ANNUAL REPORT & ACCOUNTS

2018-2019

HEALTH POVERTY ACTION

Contents

Cover image: Women from the Duinpos village in Namibia play a local San ball game. © Toby Madden

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Message from Director and Chair

The last year has been challenging for all who care about global justice. People forced into poverty around the world are suffering as a result of unprecedented cuts to funding. In some cases, there has even been an openly hostile environment for organisations like Health Poverty Action who are trying to ensure health justice for all. As such, we are incredibly grateful to all our partners, supporters, volunteers and staff for their commitment and ability, which enables us to ensure that we stay true to our values and rooted in the communities we serve.

Health Poverty Action has always worked in solidarity with those most neglected – often in places that are hard to reach (frequently for reasons of politics as well as geography). This year our partnerships for both Health Poverty Action and our linked charity Find Your Feet have benefitted almost 2 million people in 18 countries, enabling them to access family planning services, immunisations, and benefit from training to local nurses, among a multitude of other activities. We continue to follow a justice-oriented comprehensive approach – tackling not just the symptoms but the underlying causes of poor health, especially the social determinants – because we know it's the only method that works in the long term.

Much of our work is about creating environments where women and girls have a powerful voice and become leading actors for change. We must strive to ensure we prioritise listening to, understanding and empowering all whose rights are denied to them – including indigenous people, people with mental health challenges, people living with disabilities, and other marginalised groups that face discrimination.

Alongside our country programmes work, and often as part of it, we are committed to speaking out for health justice. Our policy and campaigning work is thoughtful and evidence-based, calling on us to tackle controversial issues when this is required of us. For example, we have seen that it is often injustice, inequality and vulnerability that drives people to engage in the drugs trade, and we have seen how the so-called 'War on Drugs' is so often increasing poverty and damaging public health. So, we are calling for new approaches. We have similarly seen how market fundamentalism has failed to serve the rights of all and are advocating for alternatives that contribute to achieving health for all.

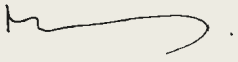
In these times our voices need to be heard, and those of us who share these concerns need to raise them together. Principles of partnership and solidarity are integral to the life and work of Health Poverty Action. We actively collaborate with others who share our aims and values – and especially value our place in the influential global network called the People's Health Movement. Our board of Trustees and senior management team try to recruit not just high calibre expertise, but people who will also live and breathe these values.

The team has continued to do incredibly valuable work and has turned new initiatives, like our growing mental health work, into a reality in just a few years. Those who support this work and make it possible by providing the resources for it are evolving too. Over the past year we have had to find new ways of fundraising to make up for shortfalls in restricted funding. As is so deeply ingrained within our culture, we think carefully about how to spend every penny to make sure we use it wisely.

We hope our communications have become much clearer and compelling too. The people behind the scenes have done incredible work with finite resources, and we're seeing a greater interest in our work from the press and broadcast media.

We thank everyone who has contributed in any way to make this happen, and we're looking forward to another year challenging the root causes of poverty and health inequality.

Oliver Benjamin Kemp
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 healthcare, 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 act in solidarity with health workers, activists and communities worldwide to improve health and challenge the causes of poverty.

Public benefit statement

Health Poverty Action's charitable purpose is carried out for the public benefit in accordance with our vision and mission. 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 current circumstances.

Health Poverty Action acts in solidarity with health workers, activists and communities worldwide to improve health and challenge the causes of poverty. 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 healthcare movement that achieved ground-breaking 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 healthcare – reclaiming power, demanding and monitoring high quality health services, as well as taking community action together to improve their health.

Healthcare 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 healthcare 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 healthcare.

One element of our integrated approach has proven profoundly effective: strengthening both the supply and demand side of healthcare 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.

Adela Ixcotoyac has worked as a *comadrona* (similar to a doula for pregnant indigenous women in Guatemala) for over 40 years.

On the ground

Health Poverty Action works in 14 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 access to family planning services in Myanmar, 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. 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. We campaign against the failed 'war on drugs' because it causes a vicious cycle of poverty around the world, targeting the most marginalised and vulnerable in society. The phenomenal successes of the global movement for drug policy reform were a key highlight this year! Our own contributions to this include cross party recognition of drug policy as a core issue of global justice. Additionally, our call for the UK to set a global example by legally regulating cannabis has moved up the political agenda rapidly.

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 continues to be exploring 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, consultancy and 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 taken steps to improve the way we communicate, largely based around the values and frames theory, to ensure we are representing the people we work with around the world in a fair and truthful way. We have also been working 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 launched a new website in December 2018 and are building relationships across media outlets to help spread our messages.

Achievements, performance and impact

Maternal health

In remote communities where people are denied access to healthcare, it is often mothers, newborn babies and very young children who are most at risk of serious health problems. That's why we work hard with local communities to address urgent issues, whether that means the marginalisation of women, minority or indigenous groups, or a lack of infrastructure or knowledge.

Almost half of all women living in very remote villages in the Khammouane Province of Laos have no access to maternal healthcare. We worked with local women to ensure they got the most nutritional benefit from locally grown foods during pregnancy – a simple way of improving the health of both mothers and very young children. To do this, we worked in 15 remote villages, running nutrition education programmes designed to build on local womens' knowledge about the importance of nutrition for mother and baby – and we even organised cooking demonstrations to bring this to life. At the same time, we trained 60 Village Nutrition Facilitators who will be able to provide crucial advice and support for mothers throughout the province – and help future generations grow up strong and healthy.

A scarcity of maternal healthcare services in some of the most isolated and remote rural communities in Kenya means that many mothers and babies die during childbirth. We were able to train 100 community based reproductive health agents to safely deliver babies and work with the experienced local women who traditionally carry out this task. Thanks to this vital work, the number of women in these communities now being assisted in childbirth by a trained health care worker has risen from 48% to 77% over two years – a huge increase that means many more lives are saved.

We ran a project in Namibia called Mothers Own Their Health Education & Rights (MOTHER), which aimed to improve the accessibility, quality and availability of maternal health services for women in remote, scattered villages across a huge area in the Otjozondjupa region of the country. A major part of this work involved raising awareness – among both men and women – of issues around sexual health.

At the end of the programme, we saw a 30% increase in the number of men and women who could spot three signs of pregnancy, and in the numbers of young people who could name three forms of contraception. This knowledge can prevent unwanted pregnancies, and ultimately help save the lives of girls and women.

We worked hard to improve the sexual and reproductive health of women and girls in the Dollo Ado and Bokolmayo districts of Ethiopia. In these remote, rural areas near the border of Somalia and Kenya there is often a lack of adequate information on aspects of sexual health. In order to reach local women and girls, we trained government health staff especially in how to offer advice and support on long-term family planning methods and contraception.

