HEALTH POVERTY ACTION

Annual report and accounts

2021-2022

Contents

Cover image: Women's economic empowerment group for survivors of gender based violence in Rwanda
Design & layout: www.causeffectdesign.co.uk

Message from Director and Chair

This has been a year of rising to the challenge of the stark inequalities of our world. Whilst the crisis in Ukraine occupied screens across the globe, the tragedies affecting the communities we work with received far less attention yet continued to devastate the lives of individuals and health systems.

The war between the government of Ethiopia and forces in Northern Tigray has resulted in human rights atrocities, killings, the blocking of humanitarian assistance and deliberate destruction of health facilities. An estimated 5.1 million people were displaced during 2021, the highest number ever recorded for a conflict. Despite a media blackout, some reports suggest that in Tigray, Afar and Amhara regions children under 5 are facing famine-like situations. The number of people who have died either directly or as result of starvation or lack of healthcare from the conflict is estimated at half a million.

Last year's military coup in Myanmar sparked mass protests, armed resistance and large-scale killings. This has created further poverty and had widespread impacts on the already weak health system, with our staff reporting shortages of supplies and health workers in many areas.

The climate emergency continues to wreak havoc on large swathes of Somalia, Ethiopia, and Kenya. The devastating droughts and consequent food crises this year caused the governments of Kenya and Somalia to declare national emergencies.

These crises are all in the context of both the ongoing pandemic and the global food crisis sparked by the Russian invasion of Ukraine, which is having particularly devastating effects on countries already facing food insecurity. Yet instead of stepping up to offer solidarity to all those affected, the British government has opted instead to drastically reduce the amount it spends on the world's poorest.[i] Funding for Ukraine has placed additional demands on an already drastically reduced and capped budget.[ii]

Whilst our hearts are with the people of Ukraine, we deplore that the government has not responded to the crises devastating other people and countries with equal vigour. The response will reinforce inequality, rather than working towards equity for all.

HPA's income fell by 24% compared to the previous year as income from institutional donors reduced. We have responded by redoubling our efforts to raise funds in a post COVID-19 world and thankfully our reserves remain at a healthy level of above 10% of budgeted income for the coming year. Despite these challenges we continue to have hope. Hope in the resistance shown by the communities we work with and the professionalism and dedication of our staff and volunteers, who have risen admirably to the obstacles they face.

i. FCDO provisional 2021 UK aid spending shows grim reality of aid cuts | IPPF
ii. Is UK aid facing another round of major cuts? – Save the Children UK

In spite of the widespread conflict affecting regions including Tigray, Amhara, Afar and other regions, we managed to reach an estimated 150,000 people with health services in Ethiopia, whilst our health education messages reached 1 million. The Ministry of Health further intends to honour our work on non-communicable disease by scaling it up to 3,000 primary health centres.

In Myanmar, we countered the challenges of the coup-weakened health system, reaching over 181,000 people with basic health care services, including taking over the running of a mobile hospital for COVID-19 patients. We also enabled 500 women and 211 children to receive emergency treatment when they needed it most, and vaccinated over 100,000 people from COVID-19.

We developed a new programme to provide health, nutrition, water and sanitation services to people affected by the drought in Somaliland, whilst working alongside the Ministry of Health to maintain and develop the lifesaving health service and provided nutrition services to 90,000 people. We were also proud to establish a unit for survivors of gender based violence and introduce a GPS system to our ambulance service to ensure that they are available to people in emergencies.

More widely we were delighted to continue to grow and innovate for people and issues most overlooked in our unequal world. Highlights this year include establishing a new integrated centre for people who use drugs in Cambodia, and a new programme to tackle perinatal depression in Guatemala.

Meanwhile our advocacy to address the root causes of inequality continues. We played a key role in encouraging the sector to step up and challenge the racism and neo-colonialism inherent in global health and launched a new campaign on vaccine justice. And as the movement to dismantle the prohibition of drugs continues to spread across the world, we mapped out the core principles for an approach to replace this that puts people and public health at the forefront.

We thank our staff, volunteers and funders for all their work. And we offer profound thanks to all our supporters, for your continued support in our struggle for a more equal world.

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 right 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 following 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

At Health Poverty Action, we work alongside ignored communities worldwide who refuse to accept the injustices that deny people a healthy life. In Guatemala, we stand with local midwives to fight the discrimination that stops Indigenous women giving birth in health centres. In the UK, we highlight how the legacy of colonialism has caused the devastating global health and inequality we see today.

We don't pick the easiest road, we pick the one that will make the biggest difference to people's lives. That's why our local team in Myanmar will trek for six weeks through the freezing mountains to run health training courses. It's why we join forces with communities in remote Somaliland villages, supporting people to demand better transport links to health facilities. Our approach partners us with some of the most remote and marginalised communities around the world.

And it's why we confront policy issues that are complex and sometimes controversial, like the fact that the so called 'war on drugs' has only made inequality – and health – worse. Taking on these barriers to health doesn't make our job easy. But, just like the communities we work with around the world, we won't accept the status quo if it takes away someone's chances of living a healthy life.

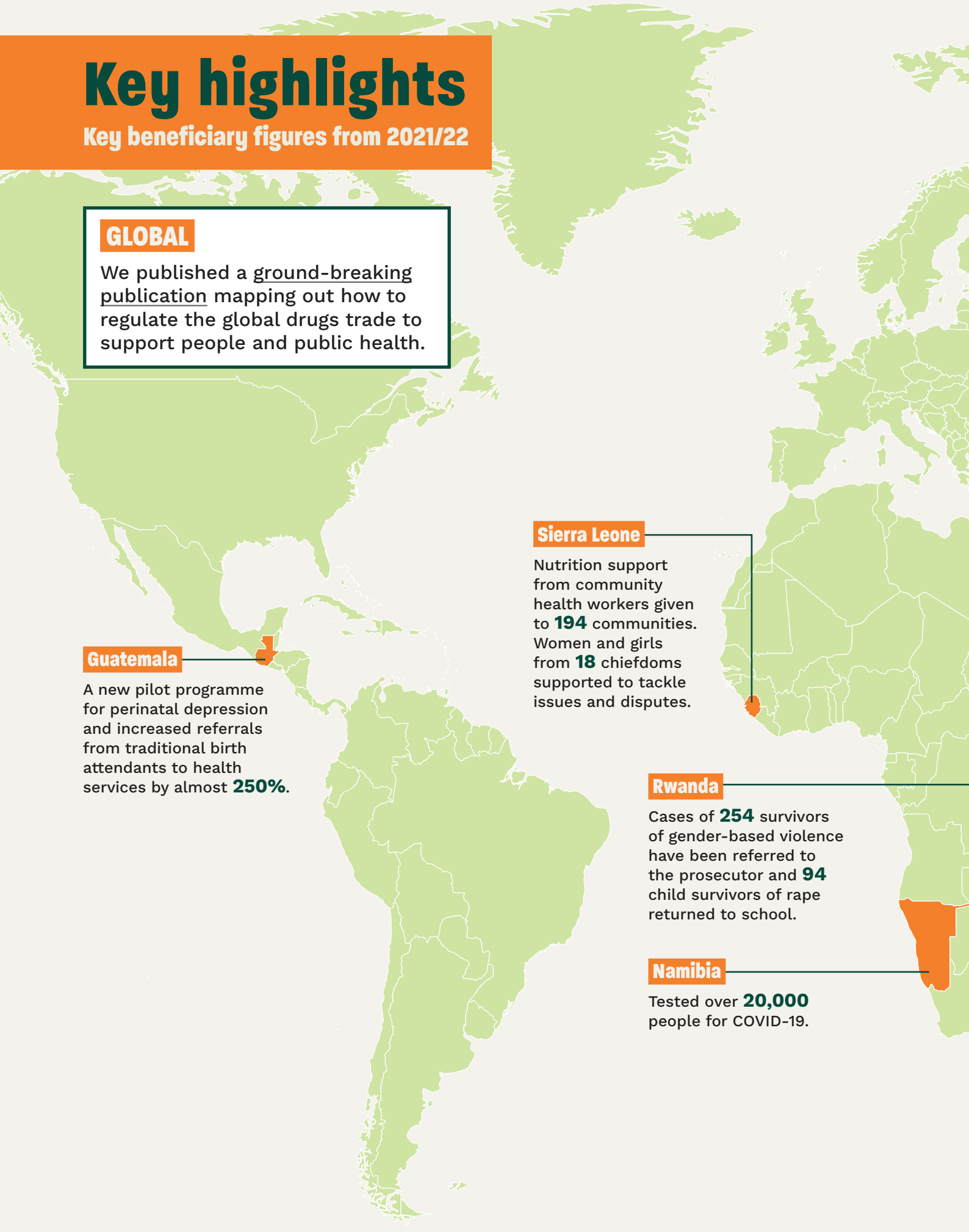
At Health Poverty Action we see health differently. We do what's needed, not what's easiest, to stop health being denied.

We draw strength from the knowledge that we are not alone, but part of a global movement for health justice – the People's Health Movement (PHM). The PHM is today's embodiment of the primary health care movement that achieved 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.

We currently work in 14 countries in Africa, Latin America, and Asia, in close partnership with Find Your Feet, whom we support with grants, managing costs and finances and who share their expertise in livelihoods, food and nutrition. We also campaign and lobby to influence policy locally, nationally and internationally, to challenge inequality and create conditions that support health in the long term. Meanwhile our fundraising team raises unrestricted funds to invest in developing further and increase our contribution to a more equal world.

Key highlights

Key beneficiary figures from 2021/22



GLOBAL

We published a ground-breaking publication mapping out how to regulate the global drugs trade to support people and public health.

Guatemala

A new pilot programme for perinatal depression and increased referrals from traditional birth attendants to health services by almost **250%**.

