain economic climate we currently live in.

Compliance risk: In 2018-19, the Finance and Programmes teams will review the current procurement guidelines and annexes to ensure that we remain compliant with donor requirements, while making processes leaner. In addition, prioritising staff allocation to ensuring and monitoring donor compliance, including a senior donor compliance manager with overall oversight and a team of specialist programme officers ensuring donor

compliance in each country, will continue to support our risk management strategy. This will mean developing strong and close relationships with institutional donors to ensure HPA is fully informed about compliance requirements, and donors understand our implementation in detail.

Brexit and impact on EC funding: As the outcome of Brexit deal is still uncertain, HPA will continue to diversify its portfolio of funding institutions to reduce the impact of any changes in EU funding.

Financial risk: These relate to ensuring cash liquidity to respond to match funding and pre-financing requirements of projects. The Senior Management Team and Trustees will continue to prioritise and monitor cash flow position during the year but will also encourage timely submission of donor reports to avoid delays in payment.

Senior staff based in London visit all field offices at regular intervals and most projects at least once a year. Trustees are also encouraged to visit programmes when appropriate and practical, and such visits have taken place throughout the year. Finances are monitored by the management team regularly using a system of monthly checks and reviews. Board meetings are held quarterly and reports on progress in programmes and finances are presented in formats approved by the Board.

Reserves policy

In order to ensure the long-term financial viability of the organisation, it is the Board's policy to maintain minimum unrestricted free reserves at 5%-10% of budgeted income for the coming financial year, which equates to £0.68m – £1.3m for the coming year. Reserves at this level will mitigate some of the financial risks faced by the organisation (such as loss of income, donor clawbacks and cash flow sensitivity) and reduce their impact on beneficiaries.

During the year to 31 March 2018, HPA recorded a decrease in unrestricted reserves by £0.142m bringing total unrestricted reserves to £1.2m. This decrease was made up of £0.112m in exchange rate loss and £0.03m in net expenditure for the year.

Despite the adverse effect of exchange rate fluctuations, the current level of free reserves (of £1.2m) is at the higher end of the target range stated above.

The Board is satisfied with this but will maintain an objective to keep healthy reserves during the coming year.

Looking ahead

Our future plans emerge and develop through a process of informed reflection.

We recognise that we work in contexts that are complex and unpredictable – and believe that developing and implementing good strategy must be an ongoing process.

Our process of informed reflection seeks to not only capture key data, but also analyse and understand the reasons for it – and feed this into our current work and development of future plans.

Current plans for 2018-19

Programmatic

Programmes development – leverage existing partnerships and mechanisms to develop new programmes; develop partnerships and consortia with NGOs; engage in humanitarian operations as needed in our current operational areas; secure funding for key country programmes

Policy dialogues – engage in policy dialogues on policy and practice gaps relevant to our programmes (SGBV,FGM, gender equity and mental health)

Innovative projects – develop innovative ways of mainstreaming community engagement and social accountability; integrate technologies in new projects; develop integrated and holistic interventions

Research grants – invest time and energy on developing relationships with academics and research institutions, to learn, generate evidence and visibility of our work, and raise new funds.

Policy and campaigns

New Internationalism – contribute to highlighting and building momentum to address the root causes of poverty and poor health

Drug policy reform – strengthen advocacy for drug policy reform linking both the domestic and international agendas

Media – create bold narratives in all areas to generate media coverage and further Health Poverty Action's voice as a progressive and outspoken advocate for health justice

National advocacy – support the advocacy work of our programmes colleagues to amplify advocacy for health justice across the world.

Fundraising

Supporter engagement – inspire current and new supporters with new engaging campaigns; explore in-country fundraising opportunities; improve brand awareness among key audiences; continually improve our communications to bring our supporters closer to those we work alongside

Community and outreach – continue to build on our successes in the London Marathon, carol singing, and our Curry for Change campaign

Partnerships – find businesses with shared values to explore new partnerships under each of our key campaigns

Trusts – focus on high-level funding opportunities for new country projects, with a focus on Latin America and Africa.

Communications

Strategy – ensure we take a values and frames approach to our communications, with a consistent and effective voice, applied across all communications channels

Digital communications – develop a new website which tells the stories of those we work alongside, and develop a new social media strategy to increase engagement

Print communications – continue working towards bringing Health Poverty Action and Find Your Feet communications together through combined newsletters and annual reviews

Storytelling – building on the success of last year with the UK team, roll out digital storytelling and photography training to our in country teams to improve our communications.