Hussein, a nurse from Dollo Ado, was serving as a family planning provider in Suftu Health Centre. He found it difficult, as he hadn't had the opportunity to develop the skills needed to give the quality of advice he wanted to on long term family planning. This changed after he received training facilitated by Health Poverty Action. He told us:

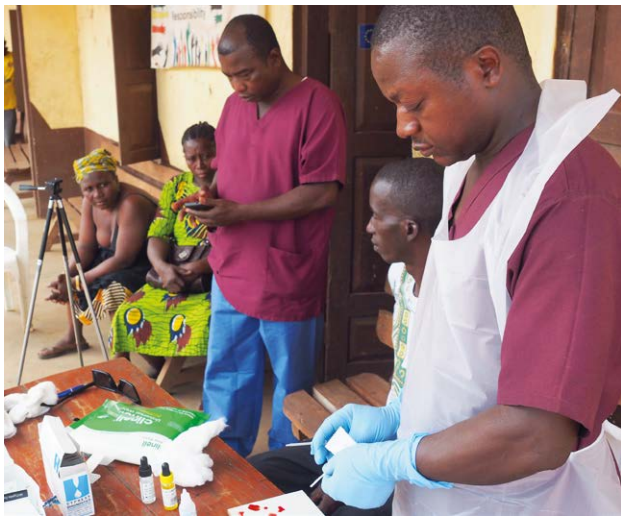
"I was very much satisfied with the training and the knowledge and skills I acquired, which enabled me to serve my clients appropriately. Now when I talk to my clients, I know that I can provide them with what they want and they will be happy."

Access to quality healthcare

Everywhere we work, improving access to healthcare is a major priority. Every community is different, so that often means adapting our approach to suit the needs of the people who live in a particular place – and working with communities to develop a variety of solutions.

A key element of the work involves strengthening existing health systems by providing local health centres with training, medical supplies and equipment. And where health centres are remote or hard to reach, we provide outreach health services and ambulance services to transport local people to health facilities.

For local populations in remote parts of Sierra Leone, a lack of access to blood for emergency transfusions can be a serious health risk. We facilitated a major community blood collection drive, which resulted in 100 units of blood being donated to a regional blood bank. We also arranged for some of the blood donors to appear on a radio discussion programme to reassure others in the local community that the procedure is safe and harmless.



Abas tests blood in Kamabaio for blood donation.

We ran a major training programme in Ethiopia in how to screen, diagnose and treat non-communicable diseases. In total, we trained 30 doctors from 15 hospitals, helping them develop the skills they need to be trainers and mentors themselves. Those trained doctors then held sessions in hospitals and regional healthcare centres, passing on vital skills and knowledge to even more nurses and health officers. By decentralising this essential expertise, the programme makes it easier for people in remote areas to get the life-saving treatment they need.

Malaria is a major problem in regions along the border of Vietnam and Cambodia. In Vietnam, the situation is made worse by the fact that these hard to reach areas are not getting the support they need to tackle this serious disease. We trained 185 community healthcare workers from these remote regions so they were fully

Our team provides malaria prevention information, testing and treatment services for people who work in the forest in Cambodia.

equipped to test for the disease and treat it effectively. We facilitated Mobile Outreach Teams to bring access to essential healthcare to the most remote areas, and provided access to information and services. In total, we tested 13,204 local people for the disease, and treated all of the people who tested positive.

In many of the places where we work, problems of poverty and health are made worse for marginalised communities for whom it is even harder to access the facilities and services available. In Guatemala, for instance, indigenous mothers face many barriers – particularly language barriers. To ensure that health services are culturally appropriate for indigenous communities, we trained 25 health workers to use indigenous languages and make services as welcoming, friendly and accessible as possible.

Our wonderful Health Poverty Action staff in Guatemala helping women access culturally appropriate healthcare.

Health knowledge and behaviour change

We work with community health volunteers and help develop local committees dedicated to providing health training and education sessions. In this way, we aim to educate communities about hygiene and disease prevention, while also raising awareness of symptoms and warning signs. We use these education sessions to inform communities of not only health but also awareness of the rights and facilities available.

Adolescence can be a difficult time for young people, no matter where they live in the world – and the issue of sexual and reproductive health is a major issue. But it can be even more difficult in Rwanda where there is a serious lack of information for young people on crucial topics such as reproductive health, family planning, sexually transmitted diseases and HIV/AIDS. That's why we're working to help make sure young people are empowered to make informed and responsible choices. In the Nyaruguru district of Rwanda, we provided 420 young women and girls from local villages with advice, information and counselling on issues around sexual health.

We carried out 2,495 health promotion and education sessions in Myanmar. These sessions covered a wide range of topics: from mother and baby health to family planning, nutrition, to sanitation, as well as the prevention of diseases such as malaria, HIV and tuberculosis. We targeted the general population in addition to some of the most vulnerable groups in the communities who face the greatest risks to health – including adolescents, migrant workers, sex workers and people in prison.

Halima is a mother of eight who lives in Busley village in Mandera East, Kenya. Like most mothers in the area, she has had several home deliveries with the help of local women. All her previous births had been safe and successful, but in 2016 she had a frightening experience while in labour. She told us:

"I remember that night so vividly. I was then eight months pregnant with my sixth pregnancy. I had just concluded my days' activities and was preparing for bed when suddenly a gush of warm blood started flowing through my legs to the floor. I did not know what was happening."

Luckily for Halima, a local woman, Mariam, had been trained by our team in Kenya to assist in difficult deliveries as a community based reproductive health agent (CBRHA). Halima continued:

"My eldest child rushed to Mariam's house to inform her of the situation. She quickly came and started reassuring me. Dizziness was then setting in. I was scared, this had never occurred in my previous pregnancies."

Mariam was able to quickly step into action. With the knowledge learned from the project training, she was quickly able to identify a serious complication in Halima's pregnancy.

"The amount of blood flow was too much" Mariam explains. "I quickly called the ambulance that then rushed her to the facility. By the time we were getting to the hospital she had lost so much blood, the nurse said her blood level was four [which is extremely low]. She was losing consciousness. She would have died that night if we didn't get her to a hospital. Our responsibility means ensuring the mothers have had access to the health services and support they need while at the health facility."

Halima received the emergency obstetric care she needed. Her son was born healthy and is doing well. She told us:

"The incident almost took my life. The trained CBRHA acted so fast and saved my life."

In Nicaragua, we helped develop a radio soap opera called In Our Footsteps, directed to reach young people and address the issues of sexual abuse, violence and self-esteem. Each of the 15 episodes was made by bilingual young people speaking both Spanish and Miskito, to help make sure these messages were accessible to as many people as possible.

We ran community conversation forums in Kenya, which encouraged women in remote rural areas to give birth in health facilities. We also trained 100 local women to be community based reproductive health agents to assist mothers in the delivery of their babies.

