

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

**TRUSTEES' REPORT**

**&**

**FINANCIAL STATEMENTS**  
**for the year ended 31 March 2012**

**Company number 1837621**  
**UK Charity Registration Number 290535**



**TRUSTEES**  
(at 31 March 2012)

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## Introducing Health Poverty Action

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

**We have a distinct approach – which sees health not as primarily a medical challenge, but as an issue of social justice.** We recognise in particular the close relationship between health and poverty, in all its manifestations

Inspired by the vision of health for all, we work with those whose health suffers as a result of injustice to increase their power over the determinants of their health and strengthen their voice – so that they are able to access their rights

Within this social justice oriented approach, three factors combine to give our work a distinctiveness that experience has proven to be extremely effective

**1 We emphasise the need for justice rather than charity**

We work to tackle not just the symptoms of poor health, but its root causes. In particular, we recognise the profound importance of the social and economic determinants of health – hence our name, Health Poverty Action

**2 We prioritise those missed out by others.**

Development organisations tend to cluster together which leaves large populations with almost no support at all. These people may be living in hard to reach areas, or difficult to support for some other reason. We make these most neglected populations our highest priority

**3 We specialise in providing a holistic approach.**

This is especially important for the poorest and most marginalised with little support. They face so many threats to their health. Tackling one in isolation might give the appearance of success, while in reality doing little more than changing the cause of death. Tackling numerous factors together can bring lasting improvements – and also give rise to new innovations through creative combined approaches

### **Our activities fall into four broad categories:**

**1) 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 millions of the poorest people in the world improve their health. We currently have programmes operating in Africa (*Somaliland, Ethiopia, Rwanda, Namibia, Kenya and Sierra Leone*), Asia (*Burma, China, Cambodia, Laos*) and Latin America (*Nicaragua, Peru and Guatemala*)

**2) Influence policy and practice**

We refuse to accept that – because there are so many poor and marginalised people in the world – some must be expendable, and the right to health can therefore not be for all. We will never accept that. Furthermore, we know the scale is far too great, and in too many countries, for NGO programmes such as ours to ever realistically provide a solution for all. We therefore do all we can

to change the policies and practices that create and sustain health injustice - working with those affected and our allies to analyse what needs to change, devise creative solutions, and help bring those changes about

### 3) Respond 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. We always remember that emergencies are not identified by what is given high profile in the global media, but by the experience of those affected. Most of these crises receive little or no media coverage – and consequently few resources. We also recognise that for the poor and marginalised, emergencies are not discrete events but one additional factor in an ongoing struggle. When emergencies strike, we work with those affected to mobilise all possible resources for urgent response – and do this as an integrated contribution to their ongoing struggle for health justice.

### 4) Provide consultancy & 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 our work.

## Roots in the People's Health Movement

Health campaigners worldwide achieved a major breakthrough in 1978, at the **UN Alma-Ata Conference on Primary Health Care**. This conference statement signalled a new approach to health care, often described as the 'primary health care approach' or the 'Alma-Ata principles' – deeply rooted in the social and structural determinants of health, and emphasising the importance of accountability to the people. Linked to this was a global target of achieving "Health for All" by the year 2000.

### 'Primary Health Care'

This term is often (mistakenly) understood to mean the primary level of the health service. This misunderstanding is a particular problem when applied to development, playing to the prejudice that what's appropriate for poor people is just basic, low-tech healthcare. In fact, Primary Health Care means something different, and embraces all sectors, not just health. 'Primary' in this context refers to two things:

- 1) Addressing the *primary* determinants of health – ie root causes and prevention, including social, economic, conflict and environmental determinants
- 2) *Primary* in terms of accountability – ie health care that is accountable and accessible to those affected

Health Poverty Action was born out of this primary health care movement. We have always been part of it, and it remains our primary global network (now known as the People's Health Movement).

### People's Health Movement (PHM)

In the year 2000, in response to failure to achieve Health for All, health activists organised the first People's Health Assembly (in Bangladesh), attended by thousands of civil society representatives (including Health Poverty Action). This gave birth to the People's Health Movement, and subsequently to its many associated initiatives such as Global Health Watch, WHO Watch, the International People's Health University, and numerous Right to Health campaigns.

The People's Health Movement's history, analysis and working principles is a fundamental part of Health Poverty Action's identity, and we actively contribute to many of its activities around the world. This is recognised by Health Poverty Action being one of only a handful of NGOs in the world that is awarded the status of being formally affiliated to the movement.

## **Led by those whose rights we serve**

Health Poverty Action doesn't replace state services. We know that charity provision is not the answer. Instead we work with communities to make services more accessible, higher quality and better resourced, and locally accountable. 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.

We take respect for local knowledge and culture extremely seriously – and approximately 95% of our staff come from the communities they serve. As insiders, they know that lasting change comes when people experience their power to develop their own solutions and work to see these implemented. Similarly, as insiders they are able to work for change in ways that no-one else could when local practices need challenging – such as working to end female genital mutilation and other gender-based injustices impacting on health.

We attach great value to the trusting relationships we have developed with so many poor and marginalised communities – many of whom have learnt through bitter experience to trust few outsiders. Marginalisation and persecution so often go together. Their marginalisation may be a consequence of factors such as ethnicity or culture, gender, geography, politics, economics – or all of these.