Sierra Leone

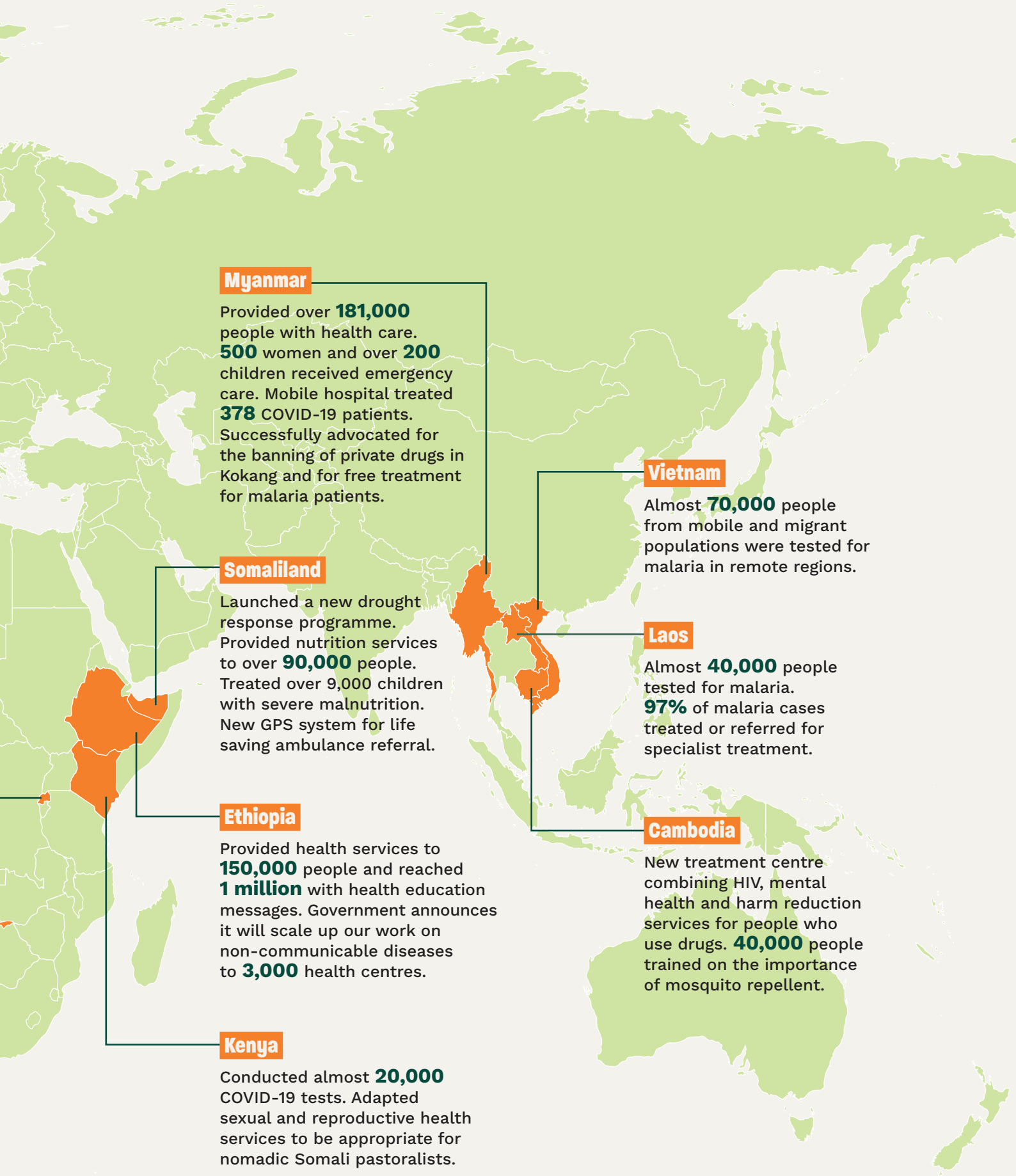
Nutrition support from community health workers given to **194** communities. Women and girls from **18** chiefdoms supported to tackle issues and disputes.

Rwanda

Cases of **254** survivors of gender-based violence have been referred to the prosecutor and **94** child survivors of rape returned to school.

Namibia

Tested over **20,000** people for COVID-19.



Myanmar

Provided over **181,000** people with health care. **500** women and over **200** children received emergency care. Mobile hospital treated **378** COVID-19 patients. Successfully advocated for the banning of private drugs in Kokang and for free treatment for malaria patients.

Somaliland

Launched a new drought response programme. Provided nutrition services to over **90,000** people. Treated over 9,000 children with severe malnutrition. New GPS system for life saving ambulance referral.

Ethiopia

Provided health services to **150,000** people and reached **1 million** with health education messages. Government announces it will scale up our work on non-communicable diseases to **3,000** health centres.

Kenya

Conducted almost **20,000** COVID-19 tests. Adapted sexual and reproductive health services to be appropriate for nomadic Somali pastoralists.

Vietnam

Almost **70,000** people from mobile and migrant populations were tested for malaria in remote regions.

Laos

Almost **40,000** people tested for malaria. **97%** of malaria cases treated or referred for specialist treatment.

Cambodia

New treatment centre combining HIV, mental health and harm reduction services for people who use drugs. **40,000** people trained on the importance of mosquito repellent.

Responding to the Coronavirus pandemic

Whilst many in the UK have returned to some sense of 'normal', across much of the majority world or Global South it is a different story. By March 31, 77% of people in the UK had received at least one vaccination dose. In contrast, the average proportion of people in the world's poorest countries was just 14%. As well as an individual crisis, the wider effects of the pandemic continue to reverberate on health and health systems across the world, including in the areas we work, placing an immense burden on already overstretched health systems and diverting resources from preventative and curative services.

For example in Kenya, as well as witnessing the socioeconomic impacts of lockdown on people's health, the closure of non-emergency services and transport restrictions has led to the scarcity, and in some cases unavailability, of condoms, contraceptive pills and other sexual and reproductive health commodities. Many health facilities have been forced to suspend family planning and antenatal care services, and to close delivery departments to make room for the pandemic response.

In Laos, the limited telephone and internet coverage amongst the remote communicates in which we work continues to pose challenges for the provision of services in times of quarantine.

Meanwhile in China and Myanmar the closure of ports has meant a lack of access to essential commodities and a stark increase in prices, while quarantine restrictions have resulted in severe staff shortages – currently 45 vacancies at the time of writing – placing an immense burden on remaining staff.

This is a challenge to which our teams continue to rise. This has included both strengthening the health systems to respond to the crises, as well as addressing public fear and mistrust of testing and vaccination which – as a result of years of discrimination and marginalisation – is rife amongst many of the communities we work with.

In **Cambodia** we trained 500 community health care providers living in remote areas to deliver rapid diagnostic tests and raise public awareness of their existence. As a result over 50,000 tests were conducted in the remote areas in which we work.

In Ethiopia we trained 56 health workers in COVID-19 awareness raising and testing, and provided personal protective equipment to 65 health clinics.

We prevented the wastage of vaccines in **Guatemala**, by providing 8 freezers for the Ministry of Health. This enabled them to take immediate delivery of vaccines which they would otherwise have been unable to use. We provided equipment, vaccination consent forms and data management tools, without which vaccination would have been delayed or suspended in rural communities. We supported the Ministry of Health to distribute information about the pandemic in the indigenous Maya language on radio stations, and worked with marginalised indigenous groups to promote testing and vaccination.

In **Kenya** we trained health workers on testing and supported community health workers to raise awareness of testing and refer clients in their communities. We addressed myths about the spread of the virus through interactive radio talk shows and embarked on a mass outreach campaign targeting pastoralists and people in remote areas. Almost 7,000 people were tested during this specific campaign and a total of 19,888 rapid tests were conducted overall.

We provided training and testing at several public health centres across Savannakhet province in **Laos.** We provided personal protective equipment to healthcare facilities and over 2,000 malaria volunteers in areas with a high malaria burden. We advocated for local health authorities to scale up the use of rapid diagnostic tests and implemented and monitored the testing.

In **Myanmar** we distributed medical supplies, trained over 2,000 health workers and supported vaccination drives and health education sessions with over 19,000 people. We supported partners to vaccinate over 100,000 people against COVID-19. In Kachin we developed a COVID-19 database for the local health department to ensure the effective tracking of tests, vaccinations, and treatment and took charge of a mobile cabin hospital donated by Tenchong county across the border in China from August 2021 to March 2022. Here we successfully treated and discharged 378 COVID-19 patients. We are proud that this work received commendation from local medical teams and government administrations in both Myanmar and the border areas of China.

In **Namibia**, we trained community health workers to provide care to the many Namibians who may not have sought care because of misinformation about the pandemic. We trained 158 community leaders to educate communities about the efficacy, availability and advantages of rapid testing and vaccination to enhance the uptake of vaccinations. Over 20,000 tests were conducted.

We integrated efforts to tackle COVID-19 with our work on gender based violence in **Rwanda,** advocating for local health centres to test project staff and patients free of charge. 198 survivors of gender based violence were vaccinated.

The pandemic has had a major impact on the delivery of essential health services in **Somaliland**. We coordinated efforts with the Ministry of Health across three regions to maintain access to health services. We set up handwashing points in all health facilities, distributed hand sanitisers, personal protective equipment and supplies. We worked with the regional health authority to provide training and free rapid diagnostic testing to health workers and tested over 23,000 people. To address the large proportion of the population reluctant to get the vaccine, we worked alongside the Ministry of Health with health workers and mobile teams to provide health education sessions to raise awareness. We conducted training for 47 community health committees and a further 54 community mobilizers from the Marodi-jeex and Sahil areas who shared information about the vaccine with their communities.

In response to the a shortage of rapid tests in **Vietnam** we distributed 113,000 tests to provincial hospitals and clinics.

Responding to the pandemic in the middle of a military coup

Roi Jar is an Auxiliary Midwife from a village in Waing Maw Township Myanmar. During the military coup many health staff left to join the civil disobedience movement, leaving only one health worker at her nearest health centre. The centre was therefore extremely overstretched and unable to conduct the vaccination and screening needed to deal with the ongoing pandemic. Ro Jar, supported by Health Poverty Action, volunteered to support her community by participating in promoting and distributing masks and information about the vaccine, as well as working as part of a team providing vaccinations.

"We did the vaccination with many sites for many villages, and we continued the activities day by day without weekends in some weeks. I also participated in screening for COVID-19 suspected cases in villages besides my village. We could do a lot of testing for many suspected cases by hard working... I can really say, 'Most people in our area have been vaccinated.'"

COVID-19 vaccination and screening in Myanmar.

Achievements, performance and impact

Maternal Health

Our work saves the lives of women and children. Much of this is through addressing inequalities in health systems, making healthcare appropriate and accessible to women who have been marginalised, whilst informing and empowering women with knowledge about their health. Women may be unable to access healthcare because services are unavailable, unaffordable, discriminatory to marginalised groups, or fail to meet their cultural needs. Often this requires bridging the gaps and facilitating communication between mainstream health services and traditional ones.

In **Ethiopia** we worked with twelve pastoralist women to identify how health services could better provide for their needs. Based on their feedback we refurbished three rural health centres in a culturally appropriate way to provide appropriate and accessible services for pastoralist women. We also trained over 100 primary health workers and 25 traditional birth attendants and ensured health centres were adequately equipped.

