BT/56/2011

HEALTH LIMITED t/a 'HEALTH POVERTY ACTION'
(Limited by Guarantee)

TRUSTEES' REPORT

&

FINANCIAL STATEMENTS
for the year ended 31 March 2011

Company number 1837621
UK Charity Registration Number 290535

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COMPANIES HOUSE

TRUSTEES
(at 31 March 2011)

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Debra Davis (Treasurer)

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Introducing Health Poverty Action

Health Poverty Action works to strengthen poor and marginalised people in their struggle for health

Three factors combine to give our approach a distinctiveness that experience has shown to be extremely effective

1) We specialise in the fundamental connection between health and poverty We believe the two must be addressed together Success in one not only requires success in the other, but contributes to it

2) W e prioritise those missed out by everyone else – the missing millions, neglected by governments, and bypassed by mainstream aid

3) W e take a holistic approach Too many development initiatives address problems in isolation, with the risk therefore of the work sometimes changing the cause of death rather than saving lives Health Poverty Action tackles the full range of health determinants in a co-ordinated way, including the social and economic factors

We attach great value to the relationships we have developed with communities who have learnt through bitter experience to trust few others They may be marginalised for many different reasons – ethnicity or culture, gender, geography, politics, economics – or all of these Because we prioritise the poorest and most marginalised, we have become particularly skilled at working in hard to reach areas, and with populations such as indigenous people and ethnic minorities While this can often mean working with remote rural communities, we also work in large cities and urban areas We know there are marginalised people there too

We commit to long-term partnerships to bring change that lasts, while also strengthening communities to respond quickly to emergencies and urgent needs We don't set up parallel or duplicate systems, but build and strengthen local capacity – so that improvements are not only sustainable, but owned and led by those whose rights they are intended to serve

Health Poverty Action sees improving health not primarily as a medical challenge, though that plays its part, but a fundamental issue of justice and human rights

Origin

> *"The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all "*
> UN Alma-Ata Declaration, September 1978

Health Unlimited (as we were then called) was established by a group of passionate young British medics in 1984 We began by delivering primary health care in southern Afghanistan during the Soviet war, meeting the needs of people other NGOs for various reasons were not able to serve.

Along with the vital link between health and poverty, our work recognised the devastating effect of conflict on health Many of the populations we work with today – such as the marginalised people of Guatemala, Cambodia, Rwanda and Sierra Leone – carry with them the memories of indescribable pain and loss The consequences still impact on their health Building just and sustainable peace is as important a part of primary health care as equipping clinics and training health workers

Today, Health Poverty Action works in 13 countries in Africa, Asia and Latin America We employ over 500 staff overseas – mostly recruited from within the populations they serve – and around 20 in our international HQ based in London

Primary health care and the Alma-Ata principles

Throughout its history Health Poverty Action has been committed to the concept of primary health care, which came to global prominence in the groundbreaking 1978 UN conference at Alma-Ata

Often misunderstood as simply the primary level of a health service (as opposed to secondary and tertiary), the primary health care approach is actually something far more profound and visionary – and applicable to all levels of health care It includes an emphasis on the primacy of the recipient of the health care – that it should be appropriate, accessible and accountable to the communities it serves It also includes working cross-sectorally to address all the primary determinants of health, not just the medical ones In particular, it emphasises the importance of primary determinants such as economic justice, gender equality, environmental sustainability and demilitarisation

Health rights

We are passionate about the work we do We believe it is not an act of charitable benevolence, but a recognition of rights Sadly not everyone can currently enjoy good health But every human being on the planet has an equal right to the factors that will enable them to sustain the best level of health they reasonably can These include sufficient food and nutrition, clean water and sanitation, education, shelter, and access to a good health service It is unacceptable that these rights are currently available to some but denied to so many others

Action today

Each year, Health Poverty Action conducts a wide range of activities to strengthen poor and marginalised people in their struggle for health These are in four broad categories

- **In-country development programmes**
  We work with communities to tackle the primary factors denying them their health rights These areas include, but are not limited to, health system strengthening, disease control, health education, harmful traditional practices and gender issues, income generation, food security and nutrition, and water and sanitation Each year, through these programmes, we are able to help tens of millions of the poorest people in the world improve their health

- **Influencing the policy and practice of others**
  We steadfastly refuse to accept that, because there are so many poor and marginalised people in the world, some must be expendable – and that the right to health can therefore not be for all We will never accept that However we recognise the scale of the problem, and know that we will never be able to meet the need through the size of our own in-country programmes We therefore believe we have a responsibility to do all we can to change the policies and practices that create and sustain health injustice We work with those affected and our allies to analyse what needs to change, devise creative alternatives, and use our influence to help bring those changes about

- **Responding to emergencies**
  Those with few resources and little support are extremely vulnerable at times of particular hardship – maybe an ongoing problem that has reached crisis proportions, or maybe a sudden disaster of some kind At such times we work with those affected to respond to these emergencies We always remember that emergencies are not identified by what is given profile in the global media, but by the experience of those affected by particular crises (most of which are never reported) We also know that for the poor and marginalised, emergencies are not discreet events, but one additional factor they face in an ongoing struggle for health and well-being We help them mobilise all possible resources for urgent response – and do this as an integrated contribution to their ongoing development work

- **Providing consultancy and other contracted services**
  The expertise, resources and relationships of Health Poverty Action mean we are in a position to provide a wide variety of valuable services to others in exchange for a fee These services can provide important benefits for the poor as well as generating income, and all profits are ploughed back into developing our work

Facts and Figures: What Health Poverty Action did in 2010/11

Total No of beneficiaries	19,203,447
We trained	
Village Doctors	218
Traditional Birth Attendants	1,249
Community Health Volunteers	43,895
Local health workers	902
Community leaders/members	273,718
Health Centre staff	3,360
Radio workers/audience group members	0
Children and Young People as health promoters	29,335
Teachers	210
Peer educators	489
We gave	
TBA kits	258
Condoms	428,247
Mosquito nets/supplies for soaking nets	122,249
HIV testing & counselling, treatment and care	100,990
With our partners we immunised ..	
Children against childhood diseases	17,158
Women	2,159
We supported .	
Civil society groups (includes amongst others village health committees, youth clubs, community theatre groups, & women's organisations)	915
With a total membership of	8,191
We worked with our partners to	
Provide:	
Women with maternal health services	35,166
People with general health services	209,612
Protect·	
People through providing clean drinking water sources	4,960
Reach (approximately).	
People through community health education	1,579,639
Beneficiaries of health related radio and TV programmes (estimated)	10,136,651
We produced & broadcast radio and TV programmes	2,539

Objectives and activities

Vision

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

Mission

We work with some of the poorest and most marginalised communities in Africa, Asia and Latin America, often in very difficult environments We work to enable these communities to achieve both immediate and long-term improvements to their health, promoting this as one of their fundamental human rights At the same time we campaign for the changes in policies and practices needed to create and sustain good health among the world's poorest people

Health Poverty Action's charitable objectives set out in our governing documents are "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" Within this, our strategy for the period to 31 March 2011 sets out our vision, mission and strategic goals

The strategy identifies twelve Strategic Objectives, divided into six relating predominantly to impact and six relating predominantly to process

Impact

1 Strengthen poor and marginalised people in their struggle for health
2 Strengthen civil society in poor countries to work for health
3 Improve access to health rights through campaigning and advocacy
4 Increase the size of our programmes
5 Increase the impact of our programmes
6 Respond to emergencies

Process

7 Involve members of the public
8 Achieve high profile for work and messages
9 Increase and diversify funding
10 Build partnerships and alliances
11 Develop the capacity of our core infrastructure
12 Manage effectively and support staff

Analysis of progress against strategic objectives during 2010/11

1. Strengthen poor and marginalised people in their struggle for health

Health Poverty Action is supporting poor and marginalised people to find their voice and strength, enabling them to recognise they have a right to health, take action to improve their health, hold service providers to account, and influence policies and practices that directly or indirectly impact on their health At the same time, we work with health service providers at the local and national level to build their capacity to deliver services to remote and marginalised communities This provides an opportunity for Health Poverty Action to sensitise health service providers to the special needs of marginalised communities, such as indigenous people, pastoralists, and women and children