Food and nutrition

Malnutrition is a major problem in the Khammouane Province of Laos – especially for mothers and young children. Around a third of all children under five are stunted because of a lack of appropriate food and nutrition. Over 40% have anaemia and a vitamin A deficiency. In children under the age of two the number is as high as 63%. We ran a nutrition and food security project in the area, to improve the situation in 5,000 vulnerable households in 100 villages – focusing on children under five and women of child-bearing age. Of the 730 children we initially screened, 492 were malnourished. We provided emergency food supplements for them and gave their families extra follow-up support to improve food production and utilisation (through cooking demonstration for example). We also supplied nutrition screening equipment to health centres throughout the province – along with training for local health workers – so they can carry on this work themselves.

A health worker screens a child for malnutrition using the Mid-Upper Arm Circumference (MUAC) measurement.

Nurses measure the height of babies in Khammouane Province in Laos.

We worked in the Sahil, Sanaag Maroodi-Jeh and Toghdeer regions of Somaliland, screening children for malnutrition and treating those who needed it. In all, we screened over 200,000 children under five years of age, and identified 17,100 severely malnourished cases and 72,000 moderate to acute cases, all of whom received nutritional support.

Our stabilisation centre in Berbera, Somaliland, is run from inside the town's mother and child health centre. It focuses on treating children whose lives are at risk from severe acute malnutrition. Every day, from early in the morning, the centre is crowded with women and children in need of its services.

Ifrah Abdi Abukir came to our stabilisation centre with her one-year old son, Abdul-Aziz Hassan Ali. When staff at the centre examined him, they found him to be severely malnourished and in need of immediate treatment. He was given vitamins, medicines and rations of Plumpy Nut – a therapeutic food product specially formulated to treat severe acute malnutrition – and was seen by staff every week. Ifrah told us:

"Abdul-Aziz was so weak and sick when I first came here. He was very thin. I was so worried that he wasn't going to make it. But he is now doing better and even looks totally different. The staff told me today that next week will be the last day for us to come here for a check up."

Water and sanitation

Many of the most remote communities where we work aren't given access to affordable and sustainable access to water, sanitation and hygiene (WASH) facilities – posing one of the biggest threats to public health. What's more, the lack of education around these issues is one of the biggest challenges communities face. To tackle these problems, we focus on providing information and education sessions to help communities use their own knowledge to improve WASH.

During September 2018, we joined with our local partners in Laos to celebrate Global Caring Month. We sent two outreach teams into schools – the Paktone and Hovlar Primary Schools in Sangthing District – to raise awareness of the importance of WASH and nutrition. The aim was to help improve children's knowledge, attitudes and behaviour around water and sanitation using

One of our teams has fun with interactive learning in a primary school.

Promoting health and hygiene has been a core part of our work in Myanmar. A major element of that has been mobilising villagers to get involved with improving sanitation in their own villages.

Labya Lu Htoi lives in Lahtaw Hkra Pra village, deep in the mountains in Kachin State in Myanmar. The village has no electricity, poor telephone signal and is largely cut off from the outside world. During the rainy season, diarrhoea is a serious health issue in the village due to the lack of a sanitary latrine and a lack of education provided around personal hygiene.

Villagers in Lahtaw Hkra Pra digging the pit for latrines.

Labya Lu Htoi standing beside the latrine she helped to build.

Labya Lu Htoi was among the villagers who partnered with Health Poverty Action to build latrines, which has made a substantial improvement to the health of the village. She told us:

"I am really proud of my work. I hope fewer people, especially children, will suffer from diarrhea in the future."

A handwashing demonstration shows primary school children how to stay clean and safe.

interactive games and songs. At the same time, we carried out demonstrations of cooking, hand washing with water and soap, and cleaning toilets. Our teams also provided teachers with posters they can use to continue the learning in their classrooms. We also provided each school with a variety of resources such as dustbins, liquid soaps and towels. In total, we reached 356 children, and gave each one of them a hygiene kit to take home. At the end of the programme we noted an increase in the knowledge of teachers and students on WASH principles, and eating nutritious food, by over 50%.

Disease prevention

In the remote areas of Kachin and Shan State in Myanmar, we worked to increase immunisation coverage in an attempt to prevent outbreaks of disease. Our government partners supported our project team with vaccines, immunisation supplies, training and monitoring. We have been working in these communities for over 20 years, and our long-term programme has led to improved health, particularly in townships along the border with China. We organised health education sessions to help raise awareness of disease prevention in remote communities and distributed over 46,000 long-lasting insecticidal nets to communities at risk of malaria. Due to years of effort, the number of new malaria cases has gone down so much that we are now working toward eliminating malaria in many townships. We also immunised more than 10,000 children in these townships against communicable diseases that affect children most each year.

In 2018, Laos experienced the worst flooding in the country's history. In Attapeu province – the most severely affected area – heavy rain and flooding caused the collapse of a dam. Tragically, six people died and 131 were missing in the wake of the disaster. The resulting flash floods displaced 3,864 families in 13 of the villages we work in. They were then moved by the government into evacuation camps. The risk of disease outbreak was extremely high: with massive devastation, overcrowding in the camps and limited access to nutritious food and clean water, as well as a lack of adequate sanitation and hygiene. We deployed an Emergency Response Team of highly experienced staff who carried out intensive awareness and education campaigns to prevent disease outbreaks. They also trained camp volunteers who helped ensure that evacuees in the camps had access to clean water, basic food supplies, first aid, hygiene kits and medicines.

We ran an innovative pilot project in the Dollo Ado and Dollo Bay areas of Ethiopia, designed to reduce the impact of tuberculosis on local populations. It introduced monitoring technology called 99DOTS, which helps health staff check that patients are taking the medicines that have been given to them. 99DOTS is a pack of anti-TB medication, and includes hidden phone numbers that only become visible once doses have been dispensed. When a patient rings the toll-free number, health workers know they've taken their medication. We trained 13 local health workers to administer the project, and supplied 30 low-cost mobile phones and solar chargers for them to lend to patients – a creative solution to a very real problem.

Our Emergency Response Team – together with local partners – train volunteers in the evacuation camps.

A room in our shelter home in Hargeisa, Somaliland

Women's rights

In many of the places where we work, patriarchal practices are still dominant. As a result, women who are already struggling to survive in poor areas face the extra burden of oppression. In turn, that means women often face many obstacles to accessing the same health, education and economic opportunities as men. We firmly believe that for a society to be truly healthy and prosperous, all members of society – including women and girls – must have equal rights.

One of the most effective ways of addressing this issue is to encourage women and girls to take leadership roles in their own communities. That's the approach we took in Myanmar where we trained 407 village health committee members – 60% of whom were women. This enables women and girls to take control of their own health and organise the services they need to live healthy lives free of disease.