Because we prioritise the *most* poor and the *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.

Our work is a balance of addressing both the long-term and the immediate. We commit to long-term partnerships where necessary to bring change that lasts – while at the same time working with communities to quickly tackle urgent health needs and respond to emergencies.

## **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 Poverty Action was created in 1984, initiated by development workers in Pakistan who were aware of tremendous unmet need in neighbouring Afghanistan, but whose organisations were unable to work there. They believed that none should be excluded, and poor and marginalised people everywhere had the same right to good health as the rich and powerful. So they turned their anger into action.

That hunger for justice still drives our staff and volunteers today – working with communities in some of the most challenging and neglected places on earth, and campaigning globally to transform systems which deny proper healthcare to the most vulnerable citizens of our world.

Along with the vital link between health and poverty, our work has always 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 approaching 500 staff worldwide – mostly recruited from within the populations they serve – and around 20 in our international HQ based in London.

## Objectives and activities 2011-12

### *Vision*

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

### *Mission*

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

Our mission statement reminds us of some fundamentally important principles relating to the ways we work with poor and marginalised communities, such as

- They do it We don't do it for them
- We respect the power and potential of poor and marginalised people to bring change We neither perceive nor portray them as helpless victims
- Our work isn't about providing the needy with services – it's about strengthening people in their struggle for justice

### Priorities for 2011-12

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" Today, built up over more than three decades, we have ongoing programmes in Africa, Asia and Latin America that benefit many millions of people each year

Our priority for 2011-12 was 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 We aimed to 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 had been denied them

In that context, we identified five strategic priorities that would collectively 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 These were

#### 1) Increase impact of our development programmes

Constantly monitor and improve the quality of our programmes, and apply learning from all available sources worldwide – our own experience and also that of others Pay particular attention to feedback from local partners and beneficiaries

#### *Innovation*

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

Design programmes 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 in recent years has been very successful in winning large amounts of restricted project funding. We celebrate this and aim to increase it further. However many important costs cannot be funded out of project budgets. If we are to be as valuable to poor and marginalised communities as they require us to be, it is essential that we are able to supplement this project-based funding with sufficient of our own unrestricted income. 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 for substantial income generation. Also, the services we provide can be valuable pieces of development work in their own right – and can introduce us to new partners and donors, and new technical and geographical areas

## **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 are committed to its ideals, and uphold the spirit of voluntarism. We believe all people can make a difference, and we want to give them opportunities to do so – not as supporters of us as an organisation, but as passionate supporters of the cause we exist to serve. The millions of poor and marginalised people currently denied their health rights deserve the strongest possible supporter base among the general public. Individuals can make a powerful difference – campaigning, fundraising, giving, and generally contributing in whatever ways they can

## **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. They have a voice – and they undeniably have important things to say – but too few people hear it. If their messages were heard loudly enough, much more would have to be done in recognition of their rights. A high and well managed media profile for Health Poverty Action and its work can increase both influence and ability to attract funds. It can also help attract and retain high calibre staff, and recruit and mobilise a powerful supporter base

## **A cross-cutting theme: networking and partnership**

Strong networking, especially at country level, is key to our success. This needs to be with all sectors – public, private and voluntary – learning from (and influencing) others, and seeking opportunities to work together in creative ways. We can do little on our own, and it is through partnerships that new opportunities are to be found – diversifying income and generating more resources, reaching new communities, and developing new technical capacity and enhancing innovation

# Analysis of progress against strategic priorities during 2011/12

## Strategic priority summaries

### 1. Increase impact of our development programmes

As indicated in the table above, in 2011-12 Health Poverty Action's programmes continued to benefit a large of poor and marginalised communities in 13 countries, addressing a range of their key health determinants. There was no change to the countries we worked in from the previous year. However overall programme size continued to grow.

Some possibilities of commencing programmes in new countries were investigated in 2011-12, and these may be progressed further in 2012-13.

A particular priority over these past 12 months has been to build our organisational capacity in key areas – increasing our ability to devise, win funding for, and oversee the implantation and contract management of high quality programmes. This has required considerable investment (mostly of time) in staff train and new systems development – both at head office and incountry. We believe this investment will raise our standards to a new level, with consequent benefits to both the communities we serve and Health Poverty Action as an organisation for many years to come.

Some key elements of this *capacity building programme* have been

- Training head office and senior incountry staff in programme and budget development
  - Training head office and senior incountry staff in contract management
  - Revising and improving contract management and reporting systems worldwide, including developing and rolling out a new and comprehensive financial and administrative procedures manual
- [A particular benefit of the above has been a marked improvement in meeting reporting deadlines, which has helped enormously with cashflow problems we had been experiencing at particular times of year. Previously we were good at submitting high quality reports to donors, but not so good at getting them in on time, which delayed disbursement of the next tranche of funds. Now almost all reports are submitted without needing deadline extensions and cashflow is no longer a problem.]
- Development of a new Monitoring and Evaluation system, to be trialled initially across Africa, with a view to later rolling it out more widely. This systematises the gathering of key pieces of data across our programmes, making it possible to measure progress beyond the life of particular projects, and also to aggregate key measurements internationally.
  - Some new Programme Development staff have been taken on in key places. An example is Rwanda, where a one year programme development post was taken on with the support of a particularly visionary major donor. This post was able to build on the successful foundations Health Poverty Action has in Rwanda (based in particular on the hugely successful radio programme Urunana) and contribute to the development of a range of successful new bids to considerably expand the size and scope of this programme, from which it will now hopefully be able to develop even further in future.