In Sierra Leone, the number of pregnant women giving birth in the presence of a trained health professional has increased to 55% because Health Poverty Action has trained 200 Community Health Volunteers who have formed health clubs in their communities, and trained 27 Village Development Committees who are now conducting maternal death conferences every time a pregnant woman in their area dies In Myanmar Special regions which are dominantly comprised of indigenous people, Health Poverty Action's work with communities has seen a drastic reduction in infant mortality, increase in clean delivery rates from 4% to 54 4% and reduction in malaria by 27% To achieve this, Health Poverty Action constructed 90 clinics and two hospitals in the region and trained over 800 nurses, TBAs, vaccinators, laboratory technicians and local medical practitioners In Ethiopia, community representatives have been trained to lead members of their village in "Community Conversations " This approach has led to, for example, 65 2% of community members reporting that they now discuss the negative effects of female genital mutilation compared to 16 3% before Health Poverty Action's programme started In Namibia, Health Poverty Action is giving a voice to indigenous San and their neighbours by creating feedback mechanisms between them and the health service workers through Clinic Health Committees It is also supporting community-based methods to improve health – such as gardens to create nutritious food for people living with HIV/AIDS and condoms delivered even to the San who live in remote bush areas through Community Based Resource Persons In Lao PDR, which has the highest maternal and child mortality rates in South East Asia, we work in the southern Province of Attapeu, one of the poorest in Laos with the target of achieving lasting food security and reducing child malnutrition levels by supporting the Provincial Health Department and Provincial Agriculture, Forestry and Fisheries Office This year the percentage of mothers exclusively breastfeeding their babies increased to 90% and the project has also supported 716 malnourished children to access supplementary feeding HPA also trained and supported 416 households to start up new agricultural activities, for example poultry raising, fish ponds and household gardens This has enabled them to increase their food production and the amount of food for household consumption

2. Strengthen civil society in poor countries to work for health

One key achievement recently has been the support Health Poverty Action provided to the Wa State government in Myanmar to develop its health policy This was done through facilitating discussions and planning meetings between Wa health authorities and academics and professionals in health policy and planning from China

Health Poverty Action has a particular and well-established strength with regard to grassroots work with those communities that suffer most from inadequate health provision We seek to empower and enable these communities to voice their own needs and concerns Of the 48 projects implemented in 2010/11, many had a strong component that sought to build communities' capacity to influence policy and practice These included a project in Namibia that empowers the San to advocate to their local health clinics for quality health services, a project in Cambodia and Peru enabling indigenous people to advocate for maternal health services, two projects in Cambodia supporting the establishment of Indigenous People's Health Associations, and a project in Peru strengthening the capacity of Ashaninka communities to access rights relating to health and well-being

Our programmes facilitate linkages between communities and health care providers We take a rights-based approach, strengthening poor and marginalised communities to advocate on their own behalf, and help build the capacity of wider networks and movements they can partner with In countries like Namibia and Sierra Leone, we create linkages between the poor and marginalised communities and health service workers through structures like Clinic Health Committees and Village Development Committees, and help to push this feedback up to higher levels through District Health Management Boards and other bodies In Cambodia we are supporting the functioning of Village Health Support Groups and Health Centre Management Committees, government mandated community structures enabling communities to directly participate in the management of the community health services

Heath Poverty Action supports existing locally-led civil society organisations and creates new ones where there they are needed Apart from implementing our own projects, we have also established independent NGOs in Brazil, El Salvador, Peru, Guatemala, Nicaragua, Rwanda, and Cambodia to build on the strengths of local partners and ensure sustainable development

Giving voice to local communities is closely linked to advocacy and campaigning, an increasingly important part of our work In Cambodia, Health Poverty Action has established two provincial level Indigenous People's Health Association (IPHA) to effectively advocate for appropriate and affordable health systems at the provincial and national levels, and raise awareness of health service providers on the health rights and needs of indigenous people and develop their capacity to respond to them

3. Improve access to health rights through campaigning and advocacy

Health Poverty Action campaigns and advocates for the right to health in partnership with local marginalised communities, as well as using its influence at the UK and international levels with donor governments and institutions

Our biggest achievement in 2010 was the launch of our first own campaign – Mothers on the Margins – which promotes better and culturally appropriate healthcare for indigenous mothers and pregnant women and girls This campaign integrates experience from Peru, Nicaragua and Ethiopia, for example, and builds on our successful interventions there To kick off the campaign we launched a policy report which garnered some media coverage and was sent to dozens of MPs and officials It also triggered some questions in Parliament about the need for health data to be broken down by ethnic group Furthermore, we have made significant headway with two online actions, one targeting Members of Parliament in the UK and one targeting the Guatemalan Government, calling for culturally appropriate birthing facilities and the disaggregation of health data by ethnicity Our campaign asks were also taken up by joint advocacy initiatives towards the Millennium Development Goals-Summit at the UN General Assembly, and our submission to the civil society consultation, in part, ensured that indigenous women were not forgotten by these decision-makers

We have continued our active membership of the Robin Hood Tax campaign, calling for global financial transaction taxes (FTT) to raise revenue for health, other development finance as well as to tackle climate change and UK poverty The campaign has built considerable political momentum For example, Members of the European Parliament voted in support of introducing a financial transaction tax Health Poverty Action made a significant contribution to the evidence base of the campaign by producing, with Stamp Out Poverty, a research report called *Raising Revenue*, which sets out case studies of countries that already have financial transaction taxes This is available to convince decision-makers that the introduction of an FTT is indeed possible and thereby raises the chance to tap new resources for health financing

Affordable medicines are the bread and butter of basic healthcare provision We have therefore joined others to campaign against a free trade agreement currently under negotiation between the European Union and India With India providing 80% of affordable generic anti-retroviral medicines and a large proportion of other essential medicines to the developing world it is vital that proposed intellectual property and investment provisions do not bar access to affordable generics Upon request from Cambodia, where this is a major issue, we also produced a briefing note on fake medicines and problems surrounding their confusion with generic medicines

Another example of linking advocacy at the local level with the international is in Sierra Leone, where we have been calling for measures to ensure a successful and smooth rollout of the Government's free healthcare initiative for pregnant women and new mothers A policy-briefing on the challenges of abolishing user fees in Sierra Leone in the previous year was followed by a briefing on one of the most neglected unintended consequences of the free healthcare policy The loss of financial incentives for traditional birth attendants to refer women to health centres for safer child delivery, thus increasing the risk of maternal death

Advocacy for the right to health is a growing part of our in-country work For example, again in Sierra Leone, Health Poverty Action is actively involved in a task force comprising government representatives, international donors and local organisations which aims to devise strategies to end obstetric fistula

We have also continued to actively engage with policy makers on a range of health finance, governance and human resources issues through NGO advocacy networks and coalitions

A number of positive changes in health policy and practice can be attributed at least in part to Health Poverty Action and the local communities it supports For example, our submission to the UN's civil society consultation on the achievement of the MDGs resulted in the issue of indigenous women's maternal health being repeatedly mentioned in the consultation report circulated to member states Another major win for us and allied organisations is that the European Commission will no longer push for data exclusivity clauses in the EU-India free trade agreement These would have potentially prolonged market registration of generic medicines

4. Increase the size of our programmes

Total expenditure on health project activities in 2010-11 was £6,985,544 up from £6,546,024 in 2009-10 The size of Health Poverty Action's work in Africa alone almost doubled over the past year For example, in Somaliland two new EC and one new DFID supported projects have begun The number of people who benefit from Health Poverty Action's programmes is high The total number of beneficiaries this year is an estimated 19,203,447

In 2010/11 Health Poverty Action ran a total of 48 projects Over half of Health Poverty Action's total programme expenditure is spent on projects in fragile states[1] including Burma/Myanmar, Cambodia, Ethiopia, Lao PDR, Sierra Leone and Somalia Our total expenditure on Fragile States went up from £3,792,197 in 2009-10 to £ 4,219,566 in 2010-11