We improved health services in five indigenous districts in **Guatemala,** focusing on ensuring obstetric complications are referred swiftly for specialised care. This included improving health information systems to enable resources to be efficiently distributed, and identify pertinent health issues. We worked with almost 200 traditional birth attendants, women with no formal training who deliver or accompany pregnant women during delivery. We focused on preparation for birth, potential danger signs and encouraging them to refer women to health services in the case of emergencies. This year annual referrals from traditional birth attendants to Ministry of Health services rose from 248 to 665, an increase of almost 250%.

We also trained 452 rural health post staff to recognise and refer obstetric emergencies, and Ministry of Health staff in managing emergency post-partum haemorrhage, and encouraged health staff to use indigenous Maya languages to improve communication with pregnant women.

We further trained over 900 pregnant or new mothers themselves on ante and post-natal health. Perinatal depression is estimated to affect 20% of mothers, yet was previously invisible within mainstream health services. We were therefore proud to this year pilot a programme recognising and providing community interventions for perinatal depression.

In **Kenya** we trained 37 health workers to better understand Somali practices and norms, in order to treat nomadic pastoralist patients from Muslim Somali communities with respect and sensitivity to their culture and beliefs. We changed health centre protocols to ensure they accommodate these preferences, combining the best of mainstream medicine with safe and familiar Somali birthing practices and traditions. We trained a further 30 pastoralist women to support other pregnant women, accompanying them to ante- and post-natal appointments and providing counselling on breastfeeding, safe new-born care, and culturally acceptable family planning methods.

As a result of the ongoing armed conflict many of the people we work with in **Myanmar** have been displaced to camps for internally displaced people. There are no government facilities or health staff in the area. Poor links between health workers and traditional birth attendants means women are often not referred for specialist healthcare, and as a result high risk pregnancies and gender-based violence are often not detected. We worked with the health authorities to train more new midwives, community health workers and traditional birth attendants and provided supervision to community volunteers. We enabled the referral of women and children for emergency obstetric and paediatric care by providing food, transportation and related costs. This year 500 women were referred for emergency obstetric care and 211 children referred for emergency care. While providing ante and post-natal care and referring women for skilled delivery we also treated over 1,000 children under five suffering with diarrhoea and 2,554 with suspected pneumonia. In Kachin Special Region 2, we piloted an adolescent reproductive health training for associated teachers in schools. This work will be evaluated and updated before being incorporated into the Kachin local authority teacher training syllabus.

Saving lives through community health

Banana plantations are growing rapidly in Waing Maw township, Kachin State, Myanmar, attracting around 80,000 migrant workers including mothers, pregnant women and children.

The absence of a health facility leaves pregnant women in a precarious situation. Health Poverty Action supports and trains hundreds of community health workers who, in the absence of formal healthcare, provide lifesaving support in marginalised villages and plantations such as these.

One of these is Ms Khaung Naw, a 36 year-old community auxiliary midwife. She became a community midwife after receiving training from Health Poverty Action in conjunction with the Ministry of Health in 2014. She is also a member of a village women’s group that was formed five years ago by Health Poverty Action to save money for women in emergencies.

One day, Ms Khaung Naw was visiting Ms Khin Than, a pregnant woman in one of the banana plantations near her village. She realised Ms Than required urgent referral to hospital for a caesarean section. However, Ms Than’s family did not have the money to pay for transport to the hospital and had no choice but to request Ms Khaung Naw deliver the baby in the shelter where they live. Because of the training she received Ms Khaung Naw knew that was not an option.

After the team leader of the plantation was unable to provide any money, Ms Khaung Naw returned to her village and borrowed some from her women’s group. This enabled her to rent a car to drive Ms Than to Waing Maw township hospital. There the doctors performed an emergency caesarean section and safely delivered Ms Than’s baby.

Health Poverty Action later reimbursed Ms Khaung Naw who was able to refund the money to the village women’s group.

Midwife Miriam with patients at Gbanti Health Centre, Sierra Leone

In **Somaliland** we play a key role in delivering the country's health service in partnership with the Ministry of Health. This year our work included promoting sexual and reproductive health and improving access to ante and post-natal care and skilled delivery. We expanded emergency obstetrics and new-born care by training 40 midwives, introduced specialist care to two district hospitals and provided an ambulance so women experiencing obstetric emergencies can be transported swiftly for treatment. We also screened and treated malnutrition in pregnant and lactating women and children, provided immunisation and outpatient services. We provided integrated mobile health services for patients not served by mainstream services such as pastoralists. This year over 50,000 of the women we serve gave birth in health facilities an increase of 20% from the previous year.

In **Sierra Leone** we provided training in basic emergency obstetric care to 58 health workers.

Access to quality healthcare

Beyond maternal healthcare, we strengthen wider state health systems, in some cases playing a pivotal role alongside Ministries of Health in the overall provision and running of the country's health service. As with all of our work our vision is a world where marginalised groups have equal access to quality healthcare.

Thanks to the so-called 'war on drugs' people who use drugs are often persecuted, criminalised and denied healthcare. In **Cambodia** we run a ground-breaking service for people who use drugs, which combines drug testing with health care services and liaison with the local authorities to provide an amnesty for people who use drugs, enabling them to access healthcare, rather than persecution. This year we constructed a new treatment centre which combines HIV, mental health and harm reduction services. We trained five doctors and five nurses to deliver clinical services for over 1,000 patients living with

HIV.

This year a total of 150,000 people have accessed healthcare services in the facilities we support in **Ethiopia.** Our work has included supporting and training health workers on non-communicable diseases decentralisation, conducting community-based outreach services and campaigns and providing mobile clinics for nomadic pastoralists. Our unique mentorship programme also enables medical doctors to travel to other health clinics to share expertise and train nurses and other primary healthcare staff. More than 25,000 people were enrolled in treatment for non-communicable diseases such as diabetes, hypertension, asthma and epilepsy.

Through many years of work in collaboration with the local authorities we have established a basic health system on the **Myanmar** side of the China-Myanmar border. Following last year's military coup and strike of government health workers, the role of community health volunteers in providing basic health and disease control services for remote communities has become even more vital. This year we reached over 181,000 people with basic health care services. We advocated on behalf of community health volunteers who play a vital role in providing health services in remote areas, but did not have enough drugs and medical supplies. As a result of our advocacy efforts, the Ministry of Health committed to increase the provision of essential medicine to community health volunteers.

In **Somaliland** we play a pivotal role in the overall provision and running of the country's health service. Particular highlights this year include introducing the Zaad mobile payment system for health professionals' salaries – an electronic payment system which has eased the frequent problems faced by the Ministry of Health when paying salaries in cash. To improve efficiency and minimise delays, we installed a GPS system in our nine ambulances. This provides the call centre with live tracking of every ambulance in the area, allowing staff to assign an ambulance that is closest to the location of the emergency and manage backups in case of breaks down ensuing that people are able to be transported to hospital in medical emergencies.

Urgent ambulance referral and treatment in Somaliland

Two weeks after losing her baby to pre-eclampsia, Halima was readmitted to hospital with severe hypertension, oliguria, and anaemia. Her situation deteriorated rapidly and the doctor advised her immediate referral to Borama Regional Hospital for further evaluation and treatment.

There is only one ambulance covering the whole of Zeila district where Halima lives. The referral process can be long and challenging, particularly when the ambulance is in the garage for maintenance or in another area, as was the case in this instance. However, thanks to the information from our new GPS system our call centre operator Sharaq was able to locate another ambulance in Lughaya district 90 km away whose driver relocated to Zeila to quickly pick up Halima. Five hours later she arrived at Baroma Regional Hospital.

Here Halima had a range of tests and was diagnosed with acute renal failure, which required her to be under the care of a specialist physician. With her life at stake, the doctor at Borama Hospital ordered urgent dialysis. She needed three treatments of dialysis and other medical interventions during treatment.

With the exception of the abdominal ultrasound (which the Hospital Director offered to pay) all Halima's tests and treatment were free of charge. Had she been referred to a hospital which was not covered by our work, Halima would have been forced to pay or be denied treatment. So far Halima has received two treatments of dialysis and is currently recovering.

Call centre tracks ambulance referrals

Health knowledge and behaviour change

In **Cambodia** we conducted training into the use of mosquito repellent among 60 remote villages as part of efforts to reduce malaria. This year over 40,000 people took part and we distributed over 12,000 bottles of mosquito repellent.

In **Ethiopia** we raised awareness of non-communicable diseases, COVID-19 prevention and precautions, and basic health services through education materials and radio. 37 religious and community leaders we work with on FGM prevention advocated against this and other harmful practices. This year our messages reached one million people!

In **Guatemala** we worked with pregnant women to recognise pregnancy danger signs, the importance of ante-natal care, and the importance of nutrition from conception through the first thousand days of life. We emphasised care of the new-born, breastfeeding, signs of distress and linked mothers to health services for weight and height monitoring and early detection of malnutrition.

In **Kenya** we supported a women's group to share health education through theatre performances reaching over 5,000 members of the local communities.

In **Myanmar** we led 623 workshops with over 25,000 people including adolescents, migrant workers and women leaders. Topics included maternal and new-born health, breast feeding, sexual and reproductive health, immunisation, nutrition, personal hygiene, environmental

Preparing for safe birth

Beverly Vásquez is 16 years old and lives in Xacana Grande in Cabricán district Guatemala. Soon after marrying she fell pregnant, which was confirmed when she visited her nearest health post. Her pregnancy went well, and she continued to visit the health post for ante-natal check-ups. Here, Beverly was informed that Health Poverty Action held meetings for pregnant women and Beverly joined these meetings.

"They were good, because I didn't know anything about pregnancy. I learned what the danger signs were, like headaches and haemorrhage. I also learned about all this in the telephone calls [that HPA made to pregnant women after meetings were suspended due to COVID-19]. So what helped me was learning to identify danger signs, and be ready for them. They also told me to keep going for my ante-natal care visits every month. I was happy with the way they treated me."

When Beverly went into labour, her husband called a traditional birth attendant to come to their home. Beverly was too frightened to go in to hospital because of COVID-19. Beverly's baby was born safely, weighing 6lbs. However, Beverly also explained:

"To other pregnant women, I'd say to them, if they ever see a danger sign they shouldn't wait too long, they should get to the hospital."

sanitation, harm reduction and the prevention of communicable diseases. Our approach included lecturing, discussions and demonstrations, singing and roleplay. These health education sessions have enabled people to gain knowledge about their rights and adopt healthy behaviours, and ensure they have trust and confidence to seek and utilize health services.