A running theme throughout this capacity building has been a gradual shift to a more *programmatic* as opposed to project-based approach. Country managers are being supported to develop more sophisticated strategies and underlying research/analysis at country level, summarised in country strategic plans. This means the when funding calls arise at short notice, Health Poverty Action will be

able to submit applications that have maximum strategic advantage, hopefully resulting in increased impact

Overall, *the Africa programme* increased in size substantially over the 12 months. Assessments on new programmatic areas were carried out and new partnerships developed including, for example, mental health and female genital cutting among others. Additional work on sexual and gender based violence also began in Somaliland and Sierra Leone, a water, sanitation and hygiene proposal was accepted in Rwanda, and funding was successfully obtained for nutrition and food security work will now commence shortly in Somaliland. We have also expanded to new geographic areas within countries, for example in Somaliland we opened a programme and office in the Sahil Region, we have widened from 5 to 13 chiefdoms in Sierra Leone, and we opened a new project that works across the Ethiopia/Kenya border. The Africa programme showed considerable success in diversifying funding streams, this year including programmes with funding from EC, DFID, PSI, Global Fund, UNICEF, AusAid, UNFPA, LSTM, IPPF and UNDEF.

Our *Asia programme* has similarly seen a rapid expansion in recent years, which continued over the last twelve months. Alongside an increase in total expenditure, the nature of activities also expanded, for example our Burma/Myanmar programme now combines health care development support alongside an emergency programme that provides food/shelter/primary health care and drinking water to internally displaced people (along the China/Myanmar border, who have been affected by the localised conflict between the Myanmar military and the Kachin Independence Army), and in Laos we have considerably developed our capacity in the area of nutrition (adopting a community-led approach) and Community-led Total Sanitation. In Laos we also undertook two emergency response projects, and won our two largest consultancy contracts so far.

Our strategic priority has been as much about continually striving to increase programme quality as well as programme size, thereby maximising global impact. In this regard we were especially pleased over these past twelve months that our two largest projects – Burma/Myanmar and Somaliland – were both independently assessed by donors and received A ratings. (Our work in these two areas represents about 40% of our global capacity, so it is especially important that they are very high quality.)

During this past year, as is always the case given the nature of the places Health Poverty Action works, we have faced a range of challenges. Perhaps the greatest was when, in May, the Global Fund, due to disagreements with the government of China, suspended all its funding to China with immediate effect. This left Health Poverty Action with a very large number of staff who were suddenly unfunded (our largest staff contingent in the world). Eventually the issue was resolved, Global Fund funding was reinstated, and Health Poverty Action's interim costs were covered. However the uncertainty was naturally very difficult for our local staff, and we are very grateful to them for their resilience and loyalty.

## **2. Strengthen our policy and technical capacity**

Despite our increasing size, we are very much aware that the contribution of a medium sized international NGO like Health Poverty Action is not primarily about scaling up, but about influencing the actions of others by pioneering, innovating and challenging policy. It is important therefore that we are constantly at the cutting edge – which means it is similarly important that we have excellent policy and technical capacity.

Strengthening the voice of poor and marginalised people – and especially those in the most powerless positions – is a frequent thread throughout our programmatic approach. We are increasingly working to link this local level advocacy with advocacy at national and international levels. To these ends we have been working hard to strengthen our policy and advocacy related capacity, as well as our programmatic technical skills. Over the past twelve months this has included

- looking at ways of integrating advocacy and communications activities into project proposals,
- holding an “Introduction to Advocacy” workshop for Africa staff,
- providing advocacy training for staff and partners in Cambodia,
- developing further our Mothers on the Margins campaign, which focuses on the health rights of mothers in indigenous communities (A particularly important component of this was undertaking research towards a later report on traditional birth attendants (TBAs),
- running a campaign jointly with the Manifesto for Motherhood coalition, calling on the Secretary of State for International Development to assess the progress of “The UK’s Framework for Results for improving reproductive, maternal and newborn health in the developing world”,
- gathering 20,000 signatures on a Mothers on the Margins e-petition and meeting with the Guatemalan embassy to present this and discuss the related issues (A media photo-call was held outside the embassy, holding up cardboard cut-outs of pregnant women (to represent those who had died needlessly) with campaign messages (This was not covered in the UK, but did gain some media coverage in Guatemala

Other policy and campaigns activity implemented over the past twelve months has included

*“Trading with Lives” generic medicines campaign*

Negotiations of the EU-India Free Trade Agreement were ongoing during much of the year, resulting in activity around some key campaign pressure points (Members of the public were asked to send emails to the negotiators on the issue