Many women and girls in Somaliland are subjected to sexual violence and female genital mutilation, so we ran a programme there helping to tackle these issues. The work included running a shelter home for women, and providing food aid, counselling and medical support to those who needed it. We also offered legal support to ensure survivors get the justice they are entitled to. As a result, we saw a 50% increase in the number of women turning to us for help, while at the same time the number of women who said they had been a victim of sexual violence fell by a third.

> ***Sometimes, the main reason mothers shy away from seeking healthcare services at the local centres is because the medics who attend to them are men, and they find it difficult to explain to them what they are going through. I offered my services to the mothers by going door-to-door, organising group forums and sharing health messages to both mothers and their children. It is always my joy to see women and their children living a healthy lifestyle because of the information we provide. I do this because I am a woman too, and I understand what fellow women are going through on a daily basis. It is not an easy job, but we do it for our community because we are the backbone of society.***
>
> **Asha Abdi**, Female Community Influencer, Sahil region, Somaliland

We worked with police, judges, teachers, health staff and other partners in Rwanda to support victims of sexual violence. Through eight monthly meetings, we met with single mothers – more than a quarter of whom had become pregnant under the age of 18 – to discuss their rights and tell them about the services available to them. Among other things, the meetings have led to greater collaboration with the local government to ensure that children are registered – an issue which came to light during the meetings.

Claudine is a member of one of our clubs in Rwanda that have helped her purchase livestock to pay for school equipment.

Key highlights

Key beneficiary figures from 2018/19

Guatemala

77 Traditional Birth Attendants within local communities were trained on recognising danger signs and emergency planning

Nicaragua

557 men in local communities took part in workshops to address the normalisation of Gender-Based Violence

Sierra Leone

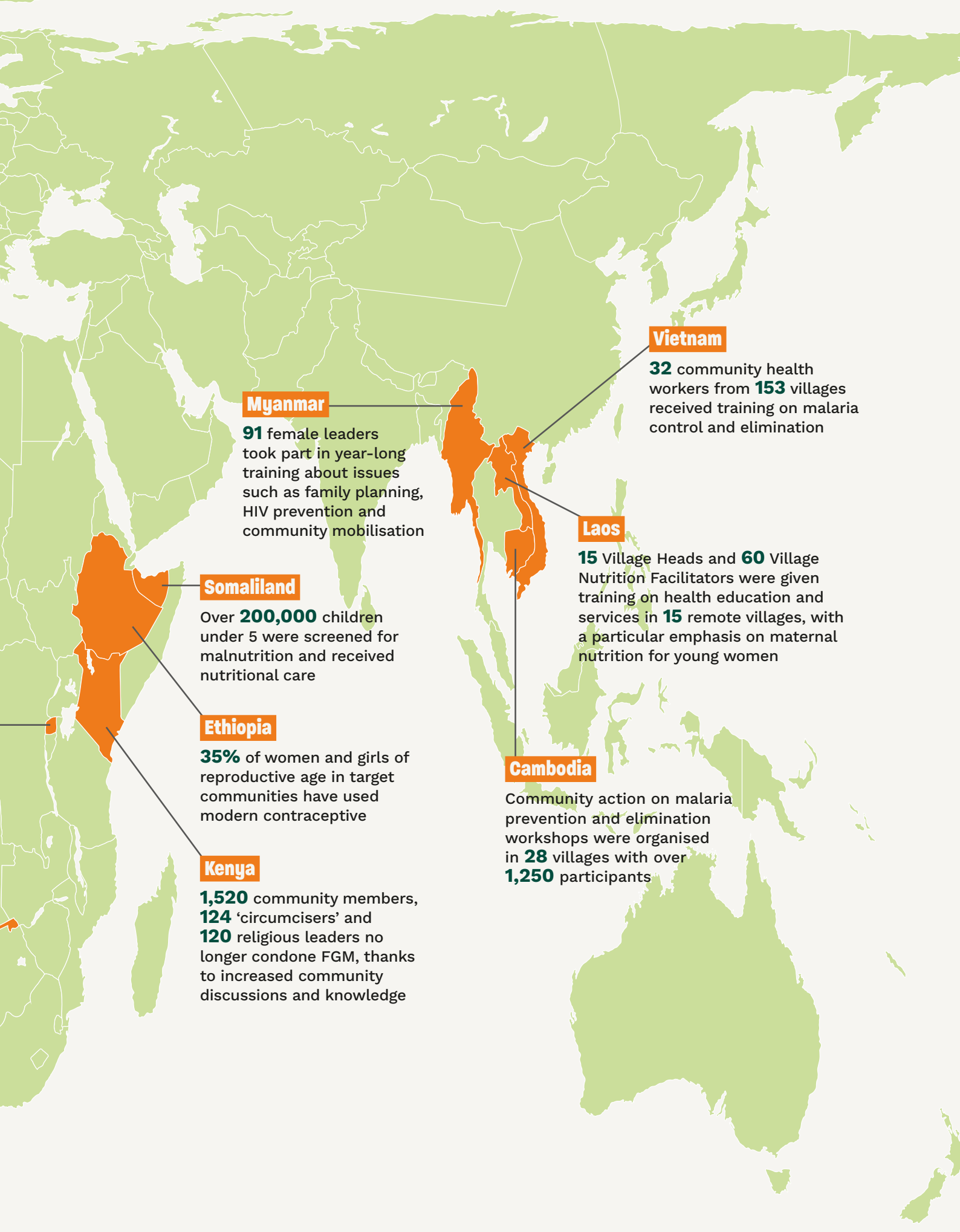
94% of women in target communities were able to cite at least 3 danger signs of pregnancy, following radio broadcasts and the distribution of print materials

Rwanda

150 female survivors of Gender-Based Violence received training to support them in securing, sustaining and creating jobs

Namibia

108 maternal and neonatal emergencies were referred to health facilities using donkey cart ambulances



Vietnam

32 community health workers from **153** villages received training on malaria control and elimination

Myanmar

91 female leaders took part in year-long training about issues such as family planning, HIV prevention and community mobilisation

Laos

15 Village Heads and **60** Village Nutrition Facilitators were given training on health education and services in **15** remote villages, with a particular emphasis on maternal nutrition for young women

Somaliland

Over **200,000** children under 5 were screened for malnutrition and received nutritional care

Ethiopia

35% of women and girls of reproductive age in target communities have used modern contraceptive

Cambodia

Community action on malaria prevention and elimination workshops were organised in **28** villages with over **1,250** participants

Kenya

1,520 community members, **124** 'circumcisers' and **120** religious leaders no longer condone FGM, thanks to increased community discussions and knowledge

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. We campaign against the failed 'war on drugs' because it causes a vicious cycle of poverty around the world, targeting the most marginalised and vulnerable in society.