Health Poverty Action is currently considering working in four new fragile states Nepal, DR Congo, Sudan and Burundi Scoping visits have occurred and proposals have been written for DR Congo and Philippines

In Brazil we have also started cooperation with the local organisation Saúde Sem Limites, Brazil (initially set up by Health Poverty Action to work with remote indigenous communities in the Amazonian region of Brazil) and are looking in to expanding work in that country

Region	Number and Expenditure (restricted) on Projects	2006/7	2007/8	2008/9	2009/10	2010-11
Africa	No of projects	10	11	13	14	14
	Expenditure (£)	1,558,090	1,579,245	2,157,628	2,016,460	1,453,542
East	No of projects	7	7	7	8	11

[1] DFID describes fragile states *as "those where the government cannot or will not deliver core functions to the majority of its people, including the poor"* (DFID, 2005), Why we need to work more effectively in fragile states http //www jica go jp/cdstudy/library/pdf/20071101_11 pdf

Asia	Expenditure (£)	1,137,419	1,157,854	1,712,928	2,024,158	2,268,997
Latin America	No of projects	5	7	5	3	4
	Expenditure (£)	841,891	943,401	720,900	525,101	553,911
South East Asia	No of projects	14	11	11	17	16
	Expenditure (£)	1,471,498	1,207,523	1,472,903	1,621,551	2,050,918
Cross Regional	No of projects			1	2	3
	Expenditure (£)			76,294	130,177	439,693
Total	No of Projects	36	36	37	44	48
	Expenditure (£)	5,008,898	4,888,023	6,140,653	6,317,447	6,767,062

5. Increase the impact of our programmes

Health Poverty Action strives to increase the sustainable impact our programmes have on the determinants of poor and marginalised people's health We take a holistic approach, focusing not just on the health sector but being prepared to do anything we can to help make the biggest possible difference to health, such as nutrition, water and sanitation, income generation, and other social, economic and environmental determinants of health For example, in Sierra Leone we are teaching people the importance of good hygiene and sanitation practices in order to improve the health of communities, which is having an impact in changing people's behaviour In the Lao PDR we are training villagers on income generating activities in order that they can increase their household income enabling them to purchase food during periods of food poverty

Our programmes attach a high priority to strengthening health systems and building local capacity to improve poor and marginalised people's access to the services and resources that determine good health

In remote pastoralist areas in Southern Ethiopia, Health Poverty Action built huts where pregnant women could wait to give birth and supported government health staff to provide quality services to them, which increased skilled birth attendance by 274% Health Poverty Action interventions in Ethiopia also increased knowledge of HIV transmission by 1220%, decreased the percentage of Erbore mothers who had their daughters undergo Female Genital Mutilation from 47 1% to 35 1%, and increased the numbers visiting health facilities from 7 2% to 53 7% In Somaliland, Health Poverty Action's training of government health workers, improvement of health structures, introduction of a successful referral system, and radio health education work has radically improved the quality and uptake of reproductive and maternal health services The Minister of Health declared this to be the most successful health programme in Somaliland Health Poverty Action has now rolled out the model throughout Hargeisa and is expanding to Sahil region with funding from several donors In Southern Rwanda, Health Poverty Action is having a positive impact on youth sexual and reproductive health through adolescent youth clubs, youth health promoters, adult support groups, and advocacy for youth friendly government services As a result, teenage pregnancy decreased from 5% to 0,5%, adolescents who can name 3 contraceptive methods increased from 30% to 100%, and 4 government health centres started providing youth friendly health services We have trained government officials in Burma/Myanmar on HIV/AIDS prevention and treatment strategies, helped regional

autonomous governments in Burma/Myanmar to develop their health sector policy, established and equipped a health post for hard-to-reach communities in Cambodia

In the indigenous North Atlantic Autonomous Region (RAAN) in Nicaragua, the health services in the town of Siuna are managed by a team of 10 nurses who are responsible for delivery of services at the health centres, hospital as well as undertaking outreach services However, the nurses, most of whom came from Managua, the capital city, did not stay in Siuna for long due to a lack of a proper and clean accommodation for them to live Health Poverty Action, with support from the Vitol Foundation, constructed a new Nurses home in the town that has not only resulted in better services through motivated nurses, but also motivated the local government to construct similar accommodation for other health functionaries in the town hospital

Health Poverty Action provides long-term support for the countries where it works For example, Health Poverty Action has worked to improve the health of the San in Namibia for 20 years, and has gained recognition as the leading organisation helping them access their health rights through projects addressing HIV/AIDS, tuberculosis and other health problems In Cambodia, where we have worked for 25 years we are recognised in Preah Vihear province as a leading health organisation and were requested by the Ministry of Health to manage the provincial health system, a service which we carried out for four years We compile, review and incorporate lessons from evaluations and other sources in order to constantly improve our work, learn from innovative pilot projects and therefore have greater impact

6. Respond to emergencies

For the people Health Poverty Action works with, the word 'emergency' might often feel ironically meaningless For them every day is a struggle for survival and they need support that is long-term, holistic, integrated and led by their priorities The search for sustainable solutions goes hand-in-hand with meeting immediate needs to stay alive

Sometimes the label 'emergency' is attributed simply because the media or international community has suddenly noticed their plight – at least for a short time

Nevertheless, amid all their other hardships sometimes poor and marginalised people face times of particular crisis – perhaps because a natural disaster has struck, or maybe because an ongoing crisis has reached extreme proportions When this happens, Health Poverty Action is committed to mobilising all possible resources in support We therefore responded to the cholera/acute watery diarrhoea outbreak in both Cambodia and the Lao PDR through funding received from various sources including the European Commission's Humanitarian Aid and Civil Protection Department (ECHO) and the Save the Children Australia Emergency relief in the form of medical equipment and supplies for mobile emergency outbreak centres and health centres, disinfection of contaminated water sources, oral rehydration solution, essential medicines, and kettles, jerry cans, soap and towels for households in the affected villages Community level health communication activities on hygiene, sanitation and cholera/AWD prevention and treatment The project supported a total of 91,854 people in 174 villages

An emergency is not always sudden, or the result of a natural or human-made disaster Much of Health Poverty Action's long-term development work can accurately be

described as emergency response – and at appropriate times should be the subject of emergency appeals and communications work

Over the last twelve months we have been recognising the emergency nature of the work we already do, and also building our capacity to do more
An emergency response procedure has been produced for Health Poverty Action Somalia, which will be used as a pilot to learn from

Health Poverty Action is also registered to receive European Community Humanitarian Aid Office (ECHO) funding, and is exploring ECHO funded responses in Kenya, Somalia, Ethiopia, and Sudan

7. Involve members of the public

A strong public supporter-base, i e people who feel ownership of its work and are passionately committed to supporting it, is probably the most valuable resource of all that an organisation can potentially mobilise on behalf of those it serves

People acting together in simple ways have a collective power and influence unlike any other – and the benefits they provide for organisations are multifold Such people are true change-makers

Health Poverty Action's historical origins as a primarily project-funded organisation from public sources means that we have tended to have a low profile and a comparatively small public supporter base We have, however, begun to change the organisation into one which is much more public-facing and have started to develop our supporter base

Our outreach strategy aims at harnessing the power and contributions to the cause that a strong supporter base could bring, including

- Donating money
- Taking campaign actions such as writing letters and sending emails
- Acting as multipliers – raising money from others, getting others to take campaign actions and generally raising awareness of the issues in the course of their lives, conversations and networks

As part of our re-brand and introduction of new communications tools we are now sending regular e-news bulletins as well as campaign action emails to supporters This is one of the most important ways in which we involve the public in our work Recipients of these communications have taken action to call on decision-makers to support the plight of indigenous women, to drop data exclusivity provisions in the EU-India free trade agreement, or to stop confusing fake with generic medicines

We have been very lucky to have some brilliant friends and supporters taking part in challenges and events to make life miles better for the world's poorest people

2010 was a great year for our London Marathon team – 31 runners raised over £55,000 in total, making it one of our most successful years ever Thank you to all the runners who did such a brilliant job racing and raising money for our work