*Financial Transaction Tax (FTT) campaign*

Health Poverty Action produced a joint briefing with 18 other organisations on an ‘FTT for Global Health’, with the aim of making health well-positioned for upcoming debates around what (and where) new revenues will be spent (The FTT interagency campaign achieved some huge wins, notably that between 9 and 24 European countries are now likely to implement an FTT this coming year (excluding the UK) (The challenge is now to continue to push for a substantial proportion of this new revenue to be spent on health (Health Poverty Action worked closely alongside and within the Robin Hood Tax group of organisations on this issue, and promoted the campaign’s actions through the our website

Health Poverty Action joined the *End Water Poverty* and the *End Fistula* campaigns, both of which have global reach (Our Sierra Leone Country Director, Regina Bash-Taqi, was invited by the UN to speak at a global meeting of the End Fistula Campaign

Several briefings and policy papers were developed during the year in partnership with other organisations, such as

- an MP briefing from the Manifesto for Motherhood,
- a briefing on Human Resources for Health in Fragile States with Action for Global Health,
- the above mentioned FTT for Global Health briefing

We also co-signed a number of key coalition letters to decision-makers, for example to the Prime Minister and the Chancellor on the Robin Hood Tax, to the WHO-DG on the security of health workers in conflict zones, and a letter demanding a democratic and merit-based process for the selection of the new World Bank President

After attending the World Health Assembly in Geneva, later that year (in October) we were one of only two UK-based NGOs to attend the WHO’s conference on the Social Determinants of Health in Rio de Janeiro (This was the largest international conference the WHO had held since Alma Ata in 1978 )

We also completed two policy-related consultancies – one relating to HIV-integration with health and livelihood programmes, and one relating to effective campaign strategies when running a global campaign

### 3. Increase unrestricted income

Over the past six years Health Poverty Action has been making sustained efforts to increase income from private sources

A key component of this has been investing in donor recruitment, primarily through face-to-face campaigns, and as a result unrestricted voluntary income has risen from £200,880 in 2002/03 to £590,757 in 2011/12

Recruitment of new donors through door-to-door donor campaigns has been a central plank of this increase, and this was implemented again during the year just ended. It proved a difficult environment this year however, with recruitment of new donors slower than expected, and we also experienced more people than usual stopping their regular donations

Income from sponsored marathon runners is an important stream for us, and events such as the London Marathon and our sponsored treks will be continue to be developed. Our marathon 2011 team was small because a number of people pulled out of the run – leaving just 21 runners compared to 28 expected in 2012 – meaning income was lower than usual. However our bigger 2012 team should bring a good level of income

As well as the London Marathon, in 2011/12 we also marketed Health Poverty Action to people with places in other running events across the country, and received income from medical electives with three people travelling to Laos and Nicaragua. (Our ability to send people on such an elective very much depends on us having hands-on health projects for participants to go to, and a doctor to sign off placements. Nicaragua and Laos are therefore currently particularly suitable for the scheme.)

A particular success this past year was organising a Health Poverty Action sponsored event called **March for Mothers**. We hope that this will develop further in future years to become one of our main annual fundraising initiatives. Leading up to this we also held an inter-faith music concert that raised significant funds for us. Both of these new events were possible because the Tony Blair Faith Foundation paid for two 'Faiths Act Fellows' to work on fundraising and supporter development at Health Poverty Action during the year.

We were also successful in 2011/12 in increasing our income from UK/European Grant Making Trusts. This is especially important for us, as it provides an essential form of match funding for our global programmes.

With a view to the longer term, legacies provide an extremely valuable and very cost-effective form of fundraising income, and one that is very much appreciated whenever it is received. In particular, legacies can provide large amounts of unrestricted funding for NOGs. In 2011/12 Health Poverty Action was very grateful to receive £83,004 in legacy income from four people.

Because our database of donors and profile among the general public is still so small, income to Health Poverty Action's work from legacies is still very variable. Over the long term, we believe that increasing Health Poverty Action's profile, and engaging more frequently and deeply with the general public, will result in increased financial support, and in this context providing income through legacies can be a particularly important way for people to contribute to the work.

#### **4. Build strong supporter base**

A strong public supporter-base – i.e. people who feel ownership of its work and are passionately committed to contributing to this – is arguably the most precious resource an organisation like Health Poverty Action can potentially mobilise on behalf of the poor. People acting together, in simple ways, have a collective power and influence unlike any other – and the benefits they provide for NGOs can be transformative. Such people are true change-makers.

Health Poverty Action's historical origins as a primarily project-funded organisation, based on income from public institutional sources, means that we have tended to have a low profile and a comparatively small public supporter base. In recent years however Health Poverty Action has been deliberately changing to become more public-facing, and developing an active and passionately committed supporter-base among the general public is a key part of Health Poverty Action's long-term strategy.

This strategy is currently still in its early days, and we have very limited resources to invest in it. Nevertheless, in 2011/12 developing and deepening our relationship with those members of the public who contribute (or could potentially contribute) to Health Poverty Action's work so valuably was an important priority.

This included

- regular email bulletins with campaign actions and news,
- an emergency appeal responding to a crisis in the Horn of Africa,
- an online petition on indigenous mothers in Guatemala, which resulted in 1000 new supporters as well as 20,000 signatures for the petition,
- a campaign action (to sign a giant Mothers Day card to Andrew Mitchell) to the participants in the March for Mothers.