It's an exciting time for the drug policy reform movement – across the world countries are increasingly shifting away from the dangers of prohibition towards healthier alternatives. Our own work on drug policy mirrors this surge in strength. We generated further evidence of the failures of global drug policy, publishing research into its impacts on people's livelihoods in India and Brazil, and demonstrated how it is denying people access to opioid pain relief in India. We used these cases to argue for the need for legally regulated drug markets that support people and public health. We also hosted a parliamentary debate with representatives of all the main UK political parties to discuss how they can create policies that support a public health approach to global drug policy. We published a report and a petition calling on the UK to lead by example and introduce a legally regulated cannabis market, generating widespread coverage across the mainstream media. We are delighted how swiftly this idea is moving up the political agenda!

We have also built resources to strengthen the progressive movement for health justice. We published a successful toolkit demonstrating how organisations can better communicate about the root causes of poverty which has been used widely by a range of organisations for communications and strategy.

We received widespread media coverage for our report looking at how much money is being diverted away from citizens to corporations globally, and our paper on health and trade is being used by a range of organisations as the basis to campaign for healthier trade policies. We promoted our messages and campaign actions through a series of high profile public events.

Strong and culturally appropriate health systems

We continue to advocate for culturally appropriate health services and for progress to be monitored using adequate data.

Our previous research into indigenous women's maternal health has provided the basis for advocacy at both a global and UK level. We have made encouraging progress in engaging with the organisations responsible for the two major international health surveys, including exploring how future surveys can be improved in terms of ethnicity-related data collection and analysis.

We worked with the Labour Party to develop a position on global public services and are delighted they have committed to end support for Public Private Partnerships and establish a centre to promote public services for all.

Fundraising

Events and community

We continue to be amazed by our London Marathon team who, in 2018, raised over £100k – 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.

One of our London Marathon runners with their medal.

London City Voices perform to raise money for Health Poverty Action at Christmas.

We'd also like to take this opportunity to thank some of our incredible corporate partners for taking on additional challenges such as the Polar Marathon, British 10k, Royal Parks and Ride London.

Huge thanks to all our incredible Curry for Change partners, ambassadors, champions, restaurants and home host supporters, without them, our events wouldn't be possible. We sincerely appreciate the time, products and skills they continue to commit to making these events such successes. A special mention to our campaign partners Kingfisher Beer and Spice Kitchen.

Curry for Change ambassador Chintal Kakaya showcasing her desserts at our event.

Choirs for Change continues to grow thanks to our wonderful singers raising their voices for health rights. This year saw school choirs and adult community choirs coming together in solidarity to use their talents to sing a range of genres and raise over £20k across tube and train stations in London.

Partnerships

The 'As One' campaign encourages UK health professionals to support health professionals working in challenging circumstances abroad. We are delighted to have formed strong partnerships with a variety of UK organisations who are passionate to continue supporting UK health professionals, whilst extending that support worldwide. Thank you to NB Medical for continuing to be our lead partner.

'It Takes a Village' launched this year and promises to unite parents, health professionals and organisations who want to make pregnancy and childbirth safe for every mother. A huge thanks to Lansinoh, West Ham United Women's Football Team, Fittamamma, Bebe Voyage, Your Baby Club, Borrago, Baby Box Company and many others for joining us at the start of this exciting journey. With their expertise, contacts and enormous audience reach we are excited about the potential to make a huge impact on maternal health worldwide.

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.

Trusts and Foundations

Overall we raised over £360,000 from Trusts and Foundations towards our work around the world, including match funding and bespoke projects. We have developed exciting new partnerships as well as continuing to work with our long-term, valued supporters. This support has enabled us to expand our key health programmes in Africa, Asia and Latin America, working with some of the most remote communities in the world. This includes our maternal health work with pastoralist women and children in Ethiopia, and with indigenous mothers and children in the highlands of Guatemala, as well as our nutrition and food security work with remote communities in central Laos.

We would like to thank all of our generous supporters, including The Mercury Phoenix Trust and The Beatrice Laing Trust.

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. Following our work last year on strengthening our organisational voice using the values and frames theory, we have been working on embedding this in the work that we do further, holding values and frames workshops for staff and applying the theory to the development of our new website.

Digital

Our following on social media continues to grow, with almost 8,000 followers on Twitter and over 4,500 likes on Facebook, using Facebook advertising to increase our reach and grow our profile.

Launching our new website earlier in the year has allowed us to ensure we're able to better present the work of Health Poverty Action to our supporters, helping us to raise awareness of our campaigns and fundraise more effectively.

Storytelling

Building on the success of our storytelling and photography training workshop last year for our in-country staff, we're continuing to develop the programme so that our colleagues around the world can help us to communicate what we do more effectively. We've used the images and stories from these workshops to produce better communications materials, from our newsletter to the new website. This has helped us to 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 wider work into the media is another key way in which we 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 work. In particular we've had numerous press around our new policy reports, including our report on the scale of global resources being diverted away from citizens towards corporations featuring in the Daily Mirror. Earlier in the year our Director appeared live on the BBC to promote our report on the hidden opioid crisis, and we had articles in the Guardian, Vice, the South African radio station Cape Talk and the British Medical Journal following our report on the need for legally regulated drugs markets that protects public health. Our report on the potential economic benefits of introducing a regulated cannabis market in the UK received coverage in The Observer, The Guardian, The Independent, Metro and RT News, among many other publications.

Financial review

Overview

During 2018-19, we maintained our financial strategy of investing in our in-country programmes while exploring new strategies to increase our unrestricted funds.

Health Poverty Action's income during the reporting period reduced by 12% (£16,859,596 compared to £19,169,688 in 2017-18). This movement is mainly due to projects ending during the course of year, as well as new projects proposals yet to be awarded. General unrestricted reserves increased by £87,826 to £1,360,090, while restricted funds reduced by £540,877 to £4,380,737.

Despite the general decrease in income we have continued to receive support from our donors, with new multi-year projects starting towards the end of the reporting period or post year-end. Funding for these new projects will be recognised in 2019-20.

Our income base includes funding from institutional, individual donors and consultancy. The income from charitable activities of £16,404,686, comes primarily from grants from international institutions, governments, trusts and foundations and represents 97% of the overall organisation income. For further detail please refer to Note 2 of the accounts.

We are extremely grateful to all our donors for their generosity in helping us achieve our goals.

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 and Finance and Audit Committee members as part of ongoing risk management.

For 2019-20 we have identified six 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
- Safeguarding risks

The main risk area for Health Poverty Action remains its dependence on restricted funds.