Finance and administration

Process – investing in processes and systems in the UK and overseas. We have good relationships with in-country Finance Managers, which will help to generate a general framework and with tailoring specific in-country finance procedures

IT systems – plans to implement a new accounting system remains one of our priorities for the coming year. Ensuring that this project is well managed with the relevant expertise on the ground will be the focus

Internal audit – we will continue to encourage internal audits of country offices to understand challenges and major areas of risk to continually improve global financial management

Financial safeguarding – an understanding of the differences between operational and management levels will be the focus this year, ensuring our procedures are not only adequate but that they also work in practice.

Trustees' report

Structure, management and governance

Structure and management

Health Poverty Action is a registered charity and a company limited by guarantee, set up in 1984 to *'preserve and protect the health, through the provision of primary health care, of communities who receive little or no external assistance because of political instability and / or conflict'.*

In keeping with the principle of devolved management, the number of staff in London has been kept small. We also have part time volunteers working from time to time. In 1999 we decentralised direct management of our programmes to four regional offices supporting locally recruited project managers. Over the past few years we have developed different approaches in response to changing circumstances in the regions where we work. Where we have had long term programmes, we have gradually devolved responsibility to country managers and offices.

Remuneration policy

The remuneration policy of the charity is reviewed on an ongoing basis at SMT level, and the governing principles of the Charity's remuneration policy are as follows:

- To ensure delivery of the Charity's objectives
- To attract and retain a motivated workforce with the skills and expertise necessary for organisational effectiveness
- That remuneration should be equitable and coherent across the organisation
- To take account of the purposes, aims and values of the Charity
- To ensure that pay levels and pay increases are appropriate in the context of the interests of our beneficiaries

Senior management remuneration

In relation to deciding remuneration for the Charity's senior management, the Charity considers the potential impact of remuneration levels and structures of senior management on the wider Charity workforce and will take account of the following additional principles:

- To ensure that the Charity can access the types of skills, experiences and competencies that it needs in its senior staff, the specific scope of these roles in the Charity and the link to pay
- The nature of the wider employment offer made to senior employees, where pay is one part of a package that includes personal development, personal fulfilment and association with the public benefit delivered. The Charity recognises that it is, on occasion, possible to attract senior management at a discount to public sector or private sector market rates.

Remuneration for the year ended 31 March 2018 comprised salary and pension contributions. There are no other pecuniary benefits for senior or other staff at the Charity.

Governance

In accordance with the Memorandum and Articles of Association, the Trustees comprise the membership of the organisation and are responsible for electing new Trustees. All Trustees resign each year, either standing down or standing for re-election. In 2004 the Trustees agreed that no trustee should serve for more than eight years. The minimum number of Trustees is five and the maximum is twelve; there were eleven Trustees at 31 March 2018.

New Trustees are recruited by advertising in the public media and a range of networks. Newly appointed Trustees receive a full induction introducing them to Health Poverty Action and its work, and covering the essentials of what being a trustee involves. Trustees are encouraged to visit projects and some have participated in project evaluation and organisational development.

The full Board of Trustees meets at least four times a year, and met four times in 2017-18. One meeting is a full day to discuss key issues facing the organisation and its responses to emerging trends. Where necessary the Board establishes working groups to deal with particular issues and reports back to the full meeting. Day-to-day management of the organisation is delegated to the Director and staff.

Trustees Indemnity Insurance

Health Poverty Action has purchased a Charity Trustees Management Liability insurance policy on behalf of all the Trustees which covers legal liabilities up to an indemnity limit of £500,000.

Fundraising disclosures

Health Poverty Action has voluntarily subscribed to the Fundraising Regulator, to which we pay an annual levy, and we adhere to the standards of fundraising activities as set out in The Code of Fundraising Practice. In the past year we did not receive any formal complaints in relation to our fundraising activities.

In the past year we have not employed professional fundraisers to bring new supporters on board with our work (such as door-to-door, street, or private-site fundraising). The only professional fundraising agency which acted on our behalf during the year is Ethicall, which specialises in ethical telephone fundraising, and we work with them on occasion to speak to our existing supporters and thank them for the work they have supported as our small team does not have the capacity to do this in-house as we would like to. We monitor the activities of Ethicall through regular feedback, recordings, listen-ins, and supporter feedback. Ethicall are required, during these calls, to make a disclosure statement that they are working on behalf of Health Poverty Action. We have been working with Ethicall for many years and are confident in them acting on our behalf.

We do our utmost to protect vulnerable people and members of the public from any behaviour which is unreasonable or places undue pressure on any person to support our work. We continually review our our fundraising practices to ensure we are adhering to the very best practice, and are confident that our fundraising activities do so.

Statement of Trustees' responsibilities

We have set out in the Trustees' Report a review of financial performance and the charity's reserves position. We have adequate financial resources and are well placed to manage the business risks. Our planning process, including financial projections, has taken into consideration the current economic climate and its potential impact on the various sources of income and planned expenditure.