A variety of talks were given around the country to active groups such as Medsin, and to lawyers working on intellectual property rights and development. About half of those attending signed up to our newsletter so that we can stay in touch with them.

A great way of engaging with people was an open evening hosted in our head office when Fatuma Mohamed Ali visited from Health Poverty Action's Somaliland programme.

#### **5. Increase media profile of work and messages**

Success in this area strengthens the organisation's work in many others, especially increasing income and influence.

At present, as with developing a public supporter base, we have limited resources to invest in it. Nevertheless, in 2011/12 achievements included

- production of a video on maternal health,
- a visit to our contacts at the unit at Guys and St Thomas hospital that specialises in reversing FGM,
- exploratory talks with a group called "theatre for development",
- private meetings with MPs,
- media coverage in 32 media outlets (including online),
- continued gradual development of our social media activity (*Twitter* followers up from 565 in March 2011 to 1293 in March 2012. *Facebook* up from 448 to 650.)

We were pleased that Health Poverty Action's initiative "Mobilising traditional birth attendants and local communities in Sierra Leone to reduce maternal deaths" was recognized as one of the "Top 50

Ideas and Solutions Improving the Lives of Girls and Women Worldwide” in the Women Deliver 50-Awards

## **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. There were six trustees at 31<sup>st</sup> March 2012.

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.

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.

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**

As well as ongoing risk management throughout the year, the Trustees review the major risks that face the organisation on an annual basis. The Board has adopted a formal Risk Policy, and senior staff have fed into this by overseeing an overall assessment of risks facing the organisation.

Senior staff from London visit all field offices at regular intervals and most projects at least once a year. Trustees are also encouraged to visit programmes when appropriate and practicable. 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.

Key risks are regularly reviewed and monitored by senior managers and trustees throughout the year.

## Financial review

Overall, our income increased by a significant amount on 2010/11, and the Department for International Development and the European Union (including ECHO) are now our two largest donors, contributing between them around 60% of our overall income. This level is consistent with the two largest donors for previous financial years.

### Using funds effectively

Expenditure on charitable activities increased from £6,985,544 to £8,450,754.

Health Poverty Action is highly cost-effective in delivering its programmes. 96% 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 £640,987 equal to 7% of overall expenditure (2011: 6.2%). 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 above the target level.

### 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 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 15% to £9,395,711. This remains in line with the Health Poverty Action long term strategic plan to increase total incoming resources.

The balance sheet 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 increased to £640,987 and are above 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.

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 2011/12: where Health Poverty Action is going

We will continue to be responsible for developing, funding and implementing major programmes in Africa, Asia and Latin America that benefit many millions of people each year, as well as our global policy/campaigns and consultancy programmes

We intend to **continue to grow these areas of work 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

Within that context, we will continue to focus particular attention on the five organisational development priorities identified in our 4 year Strategic Framework. These 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.

# THANK YOU

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 2011 to the date of signing of the accounts were:

Jonathan Barton  
Andrew Chetley (resigned October 2011)  
Debra Davis  
Dr Alison Furey (resigned October 2011)  
Martin Kyndt  
Dr Elizabeth Poskitt OBE (resigned October 2011)  
Anand Shukla (resigned March 2012)  
Dr Maryanne Freer (resigned March 2012)  
Alison Warner  
Tom Baker

## **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

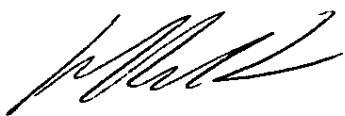
governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions

### **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**

Crowe Clark Whitehill LLP has expressed its willingness to continue as auditor for the next financial year



Martin Kyndt

11 / 12 / 12

On behalf of the trustees

## 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 2012 which comprise the Statement of Financial Activities, the Balance Sheet, the Cash Flow Statement and the related notes numbered 1 to 17

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

**Naziar Hashemi**  
Senior Statutory Auditor  
For and on behalf of  
**Crowe Clark Whitehill LLP**  
Statutory Auditor  
**London**

18 December 2012.

**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 2012**

|                                                      | Notes | Unrestricted<br>funds<br>£ | Restricted<br>funds<br>£ | Total<br>funds<br>2012<br>£ | Total<br>funds<br>2011<br>£ |
|------------------------------------------------------|-------|----------------------------|--------------------------|-----------------------------|-----------------------------|
| <b>INCOMING RESOURCES</b>                            |       |                            |                          |                             |                             |
| <b>Incoming resources from generated funds</b>       |       |                            |                          |                             |                             |
| Voluntary income                                     |       |                            |                          |                             |                             |
| Other voluntary income                               | 2     | 590,756                    | 669,300                  | 1,260,056                   | 693,120                     |
| Investment income                                    | 3     | 1,029                      | 3,356                    | 4,385                       | 3,462                       |
| <b>Incoming resources from charitable activities</b> |       |                            |                          |                             |                             |
| Institutional income                                 | 2     | -                          | 8,120,116                | 8,120,116                   | 7,439,938                   |
| <b>Other incoming resources</b>                      |       |                            | 11,154                   | 11,154                      | 20,302                      |
| <b>Total incoming resources</b>                      |       | 591,785                    | 8,803,926                | 9,395,711                   | 8,156,822                   |
| <b>RESOURCES EXPENDED</b>                            |       |                            |                          |                             |                             |
| <b>Costs of generating funds</b>                     |       |                            |                          |                             |                             |
| Costs of generating voluntary income                 | 4     | 238,139                    | 45,984                   | 284,123                     | 313,463                     |
| <b>Charitable activities</b>                         |       |                            |                          |                             |                             |
| Costs of health projects                             | 5     | 117,926                    | 8,332,828                | 8,450,754                   | 6,985,544                   |
| <b>Governance costs</b>                              | 6     | 47,272                     | -                        | 47,272                      | 44,183                      |
| <b>Total resources expended</b>                      |       | 403,337                    | 8,378,812                | 8,782,149                   | 7,343,190                   |
| <b>NET INCOME FOR THE YEAR</b>                       | 8     | 188,448                    | 425,114                  | 613,562                     | 813,632                     |
| <b>NET MOVEMENT IN FUNDS FOR THE YEAR</b>            |       | 188,448                    | 425,114                  | 613,562                     | 813,632                     |
| Funds brought forward at 1 April 2011                |       | 452,539                    | 2,653,959                | 3,106,498                   | 2,292,866                   |
| <b>TOTAL FUNDS CARRIED FORWARD at 31 March 2012</b>  |       | 640,987                    | 3,079,073                | 3,720,060                   | 3,106,498                   |