Over the year we attended several events to meet potential supporters At the Big Chill festival we motivated people to support the Mothers on the Margins campaign by stating why they love their mum and have their picture taken At the Greenbelt festival we gave several talks, mainly about the potential benefits of a Robin Hood Tax to close resource gaps in health Talks on the Robin Hood Tax were also given at events with politicians or activists such as the medical student association Medsin We ran successful stalls at seven fresher's fairs and gave talks to the International Development Society at the University of East London and also to the Wilderness Medics group at St George's University Hospital We also attended Medsin's annual conference in Cambridge and Trustee Andrew Chetley gave a well-received talk there As well as this we gave talks to Women's Institutes around the country including Northamptonshire and West Sussex And we took part in the International People's Health University – an initiative of the People's Health Movement UK that seeks to educate primary health professionals about global justice and poverty issues in relation to health A quiz night for the benefit of Health Poverty Action's work attracted approximately 80 participants This has enabled us to grow our mailing list gradually with over 1,000 new supporters and to begin telling them about the campaign actions and fundraising events they can get involved with

Inviting people who had taken regular campaign actions and those who had signed up at recent freshers' fairs or festivals, we held a small-scale but successful Activist Training Session, incl training on campaigning, fundraising and media This led to several potential opportunities for speakers, fundraising etc

We currently have 7,300 active supporters - people who have 'done something' to contribute to Health Poverty Action's work at some point over the last two years, predominantly through making donations

8. Achieve high profile for work and messages

Profile is a valuable resource for the poor The people Health Poverty Action works with are frequently suffering in a large part precisely because they have no voice The more people know about the injustices they face, the harder it is for these injustices to continue

Profile is also a valuable resource for the organisation, providing opportunities to

- Engage with members of the public
- Influence policy-makers and opinion-formers
- Generate income
- Increase visibility with donors and other organisations
- Stimulate debate, communicate our messages and influence opinion

We have sought a higher media profile in the last twelve months, and have secured coverage in the UK as well as local coverage in countries where we are working Highlights included coverage of Zoe Vowles, our midwife in Sierra Leone, in the Telegraph and the Reader's Digest She also blogged extensively and featured in Midwives Magazine Our award-winning radio show in Rwanda was featured in the Financial Times too, bringing our work to an influential audience The New Internationalist magazine and the BBC World Service covered our Mothers on the Margins campaign, and Reuters Alertnet quoted our work on the removal of user fees in Sierra Leone We also had a letter printed in the Guardian, asking the UK government not to overlook the needs of the poorest and hardest to reach people in their aid agenda

Health Poverty Action was also able to significantly build its follower base on social media outlets Facebook and Twitter, increasing the opportunity for supporters to share our publications and to drive traffic to our website A relaunch of our website also provides more dynamic content such as a blog, encouraging readers to comment and share this content

9. Increase and diversify funding

Total Health Poverty Action income in 2010/11 was £8,156,822, an increase on 2009/10's figure of £7,181,576

Voluntary income received during the year of £8,136,520 forms the largest part of our income and includes grants received from private sources (Other voluntary income) and income from institutional donors (Institutional income)

9 1 Other voluntary income

Over the past six years we have made a substantial effort to increase our levels of income from private sources Investing in donor recruitment has been crucial and as a result unrestricted voluntary income has risen from £200,880 in 2002/03 to £539,470 in 2010/11

Recruitment of new donors through door-to-door donor recruitment campaigns has been central to this increase, contributing £312,978 in 2010/11 Our recruitment of new donors was slower than expected this year, and we also experienced more people stopping their regular donations

Events such as the London Marathon and our sponsored treks will be continued and developed We have been successful in increasing our income from UK/European Grant Making Trusts in 2010/11 However, timing differences in cashflows have impacted the figures in 2010/11 accounts In particular, a major grant for £125,000 was confirmed after the year end (the corresponding grant from the prior year was booked before the year end) This resulted in £186,176 restricted income for projects but there has been a decrease in unrestricted income from Grant Making Trusts in 2010/11

We would like to take this opportunity to thank both new and loyal trusts and major donors without whom we simply could not exist With a growing programme size and hugely increased charitable expenditure (as seen in the following section called institutional funding) securing the matching funds required for projects remains crucial to release larger institutional grants and supplement those which cannot meet the whole budget

We will continue to seek to establish new partnerships with grant-making trusts and private major donors willing to provide matching funds as well as secure funding for development of key elements of our work such as institutional learning, policy and campaigning

9 2 Institutional income

The Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund) and the European Union (including ECHO) are our 2 most substantial donors and between them contributed £4,853,558, or 60% of all voluntary income This represents a slight increase on 2009/2010, where the corresponding figure was 56% This change is mainly due to a rise in the level of funding received from the EU (from £2,000,363 in 2009/10 to £3,136,109 in 2010/11) A few years ago our 2 biggest institutional donors contributed 70% of all voluntary income, so this still represents a significant reduction in reliance on our largest 2 donors

The Health Poverty Action structure of having some specialist staff located in London and some in programme countries has continued to pay dividends as synergy of local knowledge and broader donor knowledge has produced many encouraging results Local managers have continued to build relationships with all major institutional donors within their countries

Funds raised from donors based within our programme countries were £2,120,763 in 2010/11 compared to £2,355,503 the previous year These funds include grants from the Global Fund in China, Cambodia, Laos and Namibia

10. Build partnerships and alliances

Health Poverty Action believes partnership is crucial to our mission to support poor people in their efforts to achieve better health and well-being It is essential to our purpose – and also to our values and philosophy

Partnership is what drives our operation at local level, led by the communities we serve and building the capacity of local organisations, structures and services

Health Poverty Action has continued to make partnerships with and provide capacity building support for organisations we have helped set up, and also for pre-existing civil society organisations For example, Health Poverty Action operates a project that aims to control the spread of HIV/AIDS in the Burma/Myanmar-China border areas, and to educate and empower marginalised people who are especially at risk In this project we have worked closely with the Kachin Independence Council Women's Organization, and helped them build their capacity to prevent diseases and promote health-seeking behaviour

Health Poverty Action works in close partnership with a wide range of development actors In this last year, 17 new country-level partnerships and alliances were established, building on growth from previous years To that country-level list we can add others with whom we collaborated closely such as Christian Aid, the Peoples' Health Movement and the Liverpool School of Tropical Medicine

In particular, major new partnerships have recently been formed in Namibia, Rwanda, Somaliland, and Sierra Leone, and are being developed in Peru, Cambodia, and Philippines The Indigenous People's Health Association (IPHA) has been set up and is now functioning in Cambodia

11. Develop the capacity of our core infrastructure

A key challenge for Health Poverty Action is that for historical reasons the growth of our private income and public supporter base has been far outstripped by the size of our institutional grants

This means several key functions generally considered essential to an influential and marketable organisation are either missing completely or heavily under-invested These are mostly in the areas of communications, marketing, public engagement and campaigning and policy influence Our work would also benefit from further strengthening our management structure, which is still very lean for the level of operation we sustain Over the last twelve months, budget lines dedicated to developing policy and advocacy capacity have been integrated into several funding proposals

Within constrained resources however, much has been done to increase staff capacity over the last twelve months – which we believe is part of the reason we have shown growth and continued to improve quality during the economic downturn Training has included project development, proposal writing and logical framework analysis, project cycle management, programme reporting, finance and human resources, and financial management Individual country training plans are also being developed

12. Manage effectively and support staff

Health Poverty Action's managerial task is an extremely complex and challenging one

- very difficult and remote environments,
- major linguistic and cultural barriers,
- extremely complex project-based restricted funding arrangements,
- a variety of institutional donors all with different rules and reporting requirements,
- immense and ever-changing threats to the health of huge numbers of poor and marginalised people

Yet it is a challenge we aim to meet, by maintaining

- a culture of efficiency, reliability and meeting of deadlines,
- clear guidelines and procedures for all our work, with strong checks and controls in areas of finance and reporting, along with staff capacity to implement them,
- a culture of transparency and accountability