In **Rwanda**, our work against gender-based violence includes challenging beliefs and practices that perpetuate it. This is done through home visits, the "Umugoroba w'Imiryango" forum, the popular Urunana radio soap opera (established by Health Poverty Action in 2004, and now its own organisation), and Radio Rwanda.

In **Somaliland,** community health committees and their district and regional health boards are critical components of the health system, encouraging pregnant women to attend ante-natal care, and challenge norms on gender-based violence. Community conversation is an innovative approach to discussing and resolving sensitive topics. We taught this approach to health workers, religious leaders, teachers, and community leaders and established groups in Burao and Aainabo districts and in camps for internally displaced people. Men and women were able to discuss gender-based violence, female genital mutilation, and social norms. We performed outreach dramas and broadcast messages on these topics through the popular Saxansaxo radio and television programmes. We also supported children to become peer educators to lead discussions in schools, establishing school clubs in seven secondary schools as well as 'boy's clubs' in three camps for internally displaced people. These clubs hold monthly discussions on gender-based violence, sexuality, masculinity, and human rights. Throughout the first year of the project's implementation, the children in the camps were able to reach around 480 of their peers.

In **Vietnam** we provided "Test-Treat-Track" malaria prevention training to 382 mobile and migrant groups. The trainees learnt skills in behaviour change when conducting communication events in communities. Village leaders supported and successfully provided 629 awareness sessions integrated to spread the key communication messages to at-risk populations of 17,580 local people.

Soweda Gedi Ali, Kenya

Soweda Gedi Ali from Mandera Town, Kenya attended our training on a range of topics including the use of contraceptives, the importance of attending health clinics and female genital mutilation. She uses her knowledge to improve health education in her local community. She and her fellow health workers spend three days each month visiting community members and providing them with information on topics such as the importance of safe birthing practices and avoiding female genital mutilation. She explained:

"The community has been very supportive including the Elders. The people in my village previously didn't have this information. Now they know and are willing to share the message with others."

We held media events in five provinces: Binh Phuoc, Gia Lai, Dak Nong, Quang Tri and Dak Lak. In Dak Nong, we supported the local CDC to hold eight communication classes on malaria prevention, with a total of 160 participants. In the other four provinces, we organised a communication contest of paintings and photographs about malaria prevention. The contests attracted hundreds of creative and impressive works of art.

Food and nutrition

We have been distributing food since 2020 in **Cambodia** to address a lack of food among poor and homeless people during the COVID-19 outbreak and lockdowns. This year we organised 52 food distributions, disseminating 2,600 food packs. We also provided over a thousand meals for people accessing our drug treatment centre.

In **Guatemala** we work with pregnant women and new mothers on nutrition during pregnancy and the importance of the first thousand days of life (conception to two years old) for a baby's development, emphasising how to provide nutritious meals using locally available food. We also supplied storage facilities for the government's nutritional supplement programmes.

Malnutrition is a major problem in **Laos** – especially for mothers and young children. Over the last four years in partnership with Fundación Pueblo para Pueblo, we have reached over 5,000 vulnerable households in 100 villages with a particular focus on children under five, women of childbearing age – including women from ethnic minorities, urban poor, migrants – and young people. We screened 85% of the children under five years old in the target villages for malnutrition and provided 95%, 98% and 98% respectively of the children aged between 6 and 59 months with immunisation visits, deworming and vitamin A.

In **Myanmar** we distributed food supplements to over 8,000 internally displaced people and those who have returned to their communities in conflict-affected areas. We provided supplements such as folic acid, iron and vitamin B1 to pregnant and post-natal women. And every six months we provided vitamin A to over 11,000 and deworming to over 20,000 children.

Improved nutrition through backyard gardening

Aminata is from Bombali district Sierra Leone. She became a single parent after losing her husband to COVID-19. Aminata and her child have benefited from the low-cost agricultural garden implemented by Health Poverty Action and are now both thriving.

"Now we can plant and eat what we grow with much more of a balanced diet through this project. I eat on time and my breast is always filled with milk with which my child is always happy to feed on."

In **Sierra Leone** we supported 173 community and state health workers to gain knowledge and skills to provide integrated health and nutrition services. We also provided food to a total of 156 undernourished children and their mothers, supported people to rear sheep, goats and poultry and worked with community members to establish low-cost vegetable gardens with high nutrient vegetables such as potato leaf, garden eggs, tomato and onions. This year 194 communities were visited by community health workers to assess and identify undernourished children and refer them to health services for treatment. Out of 488 children assessed, a total of 272 undernourished cases (56%) were identified and referred to appropriate health facilities for immediate care.

In **Somaliland** we integrate supplementary feeding programs into our health services. We monitor the growth of young children, provide deworming, basic counselling on nutrition and diagnose and treat anaemia, pneumonia, diarrhoea, and malaria. We do this through house to house visits, including in remote villages and camps for internally displaced people. This year we provided nutrition services to over 90,000 people. We also support community nutrition workers who provided sessions on nutrition, health and hygiene to 4,281 people. We trained 56 health workers on nutrition and a further 27 on infant and young child feeding. Over 9,000 children with severe acute malnutrition received treatment.

Water and sanitation

Many of the communities we work with are denied access to clean and safe water and sanitation facilities, a key threat to health and driver of disease.

We supplied a water storage tank to Santa María Chiquimula Health Centre in **Guatemala**, whose water supply is intermittent, and can now store water when supply is unavailable.

In **Myanmar** we provided 6,310 people with a new safe water supply for drinking, cooking and personal hygiene and accessible toilets and water purification systems for three rural health clinics. We reached 16,764 people with hygiene promotion sessions and trained 3,757 teachers and volunteers in sanitation and hygiene.

Drought affected communities in Somaliland queue for hours each day to get water.

In autumn 2021, a drought in **Somaliland** affected an estimated 800,000 people, forcing them to seek refuge in overcrowded settlements for internally displaced people. Over 1.2 million people lacked access to safe drinking water, posing a hygiene threat and exacerbating and the risk of disease. In response we launched a new programme to provide life-saving health, nutrition, water and sanitation services to drought-affected populations, including immunisation, nutrition screening, water trucking, and the distribution of cleaning materials. We also participated in a drought mission to assess and report on the scale of the drought, and delivered medical supplies and cleaning materials to surrounding health centres.

Disease prevention (excluding COVID-19)

In **Ethiopia** our work in decentralising care for non-communicable diseases to enable patients in rural areas to access care locally has been recognised by both national and regional authorities. The Ministry of Health has announced its plan to scale it up to 3,000 primary health centres. We also shared experiences and best practices in strengthening the service provision at the primary health care facility through visits from other partners working on non-communicable diseases.

In **Laos** we support the government's efforts to prevent and control malaria**.** This year we have distributed personal protection packages, which includes nets and insecticide, to reduce malaria transmission among migrants and people who live in forests. We provided refresher training to 400 Village Malaria Workers and provided them with regular supervision on how to test, treat and refer malaria, report community health activities and prevent stock-outs. On average, each malaria volunteer has tested approximately eight people each month, resulting in almost 40,000 malaria tests this year. 675 cases of malaria were with 97% of those treated or referred for specialist treatment. Local malaria workers developed awareness messages in the local ethnic languages, reaching 62,000 people. The malaria burden was reduced by 40% between 2018 and 2021.

Marginalised ethnic minority groups living in the forest and its fringes in **Myanmar** often carry the greatest burden of both poverty and disease. We work to make malaria and tuberculosis services accessible for migrants and other marginalised groups. This includes training and supervising malaria, tuberculosis and village health volunteers, improving health clinics and malaria stations, running outreach services, diagnosis and treatment and supporting local teams to manage malaria cases. We have also provided high risk communities with over 23,000 long-lasting insecticidal nets, developed and produced user-friendly and ethnically appropriate malaria information and conducted community health education to ensure that people take up services. We have reached more vulnerable groups with immunisation services, through provision of vaccines, support for vaccinators and providing cold chains. Almost 16,000 cases of suspected malaria received tests and 7,813 confirmed cases received antimalarial treatment. This work was featured on CCTV's Newsweek in China. 921 people with suspected tuberculosis were referred to tuberculosis centres with all those diagnosed receiving treatment. Over 5,000 infants were immunised with pentavalent vaccines, and against measles. Over 5,000 pregnant women were given a tetanus vaccination.

In Kokang we addressed the inequality and lack of standardisation in access to malaria treatment by successfully advocating to the local authorities to ban the sale of private malaria drugs. Instead, suspect malaria patients are referred to public clinics and malaria control centres free of charge.

In **Namibia** and **Ethiopia** our research into our '99DOTS' digital solution to bring tuberculosis monitoring to marginalised mobile and migrant patients even when they are on the move was published in a medical journal.

A day in the life of a malaria volunteer

"My name is Ro O Thao, I'm 25 years old and currently work as a malaria volunteer for Health Poverty Action in Chu Rcam commune, Vietnam.

Since being recruited by HPA as a volunteer, I am in charge of the Mobile Outreach Team in the commune. My job is to take blood samples from migrant groups daily for testing at farm houses, forests and seven villages to find malaria parasites. Along with testing, I also advise and communicate to improve communities' awareness about malaria prevention.

This area has many ethnic minorities so their life is quite hard. Forest conditions germinate many tropical diseases and especially in the rainy season, fever or malaria are common. Fortunately, with the HPA project, the malaria problem has been well controlled.

My typical day at work usually starts with visiting migrant households, having a short talk about malaria and taking blood samples. I also share methods to avoid malaria by wearing proper clothes and bringing nets along. Since the outbreak of COVID-19 epidemic, examination and detection of malaria cases became extremely tough. Nevertheless, the mobile outreach team is determined to travel to every single village farm to detect and treat malaria.

On October 12, a village health worker notified me that there was a person with symptoms of high fever, shivering and sweating... We prepared tools straight away, crossing hills and mountains, crossing a fast-flowing stream, river full of mud and slippery soil. Finally, as we were about to reach the place, the motorbike broke forcing us to walk for nearly 10 km to the destination. The patient had had a fever for 3-4 days and slept in the forest for more than 14 days. I gave him a test which was positive for malaria. After getting a confirmed result via microscope by commune health staff, the patient was prescribed malaria medications. We also tested the others in the family and living nearby in case they got infected. We then conducted a talk on malaria topics, aiming to increase their knowledge in malaria prevention.

In **Somaliland,** we worked with the Ministry of Health to deliver pentavalent vaccination to 24,785 children, an 11.7% increase this year.