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 £613562

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

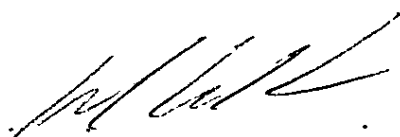
Company Registration number  
Charity Registration number

01837621  
290535

**BALANCE SHEET  
AS AT 31 MARCH 2012**

|                                                | Note | 2012<br>£        | 2011<br>£        |
|------------------------------------------------|------|------------------|------------------|
| <b>CURRENT ASSETS</b>                          |      |                  |                  |
| Debtors                                        | 10   | 1,568,058        | 740,251          |
| Cash at bank and in hand                       | 11   | 3,290,737        | 3,220,694        |
|                                                |      | <u>4,858,795</u> | <u>3,960,945</u> |
| <b>CURRENT LIABILITIES</b>                     |      |                  |                  |
| Creditors. Amounts falling due within one year | 12   | (1,138,735)      | (854,447)        |
|                                                |      | <u>3,720,060</u> | <u>3,106,498</u> |
| <b>NET CURRENT ASSETS</b>                      |      |                  |                  |
|                                                |      | <u>3,720,060</u> | <u>3,106,498</u> |
| <b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>   |      |                  |                  |
|                                                |      | <u>3,720,060</u> | <u>3,106,498</u> |
| <b>TOTAL NET ASSETS</b>                        |      | <u>3,720,060</u> | <u>3,106,498</u> |
|                                                |      | =====            | =====            |
| <br><b>FUNDS</b>                               |      |                  |                  |
| Unrestricted funds                             | 16   | 640,987          | 452,539          |
| Restricted funds                               | 16   | 3,079,073        | 2,653,959        |
|                                                |      | <u>3,720,060</u> | <u>3,106,498</u> |
|                                                |      | =====            | =====            |

Approved by the trustees on 11/12/2012 and signed on its behalf by



Martin Kyndt

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

**CASH FLOW STATEMENT**

**FOR THE YEAR ENDED 31 MARCH 2012**

|                                                        | 2011/12       | 2010/11        |
|--------------------------------------------------------|---------------|----------------|
| Net Cash Inflow from operating Activities              | 65,658        | 476,330        |
| <b>Returns on Investments and Servicing of Finance</b> |               |                |
| Bank Interest received                                 | 4,385         | 3,462          |
| <b>Capital Expenditure</b>                             |               |                |
| <b>Increase / Decrease in Cash</b>                     | <b>70,043</b> | <b>479,792</b> |

**Reconciliation of Excess of Expenditure over Income  
to Net Cash Inflow from Operating Activities**

|                                           | 2011/12   | 2010/11   |
|-------------------------------------------|-----------|-----------|
|                                           | £         | £         |
| Net incoming resources                    | 613,562   | 813,632   |
| (Increase)/Decrease in debtors            | (827,807) | 291,235   |
| Increase / (decrease) in creditors        | 284,288   | (625,075) |
| Interest received                         | (4,385)   | (3,462)   |
| Net cash inflow from operating activities | 65,658    | 476,330   |

**Analysis of Net Cash Resources**

|      | Opening<br>Balance<br>£ | Cash<br>Flow<br>£ | Closing<br>Balance<br>£ |
|------|-------------------------|-------------------|-------------------------|
| Cash | 3,220,694               | 70,043            | 3,290,737               |

**Location of Cash Resources**

|                          | 2011/12<br>£     | 2010/11<br>£     |
|--------------------------|------------------|------------------|
| HQ bank accounts         | 1,244,864        | 1,769,142        |
| In-country bank accounts | 2,045,873        | 1,451,552        |
|                          | <b>3,290,737</b> | <b>3,220,694</b> |

**Notes forming part of the financial statements for the year ended 31 March 2012**

## **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.
- Legacies: entitlement is the earlier of the estate account being finalised or cash received.
- 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.