We value our human resources and are committed to developing policies and practices that attract and retain high calibre and committed people We strive to live internally according to the values and aspirations that drive us in our work externally

- relationships built upon respect, mutual accountability and justice,
- a culture of mutual support and friendliness;
- an environment in which all can develop and grow, realising their potential and giving of their best

As an organisation we can never afford to stand still Our cause requires that we are constantly seeking ways to improve, to do things better and develop new approaches and innovations

We desire to be a global organisational community – strengthening and learning from each other, developing joint initiatives, speaking out together with one voice and acting in solidarity, and growing together through experience and dialogue

Financial constraints dictate that we are not able to consider sending Health Poverty Action staff on many external courses, but we have continued to put emphasis on coaching of staff at all levels, and facilitating staff development by, for example, encouraging staff with the relevant basic skills to participate in internal review exercises

Structure, Governance 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 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 and either stand down or stand for re-election In 2004 the trustees agreed that no trustee should serve for more than eight years The minimum number of trustees is five and the maximum twelve, during 2010/11 Judith Cavanagh, Elizabeth Muggleton, Naomi Junghae and Professor Michael Taylor OBE resigned There were eight trustees at 31st March 2011

New trustees are recruited through advertisement in the public media and a range of networks Prospective trustees are fully briefed by the Director before and after their appointment Trustees are encouraged to visit projects and some have participated in the evaluation of projects and organisational development in the regions

The trustees meet four times a year One meeting is for a full day which is devoted to discussion of key issues facing the organisation and its responses to emerging trends Where necessary the Board establishes working groups to deal with particular issues and report back to the full meeting Monthly management accounts are submitted and discussed with the Treasurer and a quarterly financial report is discussed by the Board

Day-to-day management of the organisation is delegated to the Director and staff 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 The number of staff in the field remained almost the same at 441

In 1999 we took the decision to decentralise direct management of our programme to four regional offices supporting locally recruited project managers Over the past few years we have continued to develop different approaches in response to circumstances in different regions In areas where we have had long term programmes we have gradually devolved responsibility to country managers and offices The East Asia Programme Office in Kunming has been maintained as a management office and the Africa Regional Office has been continued for technical support

Risk management

The Trustees review the major risks that face the organisation on an annual basis The Board has adopted a formal Risk Policy and London staff have undertaken an assessment of risks facing the charity The results of the risk assessment were presented to Trustees as a Risk Register at the October 2010 meeting

Senior staff from London visit all field offices at regular intervals and most projects at least once a year Finances are monitored regularly using a system of internal audit agreed with our external auditors

Board meetings are held quarterly and reports on progress in programmes and finances are presented in formats approved by the Board In addition, meetings involving

trustees, London staff and Country Directors are held in the UK when required on specific issues Trustees are encouraged to visit projects when appropriate and practicable

The Risk Register identifies the principal risks and uncertainties as being,

- failure to raise sufficient funding to continue existing programmes,
- non compliance with donor imposed restrictions, and
- corruption by Health Poverty Action partners and other organisations

These risks are regularly reviewed and monitored by senior managers and trustees

Financial review

Our income in 2010/11 was 15% higher than the previous year Income rose from £7,181,576 to £8,156,822 and expenditure increased from £6,969,377 to £7,343,190

The gap between costs of health projects and incoming resources is a result of timing differences between when income is received and when it is spent Grants from some institutional donors received before the financial year ended in March 2010 were carried forward and spent in the following financial year

Using funds effectively

Expenditure on charitable activities increased from £6,546,024 to £6,985,544

Health Poverty Action is highly cost-effective in delivering its programmes 95% of total expenditure is on the projects themselves This is a considerable achievement which is only possible because of the dedication and hard work of staff and volunteers The Trustees wish to place on record their appreciation of the commitment of so many people in the regional, country and London offices and especially those delivering our projects in Africa, Asia, and Latin America

Reserves

Health Poverty Action's Unrestricted Reserves have been established for the purpose of meeting its charitable objectives by ensuring the continued operation of its programme of work and to make provision for unforeseen or uninsurable organisational obligations At the end of the year we had Unrestricted Reserves of £452,539 equal to 6 2% of overall expenditure (2010 7 4%) The level of reserves is reviewed at least annually, and the need to increase the levels is weighed against programme implementation and development requirements, and the need to invest in fundraising to secure greater stability in the medium to long term The unrestricted reserves are currently below the target level and the trustees aim to increase this during the current financial year

Public Benefit Statement

The Trustees confirm that they have complied with the duty in section 4 of the Charities Act 2006 to have due regard to the Charity Commission's general guidance on public benefit, 'Charities and Public Benefit'

Health Poverty Action's charitable purpose is enshrined in its objects *'to preserve and protect the health, through the provision of primary health care, of communities who receive little or no external assistance because of political instability and/or conflict'* The Trustees ensure that this purpose is carried out for the public benefit in accordance with our mission statement (see page 8) thereby promoting a world in which all enjoy their right to health

Business review and principal activities

As shown in the Statement of financial activities, incoming resources have increased by 8% to £8,156,822 This remains in line with the Health Poverty Action long term strategic plan to increase total incoming resources Expenditure on projects in Least Developed and Lower Income Countries in 2010/11 was 59% of total programme expenditure The number of active projects during the year was 48, an increase of 4 from the previous year Health Poverty Action continues to provide cost efficient programmes, in line with budget 95% (94% 2009/10) of total expenditure was spent on charitable activities

The balance sheet on page 31 shows that there was an increase in overall level of assets during the year This can be attributed to an increase in the level of restricted funds Cash balances are higher, and deferred income is lower, due to the release during the financial year of pre-financing received before the previous balance sheet date The unrestricted reserves have decreased to £452,539 and are slightly below the target of £500,000 set by Trustees Further information on Reserves can be found above

There were no significant events since the balance sheet date

The environmental impact of Health Poverty Action's activities is minimal

Details of the number of employees and related costs can be found in note 10 of the accounts Applications by disabled persons are always fully considered, bearing in mind the aptitudes of the applicant concerned In the event of members of staff becoming disabled every effort is made to ensure that their employment with the company continues and that appropriate training is arranged

Health Poverty Action keeps employees informed on matters relevant to them as employees through regular meetings

Beyond 2010/11: where Health Poverty Action is going

The Strategic Plan for the period 2008 to 2011 was approved by the Board in June 2008, and concludes in 2011

Our reflection on the plan just ending is that the priorities identified within it served our work well, and the internalised strategic thinking that resulted from the process of developing it was important As a management tool however, we feel we could have something better – and something more likely to remain useful and appropriate throughout its timeframe

In particular, our reflections emphasised the importance of working strategically and opportunistically in an unstable external environment, and on our commitment to be led by local priorities – often in very differing and ever-evolving contexts We therefore decided to replace the strategic plan not with another of similar format, but with a shorter Strategic Framework at global level (covering the period 2011-2015) which will relate to more detailed plans at country level, and also to annual workplans at departmental level

The future

As we move forward to the next stage of our work, we are responsible for ongoing programmes in Africa, Asia and Latin America that benefit tens of millions of people each year We intend to **continue to grow these in both size and effectiveness**, building on our established strengths, and aiming to benefit more people in even better ways each year We will do this while remaining faithful to our organisational values, inspired by the principles of the 1978 groundbreaking UN Conference on Primary Health Care at Alma-Ata, and always seeking to place power and leadership where it should be – in the hands of those whose health rights have been denied them

In that context, we have identified five strategic priorities that will enable us to build the capacity of Health Poverty Action, so that we can do more to strengthen the poorest and most marginalised in their struggle for health

1) **Increase impact of our development programmes**
   We will strive to constantly monitor and improve the quality of our programmes, and apply learning from all available sources We will pay particular attention to feedback from local partners and beneficiaries

   Innovation
   We will attach great importance to creativity and innovation
   - pioneering new approaches that can be replicated or developed further elsewhere, potentially multiplying their benefits many times over,
   - adapting tried and tested approaches to be relevant and effective in new contexts, cultures and settings