In 2018-19, 97% of Health Poverty Action's income came from institutional donors and other restricted funding donors while 3% came from unrestricted sources. It is a slight increase in unrestricted funds (last year 2%) and while we are confident that our new Full Cost Recovery model will help generate more unrestricted funds it is still a major challenge to the organisation. We have freed resources to develop the skills of our staff to help achieve this goal. We have also increased our human resource capacities to ensure a wide range of skills that further mitigate this risk.

Exchange rate volatility still represents a challenge to us with direct impact on project activities overseas. During the year we made huge progress in developing an exchange rate policy that will mitigate the risk arising from fluctuation in exchange rate, especially when exotic currencies are concerned. This policy will be implemented in October 2019.

Brexit still raises a lot of uncertainties on our ability to secure European funds in the long term. Therefore, it increases the need to develop new partnerships in order to carry on work in countries where the EC has been a major donor over the years. This year our EC grant portfolio represented 9% of our charitable activities and 8% of our overall income. It is a slight decrease from last year's figure (11% and 9%, respectively).

Compliance risk: It is our priority to ensure that funding rules are known and carefully adhered to by all staff in order to reduce/totally avoid ineligible expenses and claw backs. Developing strong and close relationships with institutional donors to ensure we are fully informed about compliance requirements remains our priority.

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 and will also encourage timely submission of donor reports to avoid delays in payment.

Safeguarding has been our priority during the year. Our commitment to ensuring that vulnerable people are protected has led to the review of all our policies. We have ensured that all staff are aware of these policies and trained to fully understand how they work in practice. We aim to make our policies as adequate as possible and will continue to improve on these to create a safe environment where all our beneficiaries are aware of the support they have.

Programme staff visited countries where we operate during the year and gave refresher sessions on safeguarding. In addition, we recently engaged consultants to provide more in-depth training on this topic both in the UK and overseas.

Beyond avoiding reputational risk, it is at the core of our values and commitment to safeguard people with whom we work.

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 which equates to £0.76m-£1.4m 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 which have huge impact on beneficiaries. During 2018-19, our unrestricted reserves increased by £87,826 to £1,360,090 (£1,272,265 in 2017-18).

This increase was made up of £60,740 in exchange rate gains and £27,085 increase in unrestricted funds (mainly consultancy income). The current level of free reserves (£1.3m) is at the higher end of the board policy stated above (£0.76m-£1.4m) and has therefore been deemed satisfactory.

The Board will review the reserve policy in the light of new strategic plans, while maintaining the objective to keep healthy reserves in the short and long term.

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 healthcare, 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 Senior Management Team 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 2019 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. There are 15 Trustees as of July 2019.

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. 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.

Code of Governance

In response to the well publicised negative incidents in the charity sector, such as those involving safeguarding, there has been a more thoughtful approach to governance. There is an exploration as to how governance can be made as effective as possible in order to further a charity's mission in line with the values that underpin it.

As part of this we have appreciated the contribution made by the new Charity Governance Code, the contents and priorities of which resonate with the approach we have been taking. Of the seven principles identified by the code, we are currently giving particular attention to three areas:

- We are continuing to develop our understanding of the values that drive our work, and exploring how these can best be enshrined within our practice. For example, how some ethical dilemmas should be handled, such as which funding sources to pursue.
- The second area is how to increase diversity, which is something that has concerned us for some time.
- The third area is openness and accountability, and looking at what we can do to develop this further.

These priorities are being explored at governance level, but are not confined to that, with work also being done by both managers 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 Purity Fundraising, which specialises in ethical telephone fundraising; we work with them on occasion to speak to our new supporters and share more about our organisation as our small team does not have the capacity to do this in-house. We monitor the activities of Purity Fundraising through regular feedback, recordings, and supporter feedback. Purity Fundraising are required, during these calls, to make a disclosure statement that they are working on behalf of Health Poverty Action. We have worked with Purity Fundraising throughout the year 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 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 2018 up to the date of signing these accounts, are stated below.

Trustee	Role	Details
Sunit Bagree		Appointed on 28th June 2018
Mehmet Nadir Baylav		Appointed on 28th June 2019
Nouria Brikci-Nigassa		
Denis John Cavanagh[1]	Treasurer	Appointed on 28th June 2019
Emma Crewe[2]		
Elaine Gilligan		Appointed on 28th June 2019
Anna Graham		
Rory Erskine Morrison Honney		
Sharon Louise Jackson[2]		Stepped down on 30th November 2018
Anuj Kapilashrami		Appointed on 28th June 2019
Oliver Benjamin Kemp[1&2]	Chair	
Carolyn Ann Ramage[1]	Treasurer	Stepped down on 29th March 2019
Ruth Stern[1]		
James William Patrick Thornberry[1]		
Betty Ann Williams[1]		
Simon Jonathon Wright		

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

Trustees administrative report

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

Registered Company Number: 1837621

Registered Charity Number (England and Wales): 290535

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

United Kingdom Director:

Martin Drewry

Senior Management Team:

Kelly Douglas, Head of Fundraising

Natalie Sharples, Head of Policy and Campaigns

Sandra Tcheumeni Boschet,
Head of Finance and Administration

Bangyuan Wang, Head of Programmes – Asia

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 Oliver Kemp, Chair of the Board.

On behalf of the Trustees:

Oliver Benjamin Kemp
Chair of Trustees

Date: 11th October 2019

Independent Auditor's report

Opinion

We have audited the financial statements of Health Limited T/A Health Poverty Action ('the company') for the year ended 31 March 2019 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 2019 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;
- 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 22, 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: 11 / 10 / 2019

For and on behalf of
Moore 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 2019

	Notes	Unrestricted funds 2019 £	Restricted funds 2019 £	Total funds 2019 £
INCOME AND ENDOWMENTS FROM:				
Charitable activities	2	–	14,772,837	14,772,837
Donations and legacies	2	454,823	–	454,823
Gift in Kind Income	2	–	1,621,494	1,621,494
Investments		87	10,354	10,441
Total incoming resources		**454,910**	**16,404,686**	**16,859,596**
RESOURCES EXPENDED				
Raising funds	3	299,119	–	299,119
Charitable activities	4	128,705	16,995,388	17,124,093
Total resources expended		**427,825**	**16,995,388**	**17,423,212**
NET INCOME/(EXPENDITURE) FOR THE YEAR		**27,085**	(590,702)	(563,617)
Transfer between funds		–	–	–
Foreign exchange gains in year		60,740	49,825	**110,565**
NET MOVEMENT IN FUNDS FOR THE YEAR		**87,826**	(540,877)	(453,052)
Total funds brought forward at 1 April 2018		**1,272,265**	**4,921,614**	**6,193,879**
TOTAL FUNDS CARRIED FORWARD at 31 March 2019		**1,360,090**	**4,380,737**	**5,740,827**

The statement of financial activities includes all gains and losses recognised in the year.