### **i) 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.

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

**2. INCOMING RESOURCES FROM GENERATED FUNDS**

|                                                            | <b>2012</b>      | <b>2011</b>      |
|------------------------------------------------------------|------------------|------------------|
|                                                            | <b>£</b>         | <b>£</b>         |
| <b>VOLUNTARY INCOME</b>                                    |                  |                  |
| <b>Restricted Funds</b>                                    |                  |                  |
| Institutional income                                       |                  |                  |
| Department for International Development - UK              | 2,835,548        | 359,392          |
| Department for International Development - South East Asia |                  | 690,200          |
| European Union                                             | 2,623,588        | 2,738,295        |
| ECHO                                                       | 174,006          | 397,814          |
| Norwegian Ministry of Foreign Affairs                      | 547,555          | 0                |
| The Global Fund to Fight AIDS, Tuberculosis and Malaria    | 1,030,662        | 1,717,449        |
| Big Lottery Fund - Ethiopia                                | 11,700           | 1,707            |
| Big Lottery Fund - Sierra Leone                            | 108,975          | 168,681          |
| Oxfam Novib                                                | 286,366          |                  |
| Irish Aid                                                  |                  | 513,555          |
| Christian Aid                                              | 94,000           | 50,000           |
| Comic Relief                                               |                  | 137,567          |
| Other donations                                            | 163,558          | 261,963          |
| UNFPA                                                      | 125,925          | 98,070           |
| Other local donations                                      | 118,233          | 305,244          |
|                                                            | -----            | -----            |
|                                                            | 8,120,116        | 7,439,938        |
|                                                            | -----            | -----            |
| Other voluntary income                                     |                  |                  |
| UK and European trusts / foundations                       | 508,700          | 186,176          |
| Major Donors and Private Donors                            | 160,600          | 13,860           |
|                                                            | -----            | -----            |
|                                                            | 669,300          | 200,036          |
|                                                            | -----            | -----            |
| Total Restricted Funds                                     | 8,789,416        | 7,639,974        |
|                                                            | -----            | -----            |
| <b>Unrestricted Funds</b>                                  |                  |                  |
|                                                            | -----            | -----            |
| Other voluntary income                                     |                  |                  |
| Donor recruitment                                          | 313,199          | 312,978          |
| Donations from individuals                                 | 169,955          | 141,507          |
| Gift in kind income                                        | 0                | 0                |
| Legacies                                                   | 83,004           | 13,000           |
| Consultancy                                                | 11,611           | 9,058            |
| UK and European trusts / foundations                       | 12,987           | 16,541           |
|                                                            | -----            | -----            |
| Total Unrestricted Funds                                   | 590,756          | 493,084          |
|                                                            | -----            | -----            |
| <b>Total incoming resources from generated funds</b>       | <b>9,380,172</b> | <b>8,133,058</b> |
|                                                            | =====            | =====            |

**3. INVESTMENT INCOME**

|                    | <b>2012</b>  | <b>2011</b>  |
|--------------------|--------------|--------------|
|                    | <b>£</b>     | <b>£</b>     |
| Bank interest      |              |              |
| Restricted Funds   | 3,356        | 3,114        |
| Unrestricted Funds | 1,029        | 348          |
|                    | -----        | -----        |
|                    | <b>4,385</b> | <b>3,462</b> |
|                    | =====        | =====        |

**HEALTH LIMITED  
T/A HEALTH UNLIMITED  
(LIMITED BY GUARANTEE)**

**4. COSTS OF GENERATING FUNDS**

|                                                          | Direct  | Support costs | Total 2012 | Total 2011 |
|----------------------------------------------------------|---------|---------------|------------|------------|
|                                                          | £       | £             | £          | £          |
| Costs of generating voluntary income - Other             | 48,873  | 130,104       | 178,977    | 184,441    |
| Costs of generating voluntary income - Donor Recruitment | 105,146 | -             | 105,146    | 129,022    |
|                                                          | 154,019 | 130,104       | 284,123    | 313,463    |

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 2012 | Total 2011 |
|--------------------------|-----------|---------------|------------|------------|
|                          | £         | £             | £          | £          |
| Costs of health projects | 7,763,953 | 686,801       | 8,450,754  | 6,985,544  |

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 2012 | Total 2011 |
|-----------------------------------------------------------|--------|---------------|------------|------------|
|                                                           | £      | £             | £          | £          |
| Audit (internal+external)                                 | 17,793 | 4,564         | 22,357     | 21,811     |
| Staff preparation for and involvement in Trustee meetings | -      | 23,701        | 23,701     | 21,393     |
| Trustee Meeting costs                                     | 1,214  | -             | 1,214      | 979        |
|                                                           | 19,007 | 28,265        | 47,272     | 44,183     |

Fees payable to the company auditors in respect of the statutory audit for 2011/12 were £17,793 (2010/11 £15,393)

**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<br>£ | Cost of generating other<br>voluntary income<br>£ | Health<br>projects<br>£ | Governance<br>£ | Basis of apportionment   |
|---------------------------|------------|---------------------------------------------------|-------------------------|-----------------|--------------------------|
| Human resources           | 706,918    | 107,258                                           | 575,971                 | 23,689          | Allocation of staff time |
| Establishment costs       | 48,770     | 8,059                                             | 39,098                  | 1,613           | Number of employees      |
| Office and Administration | 89,479     | 14,787                                            | 71,732                  | 2,960           | Number of employees      |
|                           | 845,167    | 130,104                                           | 686,801                 | 28,262          |                          |