We have a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future. We believe that there are no material uncertainties that call into doubt the Charity's ability to continue. The financial statements have therefore been prepared on the basis that the Charity is a going concern.

Trustees

The Trustees who are directors of the company and who served during all or part of the year from 1 April 2017 up to the date of signing these accounts, are stated below.

Trustees administrative report

Health Limited t/a Health Poverty Action (limited by guarantee)

Registered Company Number: 1837621

Registered Charity Number (England and Wales): 290535

Trustee	Role	Details
Sunit Bagree		Appointed 28th June 2018
Greg Barclay[2]		Stepped down 17th March 2018
Nouria Brikci-Nigassa		
Emma Crewe[1&2]	Chair	
Anna Graham		Appointed 10th October 2017
Rory Honney		
Sharon Jackson[2]		
Oliver Kemp[2]		
Carolyn Ramage[1]	Treasurer	
Ruth Stern[1]		
James Thornberry[1]		
Betty Williams[1]		
Simon Wright		

1. members of the Finance and Audit Committee 2. members of the Fundraising Advisory Group

Registered Office:

Health Poverty Action
Ground Floor
31-33 Bondway
London SW8 1SJ
United Kingdom

Auditors:

Kingston Smith LLP
Devonshire House
60 Goswell Rd
London EC1M 7AD
United Kingdom

Banks:

CAF Bank Limited
Kings Hill
West Malling
Kent ME19 4TA
United Kingdom

HSBC plc
8 Canada Square
London
E14 5HQ
United Kingdom

Director:

Martin Drewry

Senior Management Team:

Abigail Betts, Head of Fundraising

Natalie Sharples, Head of Policy and Campaigns

Hardeep Singh, Head of Finance and Administration (resigned 5th February 2018)

Sandra Tcheumeni-Boschet, Head of Finance and Administration (appointed 12th March 2018)

Mauricio Vazquez, Head of Programmes – Asia and Latin America (resigned 11th July 2018)

Dr. Tadesse Kassaye Woldetsadik, Head of Programmes – Africa

Trustees' responsibilities

The Trustees (who are also directors of the company for the purposes of company law) are responsible for preparing the Trustees' Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice.)

Company law requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the state of the affairs of the charitable company and of its income and expenditure for that period. In preparing these financial statements, the Trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles the Charities SORP;
- Make judgements and estimates that are reasonable and prudent;
- Prepare the financial statements in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102);
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charitable company will continue in business.

The Trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charitable company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the charitable company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

None of the Trustees had any beneficial interest in any contract to which the Organisation was party during the year.

Provision of information to auditors

Each of the persons who is a trustee at the date of approval of this report confirms that: so far as the trustee is aware, there is no relevant audit information of which the company's auditors are aware; and the trustee has taken all the steps that she / he ought to have taken as a trustee in order to make herself / himself aware of any relevant audit information and to establish that the company's auditors are aware of that information. This confirmation is given and should be interpreted in accordance with the provision of section 418 of the Companies Act 2006.

Auditors

Kingston Smith LLP has expressed its willingness to continue as auditor for the next financial year.

The Annual Report and Accounts including the Strategic Report is approved by the Board of Trustees and signed on its behalf by Emma Crewe, the Chair of the Board.

On behalf of the Trustees

Emma Crewe

Date: 5/11/18

Independent Auditor's report to the members of Health Poverty Action

Opinion

We have audited the financial statements of Health Poverty Action for the year ended 31 March 2018 which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 'The Financial Reporting Standard Applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charitable company's affairs as at 31 March 2018 and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs(UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the audit of the financial statements section of our report. We are independent of the charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matter prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the strategic report and the trustees' annual report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the strategic report and the trustees' annual report have been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the strategic report or the trustees' annual report.

We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement set out on page 27, the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charitable company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charitable company or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK) we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the charitable company's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustees.

- Conclude on the appropriateness of the trustees' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charitable company's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the charitable company to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Use of our report

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to any party other than the charitable company and charitable company's members as a body, for our audit work, for this report, or for the opinions we have formed.