In **Vietnam** we controlled malaria in mobile and migrant people, especially forest goers. We supported 330 village health workers and 39 mobile outreach teams who travel to very hard-to-reach areas on personal protection measures, health care seeking behaviour and malaria testing. Almost 70,000 mobile migrant population were tested for malaria. This enabled 49 malaria cases to be detected, treated and followed-up. In Dak Lak and Binh Thuan provinces we implemented community screening activities for early detection of tuberculosis, helping patients receive early treatment and reducing the burden of tuberculosis for the community. We provided training on tuberculosis knowledge and case detection for 33 health staff. 5,299 sputum specimens were collected and 536 tuberculosis infected cases were detected and referred for treatment.

Women's rights

As across the world, in many of the countries in which we work, women lack power and face discrimination, violence and harassment. Female genital mutilation is prevalent in a number of areas.

In **Ethiopia**, we trained 12 pastoralist women in leadership, research, and rights; supported 45 religious leaders to advocate for women's rights and against gender-based violence, including female genital mutilation; and provided 25 traditional birth attendants with counselling and support to speak up for women's health and strengthen referrals to health facilities.

We trained health workers at six health centres in the Totonicapán Department of **Guatemala** on gender-based violence, focussing on how health workers can support survivors to be referred to legal, social or psychological services.

Women's economic empowerment group for survivors of gender based violence, Rwanda.

We supplied 11 health facilities with screens to improve privacy for survivors of gender-based violence, and publicity materials to inform people how to report violations. The six health facilities now have a total of 136 trained staff and are increasingly sensitive in dealing with survivors.

In **Kenya** we work with mobile Somali pastoralists in Mandera East, an area with particularly poor sexual and reproductive health, to create culturally relevant services and challenge gender-based violence. We used feminist methods to facilitate community discussion on gender-based violence and female genital mutilation (FGM), encouraged religious leaders and other opinion formers to engage on these topics, and broadcasted radio shows to over 90,000 people to influence public opinion. We trained health workers to identify gender-based violence and integrate it into to a comprehensive package of health and legal services, as well as promote justice by making referrals to legal services and collecting evidence.

Young women and girls in **Myanmar** are frequently victims of gender-based violence, yet young people have largely been left out of discussions on the topic due to sensitivity and taboos. This year we supported 80 village health committees and two youth centres to raise awareness of sexual and reproductive rights and ran courses and education activities in schools with almost 10,000 teachers taking part. We also supported survivors of gender-based violence to be referred for counselling and other health services, and supported health facilities to provide clinical services for survivors of rape. As a result of our advocacy, the authority of Special Region 4 issued the “Marriage Registration Regulations” in 2021. The policy states that marriage must be voluntary and introduces a minimum age of 18 for women. This has the potential to increase gender equality, challenging traditional gender norms and protect women from the health risks of early marriage.

In **Rwanda** survivors of gender-based violence often face stigma and shame from their community and families. We addressed this by facilitating meetings with a range of people such as police, staff from the Rwanda Investigation Bureau, judges, health workers, gender-based violence committees, opinion leaders, friends and families of survivors, community health workers, and local authorities to foster understanding and coordinate services and support. We developed 44 women friendly spaces, where women can go to feel safer, access information and support, participate in activities and build support networks.

With our help over 210 survivors formed saving groups to provide financial support to each other and promote economic independence through activities such as agriculture and farming. Some of them cultivate fruits and vegetables, and rear small domestic animals. We also encourage survivors to access HIV tests and other health care. This year we visited 5,582 women in their homes. 254 cases of gender-based violence have been referred to the prosecutor for legal justice and over 400 referred for employment training. 94 child survivors of rape returned back to school.

We promoted women's involvement in decision making structures in **Sierra Leone.** Women and girls from 18 chiefdoms in Bombali and Karene district held monthly meetings at chiefdom level to bring forward issues and disputes from their various communities and discuss potential solutions. We supported six community led radio discussions on two local radio stations on issues such as the Education Health Initiative and gender laws, and supported local community radio stations to hold live debates on issues from the role of men in the home, to national level poverty and healthcare. We further supported groups of women to raise issues with district health authorities.

We established a new specialised unit for sexual and gender-based violence in Aainabo Hospital **Somaliland**. We also supported this service in Burao Hospital and Baahikoob, the referral centre for gender-based violence in the Togdheer region. Each centre provides clinical management for survivors, medical drugs such as post-exposure prophylaxis (PEP) for HIV, emergency contraception, mental health drugs for post-traumatic stress disorder and, psychosocial counselling for survivors. We trained 30 health workers to provide medical and psychosocial support, and counsellors, lawyers, police officers, NGO personnel, and staff from government ministries to coordinate response, reporting, and recording. We trained 30 high school teachers to identify and refer survivors to services and trained high school students trained as peer educators.

Health Poverty Action has advocated against female genital mutilation (FGM) in Somaliland for many years. This year we helped to fund the establishment of an FGM response unit at a health centre in Burao district. During the commemoration of the annual "Zero-tolerance Day," we conducted a workshop to increase awareness about the dangers of FGM and trained three health workers on the clinical management of FGM complications.

Speaking out

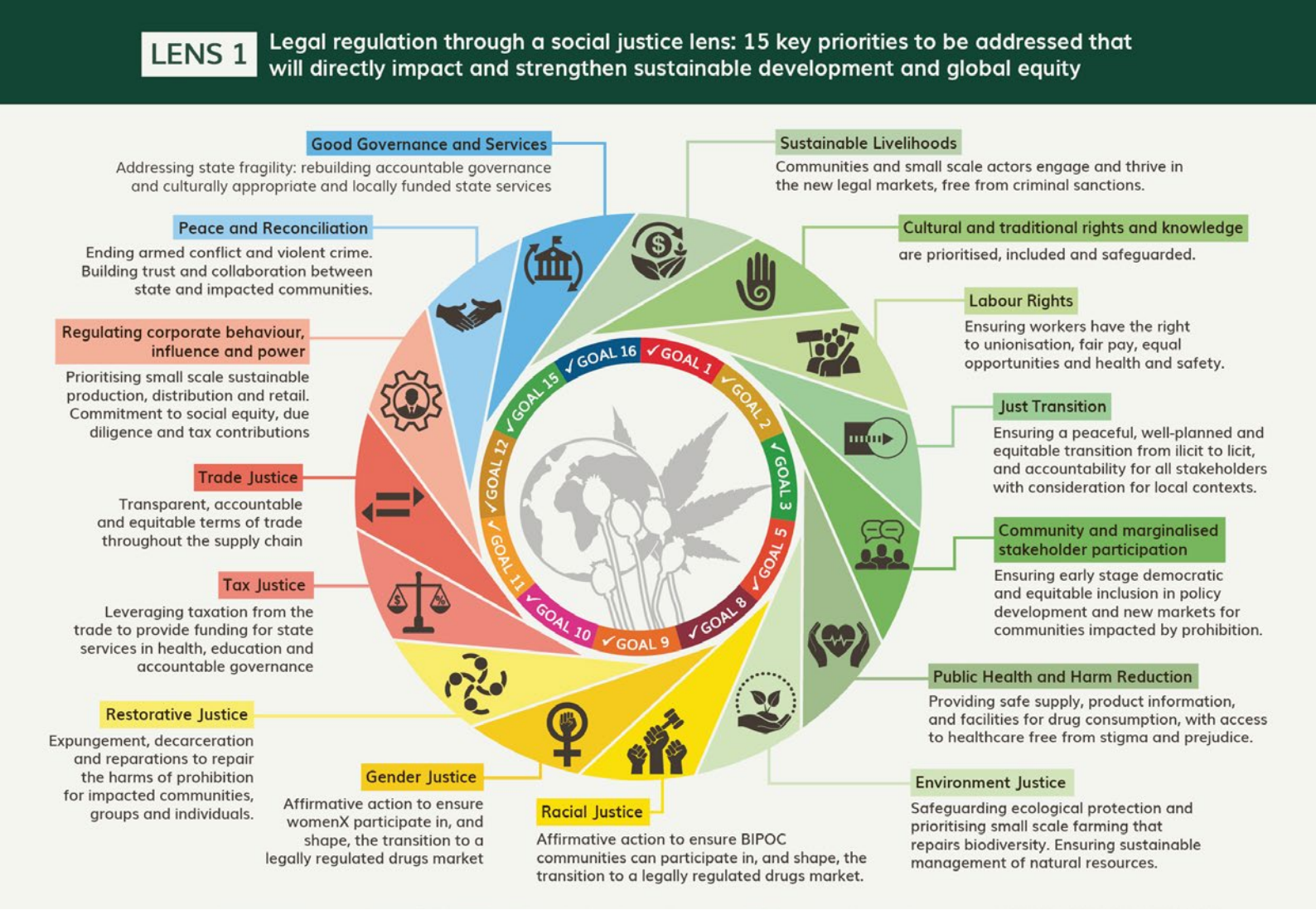
As well as supporting national-level advocacy our global policy and campaigns team works to influence international policies to challenge the power imbalances that deny people good health – often tackling issues that others can't, aren't or won't.

Building on our previous webinar series, 'A World With Drugs', we published two graphic visions, presenting possible divergent futures. The first is the opportunities for global equity if the illicit drug trade is legalised and regulated in a way that prioritises and champions social justice. The second is the oppressive consequences if corporations capture this process at the expense of those most affected. These have been used extensively, including at high-profile events such as the Commission on Narcotic Drugs and the Labour Party conference, as well as being translated into Spanish independently by our partners and used to influence the reforms of the Mexican government. We were also delighted to see it capture the attention and be cited by the influential Global Commission on Drugs – a high-profile organisation of former Heads of State and key global influencers.

We collaborated with the Cambodia programmes team to influence the UN's Commission on Narcotic Drugs. This included outlining the need for legal regulation focused on public health and social justice and highlighting the role that comprehensive and integrated harm reduction services – such as those we provide in Cambodia – can play in this.

Despite current attention on the climate emergency, drug policies' role in preventing climate action has received almost no attention to date. We decided it was time to dive into this arena this year, conveying to the public and the environmental sector that drug policy is a barrier to climate justice. Partnering with organisations of former law enforcement officials and students working on the intersection between drug policy, corruption and the environment, we produced a series of 12 short video interviews outlining the issue. We brought the message that #drugpolicyisclimatepolicy to organisations, activists and policymakers at the UN Climate Change Conference of the Parties (COP26).

We continue to coordinate a mental health steering committee to strengthen policy and practice on this issue across Health Poverty Action and work with colleagues in Somaliland towards a mental health strategy for the country.