   Programmes will be designed not just with a view to direct impact, but also with attention to how they will influence others and contribute to improving development practice more widely

2) **Strengthen our policy and technical capacity**
   In order for our programmes to be of the highest possible standards, it is essential that they are able to draw upon the strongest possible technical resources Similarly, in order for Health Poverty Action to influence the policy and practice of others, we need internal policy and technical capacity that enables us to speak with authority and credibility

3) **Increase unrestricted income**

Health Poverty Action has been very successful in winning large amounts of restricted project funding – and has so far succeeded in demonstrating considerable organisational growth in spite of the economic downturn However many important costs cannot be funded out of project budgets **Increasing our unrestricted income presents a uniquely valuable opportunity to profoundly increase our overall organisational impact, influence and capacity for growth.**

Consultancy and other services
Providing these to others represents an opportunity to substantially increase our unrestricted income But that is not the only reason we consider this an important area of our work to develop further The services we provide can be valuable pieces of development work in their own right – and providing them can introduce us to new partners, donors, geographical areas, and types of work

4) **Build strong supporter base**
Volunteers are the life blood of the voluntary sector Voluntary contributions, be they time or resources, are what gives the voluntary sector its name – and Health Poverty Action is proud to be a part of it We believe all people can make a difference, and we want to give them opportunities to do so The millions of poor and marginalised people currently denied their health rights deserve the strongest possible supporter base among the general public, and that is what we will strive to build for them People can start making a powerful difference from the moment they become involved – campaigning, fundraising, giving

5) **Increase media profile of work and messages**
If we ever doubt the importance of a strong voice, we need only look at the poorest and most marginalised communities we work with If their messages were heard loudly enough, more would have to be done to respect their rights – much more Achieving a high (and appropriate) media profile increases both our influence and our ability to attract funds It also helps us attract and retain high calibre staff, and recruit and mobilise a powerful supporter base At its best, media profile can motivate, inspire, give voice and generate income

Health Poverty Action is privileged to work in partnership with very large numbers of numbers of poor and marginalised people every day They are the leaders of the changes they are bringing – and the progress they have made is their own Within that, Health Poverty Action is both humbled and thrilled to have been able to be of support to them It is clear that this support has been of immense value to their health and well-being

That support has been made possible thanks to those who have given so generously to support our work, and to those who work with us (paid and unpaid).

We are immensely grateful – and hope that in the time ahead we will be able to grow to do even more together

Going Concern Statement

We have set out in the Trustees' report a review of financial performance and the charity's reserves position We have adequate financial resources and are well placed

to manage the business risks Our planning process, including financial projections, has taken into consideration the current economic climate and its potential impact on the various sources of income and planned expenditure We have a reasonable expectation that we have adequate resources to continue in operational existence for the foreseeable future We believe that there are no material uncertainties that call into doubt the Charity's ability to continue The financial statements have therefore been prepared on the basis that the Charity is a going concern

Trustees

The Trustees who are directors of the company and who served during the year from 1 April 2010 to 31 March 2011 are as follows

Jonathan Barton
Judith Cavanagh (resigned December 2010)
Andrew Chetley
Debra Davis
Dr Alison Furey
Elizabeth Muggleton (resigned December 2010)
Naomi Junghae (resigned October 2010)
Martin Kyndt
Dr Elizabeth Poskitt OBE
Professor Michael Taylor OBE (resigned October 2010)
Anand Shukla (appointed October 2010)
Dr Maryanne Freer (appointed June 2010)

Trustees' responsibilities

The trustees as directors are responsible for preparing the Annual Report and the financial statements in accordance with applicable law and regulations

United Kingdom company law requires the trustees to prepare financial statements for each financial year Under that law the trustees have elected to prepare financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law) The financial statements are required by law to give a true and fair view of the state of affairs of the company and the profit or loss of the company for that period In preparing these financial statements the trustees are required to

- Select suitable accounting policies and then apply them consistently,
- Make judgements and estimates that are reasonable and prudent,
- State whether applicable UK Accounting Standards have been followed,
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the 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 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 company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities

The trustees are responsible for the maintenance and integrity of the corporate and financial information included on the company's website Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions

Provision of information to auditors

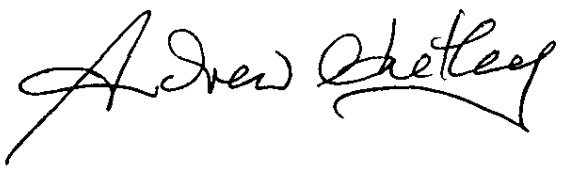
Each of the persons who is a trustee at the date of approval of this report confirms that so far as the trustee is aware, there is no relevant audit information of which the company's auditors are unaware, and the trustee has taken all the steps that she / he ought to have taken as a trustee in order 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 provisions of section 418 of the Companies Act 2006

Auditors

On 1st October 2010, Horwath Clark Whitehill LLP changed its name to Crowe Clark Whitehill LLP Crowe Clark Whitehill LLP has expressed its willingness to continue as auditor for the next financial year

Andrew Chetley



On behalf of the trustees
7 October 2011

Understanding our accounts

This page aims to help readers understand the key points in Health Poverty Action's statutory accounts

Background to Health Poverty Action's Funding and Financing

Health Poverty Action receives most of its funds directly from institutional donors, including the British Government, European Commission, The Global Fund to fight Aids, Tuberculosis and Malaria, The Big Lottery Fund and Comic Relief These grants are typically for projects in a country or region for three to five years Health Poverty Action receives a much smaller part of its funds from individual donors, private trusts and income generated in the countries we work in Most of our expenditure goes directly to our project work, the balance is spent on support costs, governance costs and fundraising

The Statement of Financial Activities

This shows the income and expenditure during the financial year The TOTAL column shows our total income and total expenditure and the net result is shown on the line 'Net Income / (Expenditure) for the year" The net result can be a surplus or deficit and is added to our Funds to be carried to the next year You will see that our TOTAL Income and Expenditure is divided between Unrestricted and Restricted Funds

Unrestricted Funds are funds available for general use for any or all of the charity's permitted activities

Restricted Funds are funds that can only be expended in accordance with specific restrictions These restrictions arise either by the wishes of the donor or by the nature of the appeal

What are the terms used in the Statement of Financial Activities?

Resources expended - Costs of generating voluntary income – are fundraising costs that comprise communications, fundraising materials and staff costs

Resources expended - Charitable activities – is expenditure incurred in operational activities, our project work

What happens to a surplus or deficit of funds at the end of the year?

Unrestricted Funds – A surplus or deficit that arises at the end of the year is added to or subtracted from Health Poverty Action's reserves Reserves are necessary to ensure sufficient bank balances to cover cash flow gaps, avoid overdraft charges and maintain continuity of programme activity Reserves are also a prudent measure against unforeseeable and uninsurable organisational costs The Trustees regularly review the level of reserves Health Poverty Action's reserves have been maintained at around £500,000 for two years

Restricted Funds –There is often a timing difference between when income is received and when it is spent Sometimes donors pay substantial amounts in advance and sometimes, substantial amounts are spent ahead of receipt from a donor Where this occurs close to the end of the financial year, a surplus or deficit may arise that is carried to the following year

Balance Sheet

This gives a snapshot of balances in the Health Poverty Action accounts at the year-end Most of Health Poverty Action's assets are in the form of cash and bank balances, being funds in the field, or funds about to be sent to the field Health Poverty Action is unlikely to have large debtors or creditors at any time other than in relation to institutional income balances The lower part of the Balance sheet shows the Funds held at the year end date

Independent Auditor's Report to the Members of Health Poverty Action

We have audited the financial statements of Health Poverty Action for the year ended 31 March 2011 which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement and the related notes numbered 1 to 18

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice)

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 charitable 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 anyone other than the charitable company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed

Respective responsibilities of trustees and auditor

As explained more fully in the Statement of Trustees' Responsibilities, the trustees (who are also the directors of the charitable company for the purpose of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error This includes an assessment of whether the accounting policies are appropriate to the company's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the directors, and the overall presentation of the financial statements