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.

BALANCE SHEET

Health Limited T/A Health Poverty Action Balance Sheet as at 31 March 2019

	Notes	2019 £	2018 £
CURRENT ASSETS			
Debtors	8	2,274,726	1,075,606
Stock		294,914	583,504
Cash at bank and in hand		4,430,331	5,350,533
		6,999,972	**7,009,643**
CURRENT LIABILITIES			
Creditors: Amounts falling due within one year	9	(1,121,221)	(594,633)
NET CURRENT ASSETS		**5,878,751**	**6,415,010**
LONG TERM LIABILITIES			
Creditors: Amounts falling due after one year	10	(137,924)	(221,131)
TOTAL ASSETS LESS LIABILITIES		**5,740,827**	**6,193,879**
TOTAL NET ASSETS		**5,740,827**	**6,193,879**
FUNDS			
Unrestricted funds	13	1,360,090	1,272,265
Restricted funds	13	4,380,737	4,921,614
		5,740,827	**6,193,879**

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

Oliver Kemp, Chair Date: 11th October 2019

Company Registration number 01837621

Cash flow statement

Health Limited T/A Health Poverty Action cash flow statement for the year ended 31 March 2019

	2019 £	2018 £
Net Cash Outflow from operating Activities	(1,041,207)	416,940
Returns on Investments and Servicing of Finance		
Bank interest received	10,441	27,173
Foreign exchange gain	110,565	(252,848)
(Decrease) / Increase in Cash	**(920,201)**	**191,265**
Reconciliation of Excess of Expenditure over Income to Net Cash Inflow from Operating Activities		
Net incoming / (outgoing) resources	(453,052)	710,966
Decrease / (Increase) in debtors	(1,199,120)	(5,045)
(Increase) in stock	288,590	(303,232)
Increase in creditors	443,381	(211,424)
Interest received	(10,441)	(27,173)
Foreign exchange gain	(110,565)	252,848
Net cash (outflow) inflow from operating activities	**(1,041,207)**	**416,940**
Analysis of Net Cash Resources		
Opening Balance	5,350,533	5,159,267
Flow	(920,201)	191,265
Closing Balance	**4,430,331**	**5,350,533**
Location of Cash Resources		
HQ bank accounts	1,051,595	2,848,358
In-country bank accounts	3,378,736	2,502,174
	4,430,331	**5,350,533**

NOTES

Notes forming part of the financial statements for year ended 31 March 2019

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.

l) Inventory/Stocks

Stocks are calculated based on unit prices given by donors. When unit prices are not disclosed, stock are valued at fair market value.

2. INCOME

	2019 £	2018 £
INCOME		
Restricted Funds		
Charitable activities		
3MDG	559,900	2,335,181
Access to Health Fund	611,092	-
Australian Department of Foreign Affairs and Trade	-	95,458
Big Lottery Fund	159,139	363,649
Canadian Department of Foreign Affairs and Trade and Development	-	14,450
Caritas Switzerland	315,767	-
Comic Relief	750,468	670,532
Cordaid	(3,370)	59,071
Department for International Development	5,442,977	5,371,653
Education Development Center	64,893	92,716
European Commission	1,250,315	1,731,477
Global Fund	2,871,865	2,723,527
Irish Aid	45,246	136,148
Liverpool School of Tropical Medicine	11,322	9,792
Other	418,334	510,784
Relief International	-	188,461
Save the Children International	-	328,284
Trusts, foundations and individuals	254,834	118,940
UCSF (University of California)	193,233	209,608
UN bodies	956,061	1,166,988
World Food Programme	870,763	478,141
	14,772,837	**16,604,860**
Other trading activities		
Gift in Kind	1,621,494	2,116,043
	1,621,494	**2,116,043**
Total Restricted Funds	**16,394,332**	**18,720,903**
Unrestricted Funds		
Donations from individuals and other	331,972	344,737
Consultancy	43,072	-
UK and European trusts / foundations	79,779	76,875
Total Unrestricted Funds	**454,823**	**421,612**
INVESTMENT INCOME		
Bank interest		
Restricted Funds	10,354	21,569
Unrestricted Funds	87	5,604
	10,441	**27,173**
TOTAL INCOME	**16,859,596**	**19,169,688**

3. RAISING FUNDS

	Direct	Support costs	Total 2019	Direct	Support costs	Total 2018
	£	£	£	£	£	£
Other costs	98,454	200,665	**299,119**	95,883	241,147	**337,030**
	98,454	200,665	**299,119**	95,883	241,147	**337,030**

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

4. CHARITABLE ACTIVITIES

	Direct	Support costs	Total 2019	Direct	Support costs	Total 2018
	£	£	£	£	£	£
Costs of health projects	16,520,852	603,242	17,124,094	17,255,323	613,520	**17,868,843**

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:

Nature of cost	Total 2019	Cost of raising funds 2019	Health projects 2019	Basis of apportionment
	£	£	£	
Human resources	655,028	176,811	478,217	Number of employees
Establishment costs	55,297	11,264	44,033	Number of employees
Office & Administration	93,582	12,590	80,992	Number of employees
	803,907	200,665	603,242	

Nature of cost	Total 2018	Cost of raising funds 2018	Health projects 2018	Basis of apportionment
	£	£	£	
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	

6. NET INCOME FOR THE YEAR is stated after charging

	2019 £	2018 £
Annual Audit		
Statutory audit	19,520	18,860
In respect of prior year	(370)	-
In respect of consolidation	5,750	-
Rentals in respect of operating leases;		
plant and machinery	4,434	2,033
other – office	56,587	59,916
Inventory expense	294,914	583,504

7. STAFF COSTS AND TRUSTEES' REMUNERATION

	2019 £	2018 £
U.K. STAFF		
Wages and salaries	728,577	780,551
Redundancy cost	18,312	-
Social security costs	80,475	88,645
Pension costs	43,308	37,680
	870,672	906,876
OVERSEAS STAFF		
Wages and salaries	3,350,764	2,888,972
Pension costs	85,155	118,516
Severance costs	183,564	136,852
	3,619,483	3,007,488
TOTAL STAFF COSTS	**4,490,155**	**3,914,364**

One employee received remuneration of between £70,000 - £80,000 in 2018-19 (2018: one).

Employer's pension cost relating to that individual was £3,607 (2018: £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 £344,253 (2018: £409,358).

The Trustees neither received nor waived any emoluments during the year (2018: £Nil).

Total reimbursements received by the Trustees in the year amounted to £689.64 (2018: £1,073.25). These reimbursements were received by 3 Trustees (2018: 1 Trustee). All reimbursements related to travel costs.