15 core principles to deliver legal regulation for social justice

This year also brought us resources for a new area of work on vaccine justice, addressing the stark inequalities in access to COVID-19 vaccinations. We began this by supporting the global campaign for a TRIPS waiver in trade agreements that would ensure that that governments force pharmaceutical companies to share the vaccine 'recipe' with poorer countries. We also engaged in an emerging process of the World Health Organisation to develop a global treaty on how the world should prepare for future pandemics.

We played a pivotal role in the work of the Kampala Initiative, a community of activists and organisations from the Minority and Majority worlds aiming to decolonise global solidarity. This includes work on 'reimagining solidarity', a webinar series, online consultation and a pledge regarding the role of language in catalysing global power inequalities. The accompanying commitment is intended to influence practice and promote more ethical action in the sector and has received endorsements from 125 organisations and practitioners. As a result, we have been invited to speak at several high-profile events and conferences on this topic.

We launched our vaccine justice campaign

Fundraising

A note from the team

We continued to feel the impact of COVID-19 and the lockdown measures in the UK, where most of our fundraising efforts are currently based. Nearly a quarter of our anticipated fundraising income was affected – from trusts working with smaller budgets than they had pre-pandemic, corporations recovering and adapting to an uncertain future, and individuals facing tough decisions on how and whether they could continue to give.

We will continue to adapt to our quickly changing environment, developing our digital presence, calling upon our friends and building new partnerships to secure the much-needed funds to support the communities who we work with and for. As part of this strategy, we opened an arm of our global operations in the United States – Health Poverty Action USA – which will allow us to access even more funds to support our mission.

We are enormously grateful to all of our supporters, who have continued or even increased their support this year.

Community and events

COVID-19 and government restrictions continued to limit in-person fundraising activities throughout much of the year. Some events were delayed, like the London Marathon, which moved to October from its regular spot in April; while other fundraising events were still prevented from happening, like our normally popular Choirs for Change in December, where local choirs typically sing carols in London tube and train stations.

We are endlessly grateful to our runners for sticking with #TeamHPA through the postponement of both the London Marathon and the Royal Parks Half Marathon. And we are particularly thankful to those who took part in the virtual events to boost their fundraising. We are also grateful for the choirs who sang socially distanced carols and created music videos when we couldn't meet in the tube and train stations in December.

Corporate partnerships

We are grateful for our continued corporate partnerships over the past year. Both those who maintained their steadfast support of Health Poverty Action throughout the pandemic, and those who needed a break in giving but returned as things calmed down. We appreciate our ongoing partnerships with Mondrian Investment Partners, Capital Group, as well as the Buchanan Programme and Gavin Pickett.

Health Poverty Action marathon runners

Supporters

Throughout this year, our committed supporters have enabled us to continue working with communities worldwide to improve people's health and challenge the causes of poverty.

On behalf of those communities, we offer our heartfelt gratitude to everyone who has left a gift in their will, supported us with regular gifts or made donations to our appeals.

As face-to-face activity has continued to be difficult, we have focused on developing our written and digital appeals to existing supporters and the wider public. In addition to our 'Privilege and Power' and 'Going Further' appeals, we also delivered a BBC Radio 4 appeal based around our maternal and child health work in Myanmar.

Trusts and Foundations

We are extremely grateful for the support we have received from Trusts and Foundations this year. This has enabled us to continue providing an effective response to the global COVID-19 pandemic, with protective equipment, hand sanitising facilities and vaccination roll-out.

In addition, our generous supporters have been enabling us to build the capacity of health workers and women's clubs in Sierra Leone, to improve health and nutrition in their local communities; improve services for victims of sexual and gender-based violence; and support internally displaced people (IDPs) in Myanmar with shelter, water, sanitation and livelihoods support. The support we have received is also ensuring vital health and nutrition care for pregnant women, new mothers and new-borns in the highlands of Guatemala; and helping to reduce the stigma associated with HIV/AIDS in Cambodia.

We would like to thank all of our supporters, including the Evan Cornish Foundation, Gunvor Foundation, The Mercury Phoenix Trust, Stanley Thomas Johnson Foundation and all of our anonymous donors.

Communications

This year, we shared two different appeals with our supporters. In our spring and summer 'Privilege and Power Appeal' we focused on our work tackling power imbalances that impact on health and poverty – from global economics and geopolitics to gender, racial and ethnic discrimination.

In the autumn and winter, we promoted our new messaging through our 'Going Further Appeal' – highlighting how HPA goes further literally to work with relatively remote and isolated communities and figuratively to address issues that are often overlooked in the 'international development' and 'health' sectors, such as the impact of colonialism and drug prohibition.

Image from our 'Going Further' appeal

Our new messaging, or at least a brief summary of it, is included below.

The hope of this messaging is to blend the different aspects of our work – from programmes to policy change – into one clear statement about the values that undergird our work.

We also had some exciting projects launched from the Policy & Campaigns team (mentioned above) which we've been able to utilise to grow our followers.

We see health differently. We do what's needed, not what's easiest, to stop health being denied. Because missing out on healthcare isn't inevitable. Neither is poverty.

These things are caused by discrimination, by racism, by companies, by governments.

They are caused by decisions made by people in power – and that means we can change them. So we work alongside ignored communities worldwide who refuse to accept the injustices that deny them a healthy life.

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 digital, face-to-face or telephone fundraising).

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.

Financial review

Overview

As the world gradually emerges from the impact of the pandemic, this year has not been without challenges.

However, in solidarity with health workers, activists and communities worldwide we were able to continue our fight to improve health and challenge the causes of poverty.

None of these would have been possible without the generosity of our supporters and we are extremely grateful.

Income

Overall income for the year fell by 24% (£14,992,209 compared to £19,836,724 in 2020-21). This decrease is largely attributed to the impact of the pandemic on the global economy, completion of several projects during the year and the UK government aid cuts.

While fundraising income streams such as community and events were affected by the various lockdowns, we noted an increase in giving from individuals, trusts and foundations (£475,306 compared to £403,282).

The income from charitable activities of £14,510,278 (compared to £19,421,832 in 2020-21) comes primarily from grants from international institutions, governments, trusts and foundations and represents 97% of the overall organisational income.

For further detail please refer to Note 2 of the accounts.

Expenditure

Unrestricted expenditure increased by £219,621 during the year (£497,390 compared to £277,769 in 2020-21). This is mainly due to activities returning to pre-pandemic level.

The decrease in expenditure on charitable activities by £6,010,776 is proportional to the decrease in income as highlighted in the income section above.

For further detail please refer to Notes 3-5 of the accounts.

Risks, uncertainties and mitigation

The Trustees, Finance team and the Senior Management Team regularly oversee major risks and how these are being managed. In 2021-22 the risks outlined on the table on the following page were identified with actions to mitigate them.

For 2021-22 and beyond, the key risks to HPA are a fall in income from donations or investment income but also the reduction in global financing for development over the next few years due to the slow recovery from COVID-19, the impact of external factors such as political instability in parts of the world, i.e. the war in Ukraine, cost of living crisis and Brexit.

The Board of Trustees and Senior Management Team have discussed short, medium and long-term action strategies, and in relation to this identified the following as some key priorities:

- Continued proactive efforts by the global team to seek new project funding.
- Focus on ensuring project budgets provide full cost recovery
- Support the fundraising team to minimise the impact of slow recovery from the pandemic compounded by cost-of-living crisis, while at the same time building strategically to increase the team's net contribution to core income.

Risks	Management actions in 2021-22
Brexit • Not possible to apply to EU calls for proposals as leading organisation • The number of EU contracts has reduced during the past few years, however the EU has a budget line for charitable organisations such as HPA to access, although level of success is still difficult to judge	• Application has been made to assess the funding available, success rate will be monitored • US office now in operation as part of diversification to expand income streams
COVID-19 pandemic • Projects suspended or even cancelled; Besides, lockdown causing delays in project implementation potentially leading to slow burn rate and more demand on unrestricted funds • Challenging fundraising environment	• Frequent reforecasting and restrategising to maximise funding opportunities • Consulting with internal and external advisors to keep abreast of developing opportunities • Reassess and reduce unnecessary expenditures (e.g., travel) and invest strategically • Social enterprise venture started in-country as part of planned COVID-19 mitigation strategy
Safeguarding • Injury or risk to child or vulnerable adult leading to legal action, negative publicity, financial and reputation loss • Staff fail to whistle blow in the event of a safeguarding issue or in any other area of severe wrong doing such as theft, fraud and corruption. Or beneficiaries are unaware of how to/unable to report an issue. Risks legal action, negative publicity, financial and reputation loss	• Child and vulnerable adult policy • PPP Policy reviewed and updated • Whistleblowing policy in place. Beneficiaries informed of reporting structures in all projects • Training conducted across the organisation including overseas staff

A new accounting system

This year marks the first year of the Iplicit Financial Software across HPA global Finance Teams.

The system has allowed for real time visibility of all countries' accounting processes and has consequently provided a unified and regularised accounting procedure. The system has allowed for transparency of all finance management and provided the means to further enhance financial processes across the board.

The versatility of the system meant that reports can be adapted to donor's requirements whilst maintaining compliance to FRS102.

We have significantly enhanced our internal control systems to cater for the needs of our colleagues working in remote areas and we are looking forward to further enhance the functionality of this system to support our full cost recovery plans.

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 a huge impact on beneficiaries. During 2021-22, our unrestricted reserves increased by £54,229 to £1,540,326 (£1,486,097 in 2020-21).

As the economic impact of the higher cost of living unfolds, the current level of free reserves is at the higher end of the board policy and has therefore been deemed satisfactory.

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

COVID-19 and Going Concern

As disruptions caused by the coronavirus pandemic begin to ease in some parts of the world, a larger part of where HPA country offices are based are still experiencing significant challenges as a result of the emergence of different variants of COVID.

In 2021-22, HPA was able to take advantage of the UK Government's Job Retention Scheme (a total of £110,580 support was received), whilst most staff returned to full time operation in the winter of 2021.

Our fundraising income showed an improvement this year in comparison to last year and we are cautiously optimistic that this trend will continue given investment in social enterprise in Cambodia and expansion into the US.

We are focused on keeping unrestricted expenditures at the lowest level while ensuring full cost recovery on our programmes.

We are starting to rebuild capacity as activities return to pre-pandemic level. New staff have been recruited in the year to support core activities especially Fundraising and Policy and Campaign's work.

Whilst the pandemic has had an impact on our funding this last year, we are optimistic about the coming year, given the additional funding confirmation from UNICEF for the African programmes and Global Fund Award for Asia at the start of the new financial year.

The Trustees have assessed the financial projections and do not believe that there are material uncertainties that call into doubt HPA's ability to continue in operation for the foreseeable future.