In addition, we read all the financial and non-financial information in the Trustees' Annual Report to identify material inconsistencies with the audited financial statements If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report

Opinion on financial statements

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 2011 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

Opinion on other matter prescribed by the Companies Act 2006

In our opinion the information given in the Trustees Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements

Matters on which we are required to report by exception

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

- 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

N. Hashemi

Nazıar Hashemi

Senior Statutory Auditor

For and on behalf of

Crowe Clark Whitehill LLP

Statutory Auditor

London

23 November 2011

HEALTH LIMITED
T/A HEALTH POVERTY ACTION
(LIMITED BY GUARANTEE)

STATEMENT OF FINANCIAL ACTIVITIES
(INCORPORATING AN INCOME AND EXPENDITURE ACCOUNT)

FOR THE YEAR ENDED 31 MARCH 2011

	Notes	Unrestricted funds	Restricted funds	Total funds 2011	Total funds 2010
		£	£	£	£
INCOMING RESOURCES					
Incoming resources from generated funds					
Voluntary income					
Institutional income	2	-	7,439,938	7,439,938	5,986,759
Other voluntary income	2	493,084	200,036	693,120	1,104,073
Investment income	3	348	3,114	3,462	3,123
Other incoming resources		20,058	244	20,302	87,621
Total incoming resources		513,490	7,643,332	8,156,822	7,181,576
RESOURCES EXPENDED					
Costs of generating funds					
Costs of generating voluntary income	4	267,784	45,679	313,463	375,532
Charitable activities					
Costs of health projects	5	264,161	6,721,383	6,985,544	6,546,024
Governance costs	6	44,183	-	44,183	47,821
Total resources expended		576,128	6,767,062	7,343,190	6,969,377
NET INCOME/(EXPENDITURE) FOR THE YEAR	8	(62,639)	876,270	813,632	212,199
NET MOVEMENT IN FUNDS FOR THE YEAR		(62,639)	876,270	813,632	212,199
Funds brought forward at 1 April 2010		515,178	1,777,688	2,292,866	2,080,667
TOTAL FUNDS CARRIED FORWARD at 31 March 2011		452,539	2,653,959	3,106,498	2,292,866

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

All incoming resources and resources expended derive from continuing activities

The profit for Companies Act 2006 purposes is £813632 (2010 profit £212,199)

HEALTH LIMITED
T/A HEALTH POVERTY ACTION
(LIMITED BY GUARANTEE)

Company Registration number 01837621
Charity Registration number 290535

BALANCE SHEET
AS AT 31 MARCH 2011

	Note	2011 £	2010 £
CURRENT ASSETS			
Debtors	10	740,251	1,031,486
Cash at bank and in hand	11	3,220,694	2,740,902
		3,960,945	3,772,388
CURRENT LIABILITIES			
Creditors Amounts falling due within one year	12	(854,447)	(1,479,522)
NET CURRENT ASSETS		3,106,498	2,292,866
TOTAL ASSETS LESS CURRENT LIABILITIES		3,106,498	2,292,866
TOTAL NET ASSETS		3,106,498	2,292,866
FUNDS			
Unrestricted funds	16	452,539	515,178
Restricted funds	16	2,653,959	1,777,688
		3,106,498	2,292,866

Approved by the trustees on 7 Oct 2011 and signed on its behalf by

Andrew Chetley
Chair

HEALTH LIMITED
T/A HEALTH POVERTY ACTION
(LIMITED BY GUARANTEE)

CASH FLOW STATEMENT

FOR THE YEAR ENDED 31 MARCH 2011	2010/11	2009/10
Net Cash Inflow from operating Activities	476,330	1,621,893
Returns on Investments and Servicing of Finance		
Bank Interest received	3,462	3,123
Capital Expenditure		
Management of Liquid Resources		
Sale of Investment		22,020
Increase / Decrease in Cash	**479,792**	**1,647,036**

Reconciliation of Excess of Expenditure over Income to Net Cash Inflow from Operating Activities	2010/11	2009/10
	£	£
Net incoming resources	813,632	212,199
Decrease in debtors	291,235	235,439
Increase / (decrease) in creditors	(625,075)	1,177,378
Interest received	(3,462)	(3,123)
Net cash inflow from operating activities	476,330	1,621,893

Analysis of Net Cash Resources

	Opening Balance	**Cash Flow**	**Closing Balance**
	£	**£**	**£**
Cash	2,740,902	479,792	3,220,694

Location of Cash Resources	**2010/11**	**2009/10**
	£	**£**
HQ bank accounts	1,769,142	4,349,164
In-country bank accounts	1,451,552	2,662,455
	3,220,694	7,011,619

HEALTH LIMITED
T/A HEALTH POVERTY ACTION
(Limited by Guarantee)

Notes forming part of the financial statements for the year ended 31 March 2011

1 PRINCIPAL ACCOUNTING POLICIES

a) Accounting convention

The financial statements are prepared on the historical cost basis These accounts have been prepared in accordance with applicable United Kingdom accounting standards, the Companies Act 2006 and the Statement of Recommended Practice - Accounting and Reporting by Charities (SORP 2005) In the trustees report there is a review of financial performance and of the charity's reserves position There are adequate financial resources and the charity is well placed to manage business risks The 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 It is a reasonable expectation that there are adequate resources to continue in operational existence for the foreseeable future There are no known material uncertainties that call into doubt the charity's ability to continue The accounts have therefore been prepared on the basis that the charity is a going concern Realised and unrealised gains and losses are recognised in the period to which they relate The principal accounting policies adopted in the preparation of the accounts are as follows

b) Incoming resources

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

- Donated services and facilities are included at the value to the charity where this can be quantified No amounts are included in the financial statements for services donated by volunteers

- Voluntary income includes income received from statutory and other government supported agencies, and income from other private sources

c) 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 generating funds are those incurred in seeking voluntary contributions and do not include the costs of disseminating information in support of the charitable activities

Governance costs are the costs associated with the governance arrangements of the charity which relate to the general running of the charity as opposed to those costs associated with fundraising or charitable activity Included within this category are costs associated with the strategic as opposed to day to day management of the charity's activities

Support 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 charitable expenditure, governance costs and the costs of generating funds The basis of the cost allocation has been explained in the notes to the accounts

d) 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

e) Fixed Assets

All UK assets costing more than £1,500 are capitalised Brought forward cost at 31st March 2011 is £0 and Net Book value is £0

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

2. INCOMING RESOURCES FROM GENERATED FUNDS

	2011	2010
	£	£
VOLUNTARY INCOME		
Restricted Funds		
Institutional income		
Department for International Development - UK	359,392	426,853
Department for International Development - South East Asia	690,200	404,253
European Union	2,738,295	1,798,032
ECHO	397,814	202,331
The Global Fund to Fight AIDS, Tuberculosis and Malaria	1,717,449	2,014,476
Big Lottery Fund - Ethiopia	1,707	153,642
Big Lottery Fund - Sierra Leone	168,681	198,421
Irish Aid	513,555	0
Christian Aid	50,000	35,000
Comic Relief	137,567	141,134
Other donations	261,963	271,590
UNFPA	98,070	75,902
Other local donations	305,244	265,125
	7,439,938	5,986,759
Other voluntary income		
UK and European trusts / foundations	186,176	479,260
Major Donors and Private Donors	13,860	60,210
	200,036	539,470
Total Restricted Funds	7,639,974	6,526,229
Unrestricted Funds		
Other voluntary income		
Donor recruitment	312,978	373,721
Donations from individuals	141,507	139,057
Gift in kind income	0	33,000
Legacies	13,000	250
Consultancy	9,058	0
UK and European trusts / foundations	16,541	18,575
Total Unrestricted Funds	493,084	564,603
Total incoming resources from generated funds	**8,133,058**	**7,090,832**

3. INVESTMENT INCOME

	2011	2010
	£	£
Bank interest		
Restricted Funds	3,114	2,890
Unrestricted Funds	348	233
	3,462	**3,123**