Neil Finlayson
Senior Statutory Auditor

Date: 7/11/2018

For and on behalf of
Kingston Smith LLP
Statutory Auditor
Devonshire House
60 Goswell Road
London
EC1M 7AD

Accounts

STATEMENT OF FINANCIAL ACTIVITIES

(Incorporating an income and expenditure account)

For the year ended 31 March 2018

	Notes	Unrestricted funds 2018 £	Restricted funds 2018 £	Total funds 2018 £
INCOME AND ENDOWMENTS FROM:				
Charitable activities	2	–	16,604,860	16,604,860
Donations and legacies	2	421,612	–	421,612
Gift in Kind Income	2	–	2,116,043	2,116,043
Investments	2	5,604	21,569	27,173
Total incoming resources		**427,216**	**18,742,472**	**19,169,688**
RESOURCES EXPENDED				
Raising funds	3	337,030	–	337,030
Charitable activities	4	120,855	17,747,989	17,868,843
Total resources expended		**457,885**	**17,747,989**	**18,205,873**
NET INCOME/(EXPENDITURE) FOR THE YEAR		(30,669)	994,483	963,815
Transfer between funds		–	–	–
Foreign exchange gains in year		(112,258)	(140,591)	(252,848)
NET MOVEMENT IN FUNDS FOR THE YEAR		**(142,927)**	**853,893**	**710,966**
Total funds brought forward at 1 April 2017		1,415,191	4,067,721	5,482,913
TOTAL FUNDS CARRIED FORWARD at 31 March 2018		**1,272,265**	**4,921,614**	**6,193,879**

The statement of financial activities includes all gains and losses recognised in the year.
All incoming resources and resources expended derive from continuing activities.

For the year ended 31 March 2017

	Notes	Unrestricted funds 2017 £	Restricted funds 2017 £	Total funds 2017 £
INCOME AND ENDOWMENTS FROM:				
Charitable activities	2	–	13,918,158	13,918,158
Donations and legacies	2	520,926	–	520,926
Gift in Kind Income	2	–	1,592,828	1,592,828
Investments	2	289	12,900	13,189
Total incoming resources		**521,215**	**15,523,886**	**16,045,101**
RESOURCES EXPENDED				
Raising funds	3	336,287	–	336,287
Charitable activities	4	–	17,201,165	17,201,165
Total resources expended		**336,287**	**17,201,165**	**17,537,453**
NET INCOME/(EXPENDITURE) FOR THE YEAR		184,928	(1,677,279)	(1,492,351)
Transfer between funds	14	–	–	–
Foreign exchange gains in year		259,211	130,227	389,438
NET MOVEMENT IN FUNDS FOR THE YEAR		**444,139**	**(1,547,052)**	**(1,102,913)**
Total funds brought forward at 1 April 2016		**971,052**	**5,614,773**	**6,585,825**
TOTAL FUNDS CARRIED FORWARD at 31 March 2017		**1,415,191**	**4,067,721**	**5,482,912**

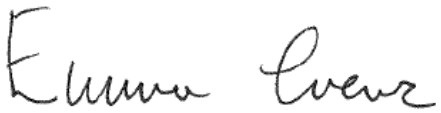
The statement of financial activities includes all gains and losses recognised in the year.
All incoming resources and resources expended derive from continuing activities.

BALANCE SHEET

Health Limited T/A Health Poverty Action Balance Sheet as at 31 March 2018

	Notes	2018 £	2017 £
CURRENT ASSETS			
Debtors	8	1,075,606	1,070,561
Stock		583,504	280,272
Cash at bank and in hand		5,350,533	5,159,267
		7,009,643	**6,510,100**
CURRENT LIABILITIES			
Creditors: Amounts falling due within one year	9	(594,633)	(601,970)
NET CURRENT ASSETS		**6,415,010**	**5,908,130**
LONG TERM LIABILITIES			
Creditors: Amounts falling due after one year	10	(221,131)	(425,218)
TOTAL ASSETS LESS LIABILITIES		**6,193,879**	**5,482,912**
TOTAL NET ASSETS		**6,193,879**	**5,482,912**
FUNDS			
Unrestricted funds	13	1,272,265	1,415,191
Restricted funds	13	4,921,614	4,067,721
		6,193,879	**5,482,913**

Approved by the Board of Trustees and signed on its behalf by:



Emma Crewe, Chair Date: 5/11/18

The Notes on pages 36-45 form part of these financial statements

Company Registration number 01837621

CASH FLOW STATEMENT

Health Limited T/A Health Poverty Action cash flow statement for the year ended 31 March 2018