Trustees' report

Structure, management and governance

Structure and management

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

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

Remuneration policy

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

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

Senior management remuneration

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

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

Remuneration for the year ending 31 March 2022 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 nine Trustees as of August 2022.

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 programmes and some have participated in programme 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. The Trustees bring professional traits and skills which provide the basis for their role as Trustees through their individual professional capabilities, bringing these into their Trustee role.

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. Trustees that retire or become former trustees are covered through a discovery period until the policy is next renewed. As we renew our policy annually, any trustee that does resign during that year would be covered for the remaining length of the annual contract.

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 served during the year and subsequent appointments and resignations are as stated below. None of the trustees held a financial interest in the company.

Trustee	Role
Mehmet Nadir Baylav[2]	
Denis John Cavanagh[1]	Treasurer
Anna Graham	
Rory Erskine Morrison Honney	
Anuj Kapilashrami	
Oliver Benjamin Kemp[1&2]	Chair
Ruth Stern[1]	Vice Chair
Betty Ann Williams[1]	
Ravi Ram	

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
152-160 City Road
London
EC1V 2NX
United Kingdom

Auditors:

Moore Kingston Smith LLP
9 Appold Street
London EC2A 2AP
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

Moore 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: 21 November 2022

Independent Auditor's report

To the members Of Health Limited T/A Health Poverty Action

Opinion

We have audited the financial statements of Health Limited T/A Health Poverty Action ('the company') for the year ended 31 March 2022 which comprise the Statement of Financial Activities, the Summary Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement and notes to the financial statements, including 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 2022 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

In auditing the financial statements, we have concluded that the Trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charitable company's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Trustees with respect to going concern are described in the relevant sections of this report.

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 contained within the annual report. 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.

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 course of 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 themselves. 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.

Opinions on other matters prescribed by the Companies Act 2006

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

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

Matters on which we are required to report by exception.

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

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

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

Responsibilities of Trustees

As explained more fully in the Trustees' responsibilities statement set out on page 29, 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

The objectives of our audit in respect of fraud, are; to identify and assess the risks of material misstatement of the financial statements due to fraud; to obtain sufficient appropriate audit evidence regarding the assessed risks of material misstatement due to fraud, through designing and implementing appropriate responses to those assessed risks; and to respond appropriately to instances of fraud or suspected fraud identified during the audit. However, the primary responsibility for the prevention and detection of fraud rests with both management and those charged with governance of the charitable company.

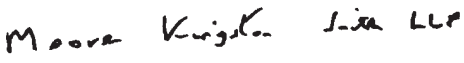
Our approach was as follows:

- We obtained an understanding of the legal and regulatory requirements applicable to the charitable company and considered that the most significant are the Companies Act 2006, the Charities Act 2011, the Charity SORP, and UK financial reporting standards as issued by the Financial Reporting Council.
- We obtained an understanding of how the charitable company complies with these requirements by discussions with management and those charged with governance.
- We assessed the risk of material misstatement of the financial statements, including the risk of material misstatement due to fraud and how it might occur, by holding discussions with management and those charged with governance.
- We inquired of management and those charged with governance as to any known instances of non-compliance or suspected non-compliance with laws and regulations.
- Based on this understanding, we designed specific appropriate audit procedures to identify instances of non-compliance with laws and regulations. This included making enquiries of management and those charged with governance and obtaining additional corroborative evidence as required.

There are inherent limitations in the audit procedures described above. We are less likely to become aware of instances of non-compliance with laws and regulations that are not closely related to events and transactions reflected in the financial statements. Also, the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion.

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: 22 November 2022

For and on behalf of
Moore Kingston Smith LLP
Statutory Auditor
6th Floor
9 Appold Street
London
EC2A 2AP

Accounts

Statement of financial activities

(Incorporating an income and expenditure account)

For the year ended 31 March 2022

	Notes	Unrestricted funds 2022 £	Restricted funds 2022 £	Total funds 2022 £
INCOME AND ENDOWMENTS FROM:				
Charitable activities	2	-	13,650,844	13,650,844
Donations and legacies	2	475,306	-	475,306
Gift in Kind Income	2	-	859,434	859,434
Investments	2	1,456	5,170	6,625
Total incoming resources		**476,761**	**14,515,448**	**14,992,209**
RESOURCES EXPENDED				
Raising funds	3	-	-	497,390
Charitable activities	4	497,390	14,432,998	14,432,998
Total resources expended		**497,390**	**14,432,998**	**14,930,388**
NET INCOME/(EXPENDITURE) FOR THE YEAR		**(20,629)**	**82,449**	**61,821**
Transfer between funds		-	-	-
Foreign exchange gains in year		74,858	22,511	97,368
NET MOVEMENT IN FUNDS FOR THE YEAR		**54,229**	**104,960**	**159,189**
Total funds brought forward at 1 April 2022		1,486,097	3,716,411	5,202,508
TOTAL FUNDS CARRIED FORWARD at 31 March 2022		**1,540,326**	**3,821,371**	**5,361,697**

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

Statement of financial activities

(Incorporating an income and expenditure account)

For the year ended 31 March 2021

	Notes	Unrestricted funds 2021 £	Restricted funds 2021 £	Total funds 2021 £
INCOME AND ENDOWMENTS FROM:				
Charitable activities	2	–	17,708,908	17,708,908
Donations and legacies	2	403,282	–	403,282
Gift in Kind Income	2	–	1,712,924	1,712,924
Investments	2	109	11,501	11,610
Total incoming resources		**403,391**	**19,433,333**	**19,836,724**
RESOURCES EXPENDED				
Raising funds	3	277,769	–	277,769
Charitable activities	4	–	20,443,774	20,443,774
Total resources expended		**277,769**	**20,443,774**	**20,721,543**
NET INCOME/(EXPENDITURE) FOR THE YEAR		**125,623**	**(1,010,441)**	**(884,819)**
Transfer between funds		–	–	–
Foreign exchange gains in year		(196,536)	(114,811)	(311,346)
NET MOVEMENT IN FUNDS FOR THE YEAR		**(70,913)**	**(1,125,252)**	**(1,196,165)**
Total funds brought forward at 1 April 2020		1,557,010	4,841,663	6,398,673
TOTAL FUNDS CARRIED FORWARD at 31 March 2021		**1,486,097**	**3,716,411**	**5,202,508**

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 2022

	Notes	2022 £	2021 £
CURRENT ASSETS			
Debtors	8	417,372	706,896
Stock		523,012	953,644
Cash at bank and in hand		5,132,656	4,990,049
		6,073,040	**6,650,589**
CURRENT LIABILITIES			
Creditors: Amounts falling due within one year	9	(396,075)	(1,345,213)
NET CURRENT ASSETS		**5,676,965**	**5,305,376**
LONG TERM LIABILITIES			
Creditors: Amounts falling due after one year		(315,268)	(102,868)
TOTAL ASSETS LESS LIABILITIES		**5,361,697**	**5,202,508**
TOTAL NET ASSETS		**5,361,697**	**5,202,508**
FUNDS			
Unrestricted funds	13	1,540,326	1,486,097
Restricted funds	13	3,821,371	3,716,411
		5,361,697	**5,202,508**

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

Oliver Kemp, Chair Date: 21 November 2022

Company Registration number 01837621

Cash flow statement

Health Limited T/A Health Poverty Action cash flow statement for the year ended 31 March 2022

	2022 £	2021 £
Net Cash Outflow from operating Activities	38,614	123,223
Returns on Investments and Servicing of Finance		
Bank interest received	6,625	11,610
Foreign exchange gain	97,368	(311,346)
(Decrease) / Increase in Cash	**142,607**	**(176,513)**
Reconciliation of Excess of Expenditure over Income to Net Cash Inflow from Operating Activities		
Net incoming / (outgoing) resources	159,189	(1,196,165)
Decrease / (Increase) in debtors	289,523	723,690
(Increase) in stock	430,632	(221,166)
Increase in creditors	(736,738)	517,128
Interest received	(6,625)	(11,610)
Foreign exchange gain	(97,368)	311,346
Net cash (outflow) inflow from operating activities	**38,614**	**123,223**
Analysis of Net Cash Resources		
Opening Balance	4,990,049	5,166,562
Flow	142,607	(176,513)
Closing Balance	**5,132,656**	**4,990,049**
Location of Cash Resources		
HQ bank accounts	2,294,025	1,902,391
In-country bank accounts	2,838,631	3,087,658
	5,132,656	**4,990,049**

NOTES

Notes forming part of the financial statements for year ended 31 March 2022

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 consider that there are no material uncertainties about HPA 's ability to continue as a going concern for 12 months from the date of signing these financial statements. Due consideration for the effects of the COVID-19 outbreak has been taken but the charity is largely sheltered from the financial impact of COVID-19 due to the high level of unrestricted funds at the year-end despite a £70k decrease from the previous year. Nonetheless, the charity has been able to take advantage of the Government's Job Retention Scheme in respect of relevant staff, whilst other aspects of the charity's activities have transitioned successfully to remote working. In making their going concern assessment, the trustees have considered the impacts of COVID-19, the charity's revised forecasts and projections for Income and Expenditure, as well as long term cash flow. These continue to be regularly monitored, and revised, by the Trustees with appropriate action being taken to reflect the changing circumstances. Accordingly, they continue to adopt a going concern basis in preparing the financial statements.

c) Incoming resources

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

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

d) Resources expended

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

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

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

e) Fund accounting

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

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

f) Foreign Currencies

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

g) Pensions

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

h) Operating leases

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

i) Liabilities

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

j) Other financial instruments

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

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

k) Critical accounting estimates and areas of judgement

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

2. INCOME

	2022 £	2021 £
INCOME		
Restricted Funds		
Charitable activities		
3MDG	–	–
Access to Health Fund	1,075,602	3,098,643
Comic Relief	-	179,896.67
Department for International Development	5,262,644	6,129,288
Education Development Centre	6,377	15,920
European Commission	158,547	341,930
Global Fund	2,101,310	2,951,308
Irish Aid	42,565	108,516
Livelihoods and Food Security Fund	554,671	108,972
Myanmar Humanitarian Fund	-	198,000
Other	1,929,239	1,705,715
UN bodies	1,616,330	2,030,646
World Food Programme	728,970	769,325
Trusts, foundations and individuals	174,589	70,748
	13,650,844	**17,708,908**
Other trading activities		
Gift in Kind	859,434	1,712,924
	859,434	**1,712,924**
Total Restricted Funds	**14,510,278**	**19,421,832**
Unrestricted Funds		
Donations from individuals and other	259,605	262,034
Consultancy	47,497	80,115
UK and European trusts / foundations	168,204	61,134
Total Unrestricted Funds	**475,306**	**403,282**
INVESTMENT INCOME		
Bank interest		
Restricted Funds	5,170	11,501
Unrestricted Funds	1,456	109
	6,625	**11,610**
TOTAL INCOME	**14,992,209**	**19,836,724**