4 COSTS OF GENERATING FUNDS

	Direct	Support costs	**Total 2011**	Total 2010
	£	£	£	£
Costs of generating voluntary income - Other	56,995	127,446	**184,441**	213,039
Costs of generating voluntary income - Donor Recruitment	129,022	-	**129,022**	162,493
	186,017	127,446	**313,463**	375,532

Costs of generating funds comprises all costs identified as wholly or mainly attributable to the generation of incoming resources other than from charitable activities and includes an apportionment of overheads

Costs of generating voluntary income, donor recruitment is the cost of investing in the recruitment of new regular monthly donors in "Door to Door" campaigns which generate income in the current and subsequent years

5 CHARITABLE ACTIVITIES

	Direct	Support costs	**Total 2011**	Total 2010
	£	£	£	£
Costs of health projects	6,452,550	532,994	**6,985,544**	6,546,024

Costs of charitable activities comprises all costs identified as wholly or mainly attributable to charitable objects of the charity These costs include staff costs, wholly or mainly attributable support costs and an apportionment of overheads

6 GOVERNANCE COSTS

	Direct	Support costs	**Total 2011**	Total 2010
	£	£	£	£
Audit (internal+external)	17,518	4,293	**21,811**	25,868
Staff preparation for and involvement in Trustee meetings	-	21,393	**21,393**	21,037
Trustee Meeting costs	979	-	**979**	916
	18,497	25,686	**44,183**	47,821

Fees payable to the company auditors in respect of the statutory audit for 2010-11 were £15,393 (2010 £16,680)

7 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 Therefore the support costs shown are a best estimate of the costs that have been so allocated

Support costs and basis of apportionment

Nature of cost	**Total** £	Cost of generating other voluntary income £	Health projects £	Governance £	Basis of apportionment
Human resources	**591,293**	109,353	459,792	22,148	Allocation of staff time
Establishment costs	**37,965**	7,243	29,306	1,416	Number of employees
Office and Administration	**56,869**	10,850	43,897	2,122	Number of employees
	686,126	127,446	532,994	25,686	

8 NET INCOME FOR THE YEAR BEFORE TRANSFERS

is stated after charging

	2011 £	2010 £
Rentals in respect of operating leases,		
plant and machinery		3,089
other - office	30,000	30,000

9 STAFF COSTS AND TRUSTEES' REMUNERATION

	2011 £	2010 £
U K STAFF		
Wages and salaries	535,460	497,038
Social security costs	55,487	57,171
Pension costs	10,052	18,011
	600,998	572,220
OVERSEAS STAFF		
Wages and salaries	1,897,212	1,852,386
Pension costs	151,874	62,293
	2,049,086	1,914,679
TOTAL STAFF COSTS	**2,650,084**	**2,486,899**

One employee received remuneration of between £60,000 - £70,000 in 2010-11 (2010 1)
Employer's pension cost relating to that individual was £3,252

The Trustees neither received nor waived any emoluments during the year (2010 £Nil)

3 Trustees received payments totalling £649 in respect of travelling costs reimbursed (2010 £755, 2 Trustees)

The average number of employees, analysed by function was

	2011 Number	2010 Number
Charitable activities - Health projects	438	456
Costs of generating funds - private voluntary income	3	3
	441	**459**

10 DEBTORS

	2011 £	2010 £
Trade debtors		
European Union	393,854	519,862
Department for International Development	-	104,098
Other donors	14,215	44,006
Total trade debtors	408,068	667,966
Other debtors in UK	1,560	31,909
Cash advances to overseas partners	11,592	39,132
Other overseas/project debtors	121,371	122,609
Prepayments	8,308	18,865
Accrued income - Gift Aid & Other	38,643	46,006
Accrued income - Trusts	-	105,000
Accrued income - Grants	150,708	
	740,251	**1,031,487**

11 CASH AT BANK AND IN HAND

	2011	2010
	£	£
Cash held for projects overseas	1,451,552	1,552,035
Bank and cash	1,769,142	1,188,867
	3,220,694	**2,740,902**

12 CREDITORS: Amounts falling due within one year

	2011	2010
	£	£
Project creditors	95,581	31,003
Other creditors	31,768	47,849
Deferred income	526,480	1,198,969
Other taxes and social security	17,551	16,202
Field Severance Pay Liability	124,093	105,969
UK Accruals	58,973	79,530
	854,447	**1,479,522**

Deferred income movement in year

	2011	2010
	£	£
Balance Brought Forward	1,198,969	98,819
Released to Income	(1,198,969)	(98,819)
Received in Year	526,480	1,198,969
Balance Carried Forward	**526,480**	**1,198,969**

Deferred income represents grants received from donors in advance of the programme start

13 SHARE CAPITAL

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

14 LEASEHOLD COMMITMENTS

Annual commitments under non-cancellable operating leases are as follows

	2011	2010
Expiry date	£	£
- between two and five years		
plant and machinery	3,139	3,151
other - office	30,000	30,000

15 ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Unrestricted Funds	Restricted Funds	Total Funds
	£	£	£
Fund balances at 31 March 2011 are represented by			
Current assets	560,833	3,400,113	3,960,945
Current liabilities	(108,293)	(746,154)	(854,447)
Total Net Assets	**452,539**	**2,653,959**	**3,106,498**

HEALTH LIMITED
T/A HEALTH POVERTY ACTION
(LIMITED BY GUARANTEE)

NOTES TO THE FINANCIAL STATEMENTS

16. STATEMENT OF FUNDS

	Funds at 2010 £	Income £	Expenditure £	Funds at 2011 £
Restricted Funds				
Somaliland -	1,432	910,409	467,318	**441,659**
Rwanda	38,949	133,861	235,864	**(63,053)**
Ethiopia	205,227	296,932	275,327	**226,831**
Namibia	28,182	151,211	163,122	**16,272**
Sierra Leone	102,979	250,003	275,208	**77,773**
Kenya	21,178	27,183	36,703	**11,658**
Cambodia	179,383	996,429	973,912	**201,901**
Laos	123,076	1,228,973	1,077,006	**275,042**
Guatemala	5,270	120,631	124,159	**1,742**
Peru	3,280	18,353	19,970	**1,663**
Nicaragua	77,812	239,220	409,782	**(92,750)**
Burma&China	930,924	2,228,803	2,268,997	**890,730**
Global	62,862	1,041,322	439,693	**664,491**
Total restricted funds	**1,777,688**	**7,643,332**	**6,767,062**	**2,653,959**
Unrestricted funds	515,178	513,490	576,128	**452,539**
Total Funds	**2,292,866**	**8,156,822**	**7,343,190**	**3,106,498**

Deficits in the funds noted above are to be met by guaranteed future funding

NOTES TO THE FINANCIAL STATEMENTS

16. STATEMENT OF FUNDS Continued

Big Lottery Fund balances as at 31 March 2011 (Restricted Funds) included Statement of Funds

	£
Sierra Leone	58,084
Big Lottery Fund balances at 31 March 2011	**58,084**

DFID CSCF funding in 2010-11

Grant Number	DFID CSCF Receipts	DFID CSCF Expenditure
CSCF 0414	169,273	139,758
CSCF 0417	116,097	109,666
CSCF 0432	121,517	134,060
CSCF 0432	56,603	41,161

DFID Burma PHC Programme

	Receipts	Expenditure
107615-102	742,359	683,002

17. RELATED PARTY TRANSACTIONS

Martin Kyndt, a senior management employee of Christian Aid, has been appointed to the Board of Health Poverty Action as their trustee representative on 8 February 2007 During the year, Christian Aid donated £50,000 to Health Poverty Action (2009/10 £35,000) Andrew Martin, a Country Director for Health Poverty Action, is also a board member of Cambodia Health Education Services Cambodia Health Education Services is an approved partner for the EC NSA grant Health Poverty Action forwards sub grant payments to Cambodia Health Education Services During the year, these totalled £32,550

18. TAXATION

Health Poverty Action is a registered charity and as such is potentially exempt from taxation of its income and gains to the extent that they fall within the charity exemptions in the Corporation Taxes Act 2010 or Section 256 Taxation of Chargeable Gains Act 1992 No tax charge has arisen in the year