	2018 £	2017 £
Net Cash Outflow from operating Activities	416,940	(1,147,161)
Returns on Investments and Servicing of Finance		
Bank Interest received	27,173	12,900
Foreign exchange gain	(252,848)	389,438
(Decrease) / Increase in Cash	**191,265**	**(744,823)**
Reconciliation of Excess of Expenditure over Income to Net Cash Inflow from Operating Activities		
Net incoming / (outgoing) resources	710,966	(1,102,913)
Decrease / (Increase) in debtors	(5,045)	241,248
(Increase) in stock	(303,232)	(55,966)
Increase in creditors	(211,424)	172,808
Interest received	(27,173)	(12,900)
Foreign exchange gain	252,848	(389,438)
Net cash (outflow) inflow from operating activities	**416,940**	**(1,147,161)**
Analysis of Net Cash Resources		
Cash		
Opening Balance	5,159,267	5,904,090
Flow	191,265	(744,823)
Closing Balance	**5,350,533**	**5,159,267**
Location of Cash Resources		
HQ bank accounts	2,848,358	2,260,877
In-country bank accounts	2,502,174	2,684,829
Funds attributed to Connected Party (Note 14)	–	213,561
	5,350,533	**5,159,267**

NOTES

Notes forming part of the financial statements for year ended 31 March 2018

1. PRINCIPAL ACCOUNTING POLICIES

A summary of the principal accounting policies adopted, judgements and key sources of estimation uncertainty, is set out below.

a) Accounting convention

The financial statements have been prepared in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102). The company is a public benefit entity for the purposes of FRS 102 and a registered charity established as a company limited by guarantee and therefore has also prepared its financial statements in accordance with the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (The FRS 102 Charities SORP), the Companies Act 2006 and Charities Act 2011.

The functional currency of the charity is pound sterling.

b) Going Concern

The trustees have assessed whether the use of going concern and have considered possible events or conditions that might cast significant doubt on the ability of the charitable company to continue as a going concern. The trustees have made this assessment for a period of at least one year from the date of the approval of these financial statements. After making enquiries, the trustees have concluded that there a reasonable expectation that the charitable company has adequate resources to continue in operational existence for the foreseeable future. The charitable company therefore continues to adopt the going concern basis in preparing its financial statements. There are no material uncertainties.

c) Incoming resources

All incoming resources are included in the SOFA when the charity is legally entitled to the income and the amount can be quantified with reasonable accuracy. The following specific policies apply to categories of income:

- Donated services and facilities: are included at the value to the charity where this can be quantified. No amounts are included in the financial statements for services donated by volunteers.
- Income includes: income received from statutory and other government supported agencies, and income from other private sources.
- Gifts in kind are recognised as both income and expenditure. The value of gifts in kind from donors is pre-determined by the donor according to grant agreements, typically based on market prices for relevant goods. The value of the gifts received from the donor in the year is recognised as income. Only the gifts distributed in the year are recognised as expenditure. Any gifts not yet distributed at year end are held in stock.

d) Resources expended

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to that category. Where costs cannot be directly attributed to particular headings they have been allocated to activities on a basis consistent with use of resources. Staff costs are allocated on an estimate of time usage and other overheads have been allocated on the basis of the head count.

Costs of raising funds are those incurred in seeking voluntary contributions and do not include the costs of disseminating information in support of the charitable activities.

Support costs (including governance costs), which include the central office functions such as general management, payroll administration, budgeting and accounting, information technology, human resources, and finance are allocated across the categories of raising funds and charitable expenditure. The basis of the cost allocation has been explained in the notes to the accounts.

e) Fund accounting

Unrestricted funds are available for use at the discretion of the directors in furtherance of the general objectives of Health Poverty Action. Restricted funds are subject to restrictions imposed by donors or the purpose of the appeal.

All income and expenditure is shown on the Statement of Financial Activities.

f) Foreign Currencies

Transactions in foreign currencies are translated into sterling at the weighted average rate of exchange during the period and are disclosed in the Statement of Financial Activities. Current assets and liabilities held on the balance sheet are retranslated at the year end exchange rate.

g) Pensions

The charity contributes to personal pension plans in respect of certain employees. The expenditure charged in the financial statements represents contributions payable in respect of these schemes during the year.

h) Operating leases

Rentals under operating leases are charged to the income and expenditure account as payments are made.

i) Liabilities

Liabilities are recognised when a charity has a legal or constructive obligation to a third party

j) Other financial instruments

i. Cash and cash equivalents
Cash and cash equivalents include cash at banks and in hand and short term deposits with a maturity date of three months or less.

ii. Debtors and creditors
Debtors and creditors receivable or payable within one year of the reporting date are carried at their at transaction price. Debtors and creditors that are receivable or payable in more than one year and not subject to a market rate of interest are measured at the present value of the expected future receipts or payment discounted at a market rate of interest.

k) Critical accounting estimates and areas of judgement

In the view of the trustees in applying the accounting policies adopted, no judgements were required that have a significant effect on the amounts recognised in the financial statements nor do any estimates or assumptions made carry a significant risk of material adjustment in the next financial year.