3. RAISING FUNDS

	Direct £	Support costs £	Total 2022 £	Direct £	Support costs £	Total 2021 £
Other costs	-	497,390	**497,390**	-	277,769	**277,769**
	-	497,390	**497,390**	-	277,769	**277,769**

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

4. CHARITABLE ACTIVITIES

	Direct £	Support costs £	Total 2022 £	Direct £	Support costs £	Total 2021 £
Costs of health projects	-	730,902	**730,902**	19,718,558	725,216	20,443,774
	-	730,902	**730,902**	19,718,558	725,216	**20,443,774**

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 2022 £	Cost of raising funds 2022 £	Health projects 2022 £	Basis of apportionment
Human resources	1,000,618	428,541	572,078	Number of employees
Establishment costs	18,644	13,610	5,034	Number of employees
Office & Administration	209,030	55,239	153,791	Number of employees
	1,228,292	**497,390**	**730,902**	

Nature of cost	Total 2021 £	Cost of raising funds 2021 £	Health projects 2021 £	Basis of apportionment
Human resources	760,341	227,079	533,262	Number of employees
Establishment costs	37,562	9,503	28,059	Number of employees
Office & Administration	205,081	41,186	163,895	Number of employees
	1,002,985	**277,769**	**725,216**	

6. NET INCOME FOR THE YEAR is stated after charging

	2022 £	2021 £
Annual Audit		
Statutory audit	22,530	20,955
In respect of prior year		
In respect of consolidation		
Rentals in respect of operating leases;		
plant and machinery	3,310	4,508
other – office		56,062
Inventory	523,012	953,644

7. STAFF COSTS AND TRUSTEES' REMUNERATION

	2022 £	2021 £
U.K. STAFF		
Wages and salaries	589,975	859,230
Redundancy cost	-	-
Social security costs	62,322	76,565
Pension costs	25,807	47,385
	678,103	983,181
OVERSEAS STAFF		
Wages and salaries	2,992,371	2,348,305
Pension costs	39,462	70,758
Severance costs	134,520	149,251
	3,166,353	2,568,314
TOTAL STAFF COSTS	**3,844,457**	**3,551,494**

One employee received remuneration of between £60,000-£69,000 in 2021-22 (2021: one). Employer's pension cost relating to that individual was £3,360 (2021: £3,629).

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 and Latin America 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 £370,901 (2021: £400,020). The Trustees neither received nor waived any emoluments during the year (2021: £Nil). There was one reimbursement of £414.45 received by a Trustee during the year (2021: Nil).

The average number of employees, analysed by function was:

	2022	2021
	Number	Number
Charitable activities	379	351
Raising funds	4	9
	382	**360**

8. DEBTORS

	2022	2021
	£	£
Other debtors in UK	5,385	8,661
Other overseas/project debtors	(3,789)	62,644
Accrued income – Gift Aid & Other	6,736	9,777
Accrued income – Grants	384,710	605,708
Prepayments	24,331	20,105
	417,372	**706,896**

All debtors, except prepayments of £24,331 (2021: £20,105), are financial instruments measured at present value.

9. CREDITORS: Amounts falling due within one year

	2022	2021
	£	£
Project creditors	19,253	784,794
Other creditors	9,562	27,967
Field severance pay liability and pensions	304,004	403,067
Other taxes and social security	40,437	20,715
UK Accruals	22,819	108,670
	396,075	**1,345,213**

All creditors, except for the social security creditor £20,715 (2020: £25,911), are financial instruments measured at present value.

Creditors includes pension liabilities of £403,067 (2020: £282,550).

10. CREDITORS: Amounts falling due after one year

	2022	2021
	£	£
Field severance pay liability	315,268	102,868
	315,268	**102,868**

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:

	2022	2021
Committed to payments of:	**£**	**£**
Within One Year		
Other – office	-	17,436
Between One and Two Years		
Provision for dilapidation	2,467	23,018
Other – office	-	2,927
Between Two and Five Years		
Plant and machinery		-
Other – office	843	383
Total	**3,310**	**43,764**

13. ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Unrestricted Funds 2022 £	Restricted Funds 2022 £	Total Funds 2022 £	Unrestricted Funds 2021 £	Restricted Funds 2021 £	Total Funds 2021 £
Fund balances at 31 March 2022 are represented by:						
Current assets	1,590,325	4,482,715	6,073,040	1,534,779	5,115,810	6,650,589
Current liabilities	(49,999)	(346,076)	(396,075)	(48,682)	(1,296,531)	(1,345,213)
Long Term Liabilities		(315,268)	(315,268)	-	(102,868)	(102,868)
Total Net Assets	**1,540,326**	**3,821,371**	**5,361,697**	**1,486,097**	**3,716,411**	**5,202,508**

14. STATEMENT OF FUNDS

	Funds at 2021 £	Income £	Expenditure £	Transfers £	Funds at 2022 £
Myanmar & China	1,004,635	6,661,119	(6,144,939)	–	1,520,815
Cambodia	137,569	296,536	(394,129)	–	39,975
Ethiopia	28,778	2,814	(164,961)	–	(133,369)
Guatemala	216,478	5,261	(122,385)	–	99,354
Kenya	(23,633)	219,453	(183,060)	–	12,760
Laos	278,163	538,384	(609,311)	–	207,237
Namibia	(58,316)	0	(107,507)	–	(165,823)
Nicaragua	72,349	7	(2,117)	–	70,240
Rwanda	48,320	25,325	(147,816)	–	(74,171)
Sierra Leone	(187,163)	33,687	(156,992)	–	(310,468)
Somaliland	470,831	3,610,613	(3,408,144)	–	673,301
Vietnam	398,068	1,149,762	(991,900)	–	555,930
Multi-Country Projects	340,885	869,857	(556,979)	–	653,763
Global Campaigns	35,803	243,195	(130,183)	–	(277,981)
Gift in Kind	953,644	859,434	(1,290,066)	–	523,012
Total restricted funds	**3,716,411**	**14,515,448**	**(14,410,488)**	**–**	**3,394,576**
Unrestricted funds	1,486,097	476,761	(422,532)	–	1,540,326
Total funds	**5,202,508**	**14,992,209**	**(14,833,020)**	**–**	**5,361,697**

	Funds at 2020 £	Income £	Expenditure £	Transfers £	Funds at 2021 £
Myanmar & China	1,038,676	7,875,265	(7,909,306)	–	1,004,635
Cambodia	129,374	454,435	(446,240)	–	137,569
Ethiopia	146,262	70,825	(188,309)	–	28,778
Guatemala	164,482	284,182	(232,186)	–	216,478
Kenya	(13,248)	173,966	(184,351)	–	(23,633)
Laos	865,807	276,545	(864,188)	–	278,163
Namibia	(7,688)	225	(50,853)	–	(58,316)
Nicaragua	186,261	4,064	(117,976)	–	72,349
Rwanda	163,959	42,046	(157,685)	–	48,320
Sierra Leone	(172,493)	422,791	(437,461)	–	(187,163)
Somaliland	884,116	6,120,934	(6,534,219)	–	470,831
Vietnam	(16,646)	468,340	(53,627)	–	398,068
Multi-Country Projects	717,090	1,420,950	(1,797,155)	–	340,885
Global Campaigns	23,231	105,841	(93,270)	–	35,803
Gift in Kind	732,478	1,712,924	(1,491,757)	–	953,644
Total restricted funds	**4,841,663**	**19,433,333**	**(20,558,585)**	**–**	**3,716,411**
Unrestricted funds	1,557,010	403,391	(474,304)	–	1,486,097
Total funds	**6,398,673**	**19,836,724**	**(21,032,889)**	**–**	**5,202,508**

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 unrestricted funds).

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, e.g. 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. 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 2021-22 HPA and FYF ended their linking partnership. However, HPA continues to provide management and support services to FYF at it's UK headquarters. Both charities shared the same trustees, although none of the trustees have been appointed to the FYF board as representatives of HPA.

In 2021-22, a total of £69,357 of HPA's UK staff cost was recharged to FYF (2020-21: £80,505). A further £446 (2020-21: £2,841) was charged as part of office costs.

16. STATEMENT OF FUNDS

	2022 Receipts	2022 Expenditure	2021 Receipts	2021 Expenditure
Irish Department of Foreign Affairs and Trade				
CSF09-19 Kenya, Ethiopia, Nicaragua and Rwanda	42,565.00	70,535.29	108,516.00	93,813.00
Department for International Development / Foreign, Commonwealth and Development Office				
HARP-DEL-017 Myanmar	-	-	1,392,944	1,976,665
UK Aid Direct: 9TGE-DHP5-JZ (with MRG) Kenya, Ethiopia, Myanmar, Cambodia	114,048.58	35,193.60	133,318	201,994
FCDO Myanmar Humanitarian	2,052,666	2,001,970	-	-
FCDO Myanmar Humanitarian	-	-	602,697	671,962
HARP-RRF-006 COVID-19	(193,101)	17	589,843	590,075
UK Aid Match: 205210 – 254 Sierra Leone	54,188	49,684	8,078	49,270
Girls Education Challenge – GEC-T				
6317 Rwanda	-	-	112,275	-
Population Services International				
4289-HPA-01APR2016 Somaliland	257,903	264,303	1,251,252	939,502
4476-HPA-01JULY2018 Somaliland	-	-	248,883	-
4313-HPA-01DEC2018 Somaliland	-	-	152,205	87,905
BMB Mott MacDonald BV				
376106 – Lot 3 Somaliland	116,304	228,239	1,215,689	1,398,264
376106 – Lot 4 Somaliland	79,727	263,281	1,337,595	1,501,593
Comic Relief				
2572521 Cambodia & Laos	-	-	154,997	461,811.00
2712084 Sierra Leone	-	-	55,128	17,492

WITH THANKS TO:

Irish Aid
Rialtas na hÉireann
Government of Ireland

UKaid
from the British people

European Union

Enabel

ECF
EVAN CORNISH FOUNDATION

FIND
Diagnosis for all

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GUNVOR

THE MERCURY PHOENIX TRUST

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WFP

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and Cooperation SDC

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Livelihoods and Food Security Fund

LIFT

UKaid

EUROPEAN UNION

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
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Swiss Agency for Development
and Cooperation SDC

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