The average number of employees, analysed by function was:

	2019	2018
	Number	Number
Charitable activities	410	386
Raising funds	6	5
	416	**391**

8. DEBTORS

	2019	2018
	£	£
Other debtors in UK	5,520	100,458
Other overseas/project debtors	195,749	267,941
Accrued income – Gift Aid & Other	12,164	9,581
Accrued income – Grants	2,040,512	676,795
Prepayments	20,780	20,832
	2,274,726	**1,075,606**

All debtors, except prepayments of £20,780 (2018: 20,832), are financial instruments measured at present value.

9. CREDITORS: Amounts falling due within one year

	2019	2018
	£	£
Project creditors	421,755	145,867
Other creditors	117,855	130,983
Dilapidation provision	19,596	-
Field severance pay liability and pensions	337,550	219,747
Other taxes and social security	19,697	185
UK Accruals	204,767	92,388
	1,121,221	**594,633**

All creditors, except for the social security creditor £19,697 (2018: £185), are financial instruments measured at present value.

Creditors includes pension liabilities of £337,993 (2018: 219,747).

10. CREDITORS: Amounts falling due after one year

	2019	2018
	£	£
Field severance pay liability	137,924	221,131
	137,924	**221,131**

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. LEASEHOLD COMMITMENTS

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

	2019	2018
Committed to payments of:	**£**	**£**
Within One Year		
Plant and Machinery	-	-
Other – office	59,483	59,483
Between One and Two Years		
Plant and machinery	19,596	-
Other – office	44,471	59,483
Between Two and Five Years		
Plant and machinery	-	-
Other – office	6,761	51,070
Total	**130,311**	**171,200**

13. ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Unrestricted Funds 2019 £	Restricted Funds 2019 £	Total Funds 2019 £	Unrestricted Funds 2018 £	Restricted Funds 2018 £	Total Funds 2018 £
Fund balances at 31 March 2019 are represented by:						
Current assets	1,626,031	5,373,941	6,999,972	1,501,284	5,508,359	7,009,643
Current liabilities	(265,941)	(855,280)	(1,121,221)	(229,019)	(365,614)	(594,633)
Long Term Liabilities	–	(137,924)	(137,924)	-	(221,131)	(221,131)
Total Net Assets	**1,360,090**	**4,380,737**	**5,740,827**	**1,272,265**	**4,921,614**	**6,193,879**

14. STATEMENT OF FUNDS

	Funds at 2018 £	Income £	Expenditure £	Transfers £	Funds at 2019 £
Myanmar & China	2,044,886	4,861,422	(6,170,322)	–	735,987
Cambodia	167,196	243,502	(296,869)	–	113,829
Ethiopia	113,185	211,086	(203,388)	–	120,882
Global	162,637	282	(147,615)	–	15,304
Guatemala	(34,475)	131,034	(107,022)	90,000	79,537
Kenya	144,949	248,945	(463,242)	–	(69,348)
Laos	731,569	681,222	(751,682)	–	661,109
Namibia	6,669	73,772	(92,646)	–	(12,206)
Nicaragua	248,328	645,626	(425,326)	(30,000)	438,628
Rwanda	51,048	755,288	(549,176)	(60,000)	197,160
Sierra Leone	411,498	479,652	(579,200)	–	311,950
Somaliland	549,455	4,492,223	(3,657,399)	–	1,384,279
GIK	303,232	1,621,494	(1,910,084)	-	14,642
SE Asia Regional	47,717	1,959,131	(1,568,743)	-	438,105
Vietnam	(26,280)	6	(22,849)	–	(49,123)
Total restricted funds	**4,921,614**	**16,404,686**	**(16,945,563)**	**–**	**4,380,737**
Unrestricted funds	1,272,265	515,650	(427,825)	–	1,360,090
Total funds	**6,193,879**	**16,920,336**	**(17,373,388)**	**–**	**5,740,827**

	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	(1,208,016)	–	167,196
Ethiopia	137,021	258,256	(282,092)	–	113,185
Global	112,722	163,333	(113,418)	–	162,637
Guatemala	92,778	9	(127,262)	200,000.00	(34,475)
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	(449,682)	(200,000)	248,328
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	(286,477)	–	(26,280)
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**	**19,057,430**	**(18,346,464)**	**–**	**6,193,879**

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 2019 relate to the transfer of funds between projects for the same programme of activities that are being implemented in different countries.

All Negative balances on project accounts have been covered by post balance sheet receipts.

Deficits on country office funds are not a concern and there shouldn't be a need to receive funds to cover them in the short term (or to transfer from unrestrictedfunds).

Although country office funds are treated as restricted, they are in effect unrestricted and there is a large net surplus in country office funds globally. We treat them as restricted for practical reasons, eg because the cash funds are usually in local bank accounts, may be tied up with local pre-financing and in some cases may be hard to 'repatriate' to the UK due to local law. So we can't add them to general unrestricted reserves in the accounts. They are long term balances and while it's better for them to be in surplus than deficit, there is no particular short-term need to make good a deficit in one country office.

15. RELATED PARTY TRANSACTIONS

During the 2018-19 financial year, Find Your Feet became a linked charity of Health Poverty Action. Health Poverty Action provides management and support services to Find Your Feet at its UK headquarters.

In 2018-19, a total of £176,321 of Health Poverty Action's UK staff cost was recharged to Find Your Feet (2017-18: £102,356).

16. STATEMENT OF FUNDS

	2019 Receipts	2019 Expenditure
Big Lottery Fund		
URN: 0010237333 Nicaragua (main grant)	133,230	133,325
URN: 0010231645 Namibia (main grant)	25,909	42,484
Irish Aid		
CSF07-15 Nicaragua and Rwanda	89,148	76,287
DFID funding		
UKAD-IMP-119 Myanmar	802,415	816,443
UKAD-IMP-120 Kenya	146,200	156,200
HARP-TRN-001 Myanmar	1,418,569	1,510,641
Girls Education Challenge – GEC-T		
6317 Rwanda	462,616	481,687
Population Services International		
4289-HPA-01APR2016 Somaliland	972,362	1,255,718
4115SOM-HPA-01Nov17 Somaliland	68,793	68,818
4476-HPA-01JULY2018 Somaliland	128,414	377,296
4313-HPA-01DEC2018 Somaliland	44,582	15,270
BMB Mott MacDonald BV		
376106 - Lot 3 Somaliland	217,308	177,196
376106 - Lot 4 Somaliland	274,788	188,644
Caritas Switzerland		
P170086 Somaliland	315,767	217,520
Cordaid		
113336-SAN Sierra Leone	(3,370)	-
Comic Relief		
1867316 Sierra Leone	138,552	212,381
2572521 Cambodia & Laos	525,000	286,339
2712084 Sierra Leone	74,500	185,017

WITH THANKS TO:

UKaid from the British people

European Union

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BIG LOTTERY FUND

LOTTERY FUNDED

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