2. INCOME

	2018 £	2017 £
VOLUNTARY INCOME		
Restricted Funds		
Charitable activities		
3MDG	2,335,181	388,728
Australian Department of Foreign Affairs and Trade	95,458	464,017
Big Lottery Fund	363,649	432,234
Canadian Department of Foreign Affairs, Trade and Development	14,450	–
Comic Relief	670,532	132,490
Concern Worldwide	–	97,817
Cordaid	59,071	70,392
Department for International Development	4,163,832	4,886,029
Education Development Center	92,716	173,222
European Commission	1,731,477	876,126
Global Fund	2,723,527	3,001,807
Irish Aid	136,148	–
Liverpool School of Tropical Medicine	9,792	291,142
Malaria Consortium	–	(42)
Other	510,784	324,128
Population Services International	1,207,821	963,857
UN bodies	1,166,988	1,394,292
World Food Programme	478,141	301,075
Save the Children International	328,284	111,896
World Bank	–	8,948
Relief International	188,461	–
UCSF (University of California)	209,608	–
	16,485,920	**13,918,158**
Other trading activities		
Trusts, foundations and individuals	118,940	–
Gift in Kind	2,116,043	1,592,828
	2,234,983	**1,592,828**
Total Restricted Funds	**18,720,903**	**15,510,986**
Unrestricted Funds		
Donations from individuals	344,737	412,744
Consultancy	–	2,832
UK and European trusts / foundations	76,875	105,350
Total Unrestricted Funds	**421,612**	**520,926**
INVESTMENT INCOME		
Bank interest		
Restricted Funds	21,569	12,900
Unrestricted Funds	5,604	289
	27,173	**13,189**
TOTAL INCOMING RESOURCES	**19,169,688**	**16,045,101**

3. RAISING FUNDS

	Direct	Support costs	Total 2018	Direct	Support costs	Total 2017
	£	£	£	£	£	£
Other costs	95,883	241,147	**337,030**	171,261	165,026	**336,287**
	95,883	241,147	**337,030**	171,261	165,026	**336,287**

For further breakdown of support costs please refer to Note 5.

4. CHARITABLE ACTIVITIES

	Direct	Support costs	Total 2018	Direct	Support costs	Total 2017
	£	£	£	£	£	£
Costs of health projects	17,255,323	613,520	**17,868,843**	16,500,961	700,204	**17,201,165**

For further breakdown of support costs please refer to Note 5.

5. SUPPORT COSTS

Cost allocation includes an element of judgement and the charity has had to consider the cost benefit of detailed calculations and record keeping. To ensure full cost recovery on projects the charity adopts a policy of allocating costs to the respective cost headings. This allocation includes support costs where they are directly attributable.

Support costs and basis of apportionment:

	Total 2018	Cost of generating other voluntary income 2018	Health projects 2018	Basis of apportionment
Nature of cost	£	£	£	
Human resources	**662,672**	203,408	459,264	Number of employees
Establishment costs	**84,853**	20,559	64,294	Number of employees
Office & Administration	**107,142**	17,180	89,962	Number of employees
	854,667	241,147	613,520	

	Total 2017	Cost of generating other voluntary income 2017	Health projects 2017	Basis of apportionment
Nature of cost	£	£	£	
Human resources	**725,371**	147,874	577,4967	Number of employees
Establishment costs	**28,962**	3,552	25,410	Number of employees
Office & Administration	**110,897**	13,600	97,297	Number of employees
	865,230	165,026	700,204	

6. NET INCOME FOR THE YEAR is stated after charging

	2018 £	2017 £
Annual Audit		
Statutory audit	18,860	20,000
Additional fee for overruns incurred	-	6,552
Rentals in respect of operating leases;		
plant and machinery	2,033	3,867
other – office	59,916	32,563
Inventory expense	583,504	1,536,862

7. STAFF COSTS AND TRUSTEES' REMUNERATION

	2018 £	2017 £
U.K. STAFF		
Wages and salaries	780,551	760,662
Redundancy cost	-	11,496
Social security costs	88,645	73,529
Pension costs	37,680	36,358
	906,876	882,045
OVERSEAS STAFF		
Wages and salaries	2,888,972	3,820,531
Pension costs	118,516	117,450
	3,007,488	3,937,981
TOTAL STAFF COSTS	**3,914,364**	**4,820,026**

One employee received remuneration of between £70,000 – £80,000 in 2017-18 (2017: one).

Employer's pension cost relating to that individual was £3,607 (2017: £3,607).

It should be noted that for purposes of fund accounting pension costs are allocated as follows;
UK staff are allocated to unrestricted funding, and overseas staff allocated to restricted funding.

Key management personnel consists of the Senior Management Team (SMT) members. The SMT is comprised of the Trustees, Director, Head of Finance and Administration, Head of Asia Programmes, Head of Africa Programmes, Head of Fundraising and the Head of Policy and Campaigns.

Total salary costs relating to key management personnel in the year was £409,358 (2017: £403,180).

The Trustees neither received nor waived any emoluments during the year (2017: £Nil).

Total reimbursements received by the Trustees in the year amounted to £1,073.25 (2017: £939). These reimbursements were received by 1 Trustee (2017: 2 Trustees). All reimbursements related to travel costs.

The average number of employees, analysed by function was:

	2018 Number	2017 Number
Charitable activities	386	566
Raising funds	5	4
	391	**570**

8. DEBTORS

	2018 £	2017 £
Other debtors in UK	100,458	587
Other overseas/project debtors	267,941	237,566
Accrued income – Gift Aid & Other	9,581	8,865
Accrued income – Grants	676,795	823,543
Prepayments	20,832	–
	1,075,606	**1,070,561**

All debtors, except prepayments of £20,832 (2017: Nil), are financial instruments measured at present value.

9. CREDITORS: Amounts falling due within one year

	2018 £	2017 £
Project creditors	145,867	213,098
Other creditors	130,983	221,039
Field pensions liability	22,162	52,039
UK Pension liabiltiy	72,642	54,667
Field severance pay liability	197,585	–
Other taxes and social security	–	20,999
UK Accruals	25,394	40,128
	594,633	**601,970**

All creditors, except for the social security creditor of £185 (2017: £20,999), are financial instruments measured at present value.

Creditors includes pension liabilities of £22,162 (2017: nil).

10. CREDITORS: Amounts falling due after one year

	2018 £	2017 £
Field severance pay liability	221,131	425,218
	221,131	**425,218**

All creditors are financial instruments measured at present value.

11. MEMBERS' GUARANTEE

The company has no share capital as it is limited by guarantee, the liability of each member being a maximum of £1.

12. FINANCIAL COMMITMENTS

Total commitments under non-cancellable operating leases are as follows:

	2018	2017
Committed to payments of:	**£**	**£**
Within One Year		
Plant and Machinery	-	–
Other – office	59,483	56,063
Between Two and Five Years		
Plant and machinery	-	–
Other – office	111,679	98,109
Total	**171,162**	**154,172**

13. ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Unrestricted Funds 2018 £	Restricted Funds 2018 £	Total Funds 2018 £	Unrestricted Funds 2017 £	Restricted Funds 2017 £	Total Funds 2017 £
Fund balances at 31 March 2018 are represented by:						
Current assets	1,501,284	5,508,359	7,009,643	1,752,023	4,758,077	6,510,100
Current liabilities	(229,019)	(365,614)	(594,633)	(336,832)	(265,138)	(601,970)
Long Term Liabilities	–	(221,131)	(221,131)	–	(425,218)	(425,218)
Total Net Assets	**1,272,265**	**4,921,614**	**6,193,879**	**1,415,191**	**4,067,721**	**5,482,912**

14. STATEMENT OF FUNDS

	Funds at 2017 £	Income £	Expenditure £	Transfers £	Funds at 2018 £
Myanmar & China	1,370,968	8,075,577	(7,401,660)	–	2,044,886
Cambodia	675,771	699,442	(1,234,154)	–	141,059
Ethiopia	137,021	258,256	(282,092)	–	113,185
Global	112,722	163,333	(113,418)	–	162,637
Guatemala	92,778	9	(8,671)	–	84,116
Kenya	88,117	673,063	(616,230)	–	144,949
Laos	417,247	1,590,709	(1,276,387)	–	731,569
Namibia	84,622	260,118	(338,071)	–	6,669
Nicaragua	173,167	524,843	(568,273)	–	129,737
Peru	–	–	–	–	–
Rwanda	80,108	530,148	(559,208)	–	51,048
Sierra Leone	240,623	572,256	(401,381)	–	411,498
Somaliland	658,543	2,829,513	(2,938,601)	–	549,455
GIK	–	2,116,043	(1,812,811)	–	303,232
SE Asia Regional	–	125,000	(77,283)	–	47,717
Vietnam	(63,966)	324,163	(260,339)	–	(143)
Total restricted funds	**4,067,721**	**18,742,472**	**(17,888,579)**	**–**	**4,921,614**
Unrestricted funds	1,415,191	427,216	(570,142)	–	1,272,265
Total funds	**5,482,912**	**19,169,688**	**(18,458,721)**	**–**	**6,193,879**

14. STATEMENT OF FUNDS (continued)

	Funds at 2016 £	Income £	Expenditure £	Transfers £	Funds at 2017 £
Myanmar & China	2,929,602	6,368,228	(7,926,862)	–	1,370,968
Cambodia	398,163	1,115,761	(838,153)	–	675,771
Ethiopia	314,380	81,723	(259,081)	–	137,021
Global	25,975	154,758	(68,011)	–	112,722
Guatemala	109,865	73,774	(161,216)	70,355	92,778
Kenya	(26,374)	833,347	(718,856)	–	88,117
Laos	469,236	965,556	(1,017,545)	–	417,247
Namibia	144,888	323,361	(383,627)	–	84,622
Nicaragua	165,573	547,656	(472,624)	(67,438)	173,167
Peru	2,917	–	–	(2,917)	–
Rwanda	100,313	746,071	(766,276)	–	80,108
Sierra Leone	202,692	471,747	(433,816)	–	240,623
Somaliland	777,543	3,650,175	(3,769,175)	–	658,543
GIK	–	–	–	–	–
SE Asia Regional	–	–	–	–	–
Vietnam	–	191,729	(255,695)	–	(63,966)
Total restricted funds	**5,614,773**	**15,523,886**	**(17,070,938)**	**–**	**4,067,721**
Unrestricted funds	971,052	780,426	(336,287)	–	1,415,191
Total funds	**6,585,825**	**16,304,312**	**(17,407,225)**	**–**	**5,482,912**

Restricted funds balances are held to ensure that there are adequate funds to implement programme activities.

It should be noted that transfers between restricted funds for the year ended 31 March 2017 relate to the transfer of funds between projects for the same programme of activities that are being implemented in different countries.

15. RELATED PARTY TRANSACTIONS

During the 2016-17 financial year, HPA entered into a strategic partnership with another charity, Find Your Feet (FYF). FYF became a linked charity of HPA after the 2017-18 year end.

HPA provides management and support services to FYF at its UK headquarters.

In 2017-18, HPA made purchases for FYF and a total of £265,838 of direct costs were recharged to FYF.

Additionally, a total of £102,356 of HPA's staff cost was recharged to FYF.

At year end, there was a debtor balance of £100,313.54 owed by FYF to HPA.

16. STATEMENT OF FUNDS

	2018 Receipts	2018 Expenditure	2017 Receipts	2017 Expenditure
Big Lottery Fund				
ICB/2/010415059 Ethiopia (main grant)	–	–	–	1,720
ICB/2/010445412 Cambodia (main grant)	–	–	–	3,125
ICB/2/010462606 Guatemala (main grant)	–	–	73,743	82,436
URN: 0010065516 Sierra Leone (main grant)	108,672	144,296	169,432	208,906
URN: 0010237333 Nicaragua (development grant)	-	–	–	5,000
URN: 0010237333 Nicaragua (main grant)	115,105	115,010	145,071	145,188
URN: 0010231645 Namibia (main grant)	139,872	167,369	43,988	133,097
Christian Aid				
AB290 Myanmar	–	–	–	13,975
Irish Aid				
CSF07-15 Nicaragua and Rwanda	92,246	89,099	–	50,972
DFID				
GPAF-IMP-045 Somaliland	–	–	7,316	–
GPAF-IMP-081 Kenya	–	–	9,110	–
GPAF-IMP-069 Laos	–	–	9,999	–
AGA 203400-107 Myanmar	1,199,912	985,582	2,288,146	3,350,271
UKAD-IMP-119 Myanmar	1,142,920	1,117,108	613,122	664,318
UKAD-IMP-120 Kenya	231,592	231,592	378,713	383,648
HARP-TRN-001 Myanmar	1,518,091	1,505,216	–	–
Girls Education Challenge – GEC				
6317- Rwanda -GEC	265,750	–	325,728	554,862
6317- Rwanda -GEC-T	181,731	310,907	–	–
Population Services International				
4115SOM-HPA-01Nov17 Somaliland	18,865	18,825	–	–
4289-HPA-26JUL2016 Somaliland	1,188,955	1,169,367	932,626	931,642
3620-HPA-01JAN11 Somaliland	–	–	31,230	215,400
Save the Children International				
203462-107 Somaliland	328,284	419,876	111,896	20,304
Cordaid				
110811 Sierra Leone	–	–	–	2,026
111634 Sierra Leone	–	–	(18,103)	4,715
111077 Ethiopia	86,653	–	–	120,124
113336-SAN Sierra Leone	60,913	57,200	–	–
Medici con l'Africa CUAMM				
CFMCH-109957- Ethiopia	–	–	(6,772)	–
Comic Relief				
219206 Ethiopia	191,259	246,813	–	150,617
1867316 Sierra Leone	198,433	186,818	132,490	43,227
2572521 Cambodia & Laos	125,000	45,584	–	–
2712084 Sierra Leone	155,840	24,694	–	–

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