**HEALTH LIMITED  
T/A HEALTH UNLIMITED  
(LIMITED BY GUARANTEE)**

**8. NET INCOME FOR THE YEAR BEFORE TRANSFERS  
is stated after charging**

|                                                                | <b>2012</b> | <b>2011</b> |
|----------------------------------------------------------------|-------------|-------------|
|                                                                | <b>£</b>    | <b>£</b>    |
| Rentals in respect of operating leases,<br>plant and machinery | 2,980       | 3,089       |
| other - office                                                 | 30,000      | 30,000      |

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**9 STAFF COSTS AND TRUSTEES' REMUNERATION**

|                       | <b>2012</b> | <b>2011</b> |
|-----------------------|-------------|-------------|
|                       | <b>£</b>    | <b>£</b>    |
| <b>U K STAFF</b>      |             |             |
| Wages and salaries    | 675,159     | 535,460     |
| Social security costs | 70,492      | 55,487      |
| Pension costs         | 23,695      | 10,052      |

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**OVERSEAS STAFF**

|                    |           |           |
|--------------------|-----------|-----------|
| Wages and salaries | 1,986,071 | 1,897,212 |
| Pension costs      | 161,153   | 151,874   |

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**TOTAL STAFF COSTS**

**2,916,570**

**2,650,085**

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One employee received remuneration of between £60,000 - £70,000 in 2011-12 (2011 1)  
Employer's pension cost relating to that individual was £7,927

The Trustees neither received nor waived any emoluments during the year (2011 £Nil)

2 Trustees received payments totalling £826 in respect of travelling costs reimbursed  
(2011 £649, 3 Trustees)

The average number of employees, analysed by function was

|                                                      | <b>2012</b>   | <b>2011</b>   |
|------------------------------------------------------|---------------|---------------|
|                                                      | <b>Number</b> | <b>Number</b> |
| Charitable activities - Health projects              | 437           | 438           |
| Costs of generating funds - private voluntary income | 4             | 3             |

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**10 DEBTORS**

|                                    | <b>2012</b> | <b>2011</b> |
|------------------------------------|-------------|-------------|
|                                    | <b>£</b>    | <b>£</b>    |
| Amounts due from donors            | 0           | 408,068     |
| Other debtors in UK                | 47          | 1,560       |
| Cash advances to overseas partners | - 8,875     | 11,592      |
| Other overseas/project debtors     | 242,203     | 121,371     |
| Prepayments                        | 10,708      | 8,308       |
| Accrued income - Gift Aid & Other  | 70,982      | 38,643      |
| Accrued income - Trusts            | 110,000     | -           |
| Accrued income - Grants            | 1,142,993   | 150,708     |

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**1,568,058**

**740,251**

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**HEALTH LIMITED**  
**T/A HEALTH POVERTY ACTION**  
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**11 CASH AT BANK AND IN HAND**

|                                 | <b>2012</b>      | <b>2011</b>      |
|---------------------------------|------------------|------------------|
|                                 | <b>£</b>         | <b>£</b>         |
| Cash held for projects overseas | 1,244,864        | 1,451,552        |
| Bank and cash                   | 2,045,873        | 1,769,142        |
|                                 | -----            | -----            |
|                                 | <b>3,290,737</b> | <b>3,220,694</b> |
|                                 | =====            | =====            |

**12 CREDITORS' Amounts falling due within one year**

|                         | <b>2012</b>      | <b>2011</b>    |
|-------------------------|------------------|----------------|
|                         | <b>£</b>         | <b>£</b>       |
| Project creditors       | 510,561          | 95,581         |
| Tax and Social Security | 21,073           | 17,551         |
| Other creditors         | 185,028          | 155,861        |
| Accruals                | 40,264           | 58,973         |
| Deferred Income         | 381,809          | 526,480        |
|                         | -----            | -----          |
|                         | <b>1,138,735</b> | <b>854,447</b> |
|                         | =====            | =====          |

**Deferred income' movement in year**

|                         | <b>2012</b>    | <b>2011</b>    |
|-------------------------|----------------|----------------|
|                         | <b>£</b>       | <b>£</b>       |
| Balance Brought Forward | 526,480        | 1,198,969      |
| Released to Income      | (526,480)      | (1,198,969)    |
| Received in Year        | 381,809        | 526,480        |
|                         | -----          | -----          |
| Balance Carried Forward | <b>381,809</b> | <b>526,480</b> |
|                         | =====          | =====          |

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

|                              | <b>2012</b> | <b>2011</b> |
|------------------------------|-------------|-------------|
|                              | <b>£</b>    | <b>£</b>    |
| Expiry date                  |             |             |
| - between two and five years |             |             |
| plant and machinery          | 3,139       | 3,139       |
| other - office               | 30,000      | 30,000      |
|                              | =====       | =====       |

**15 ANALYSIS OF NET ASSETS BETWEEN FUNDS**

|                                                   | <b>Unrestricted</b> | <b>Restricted</b> | <b>Total</b>     |
|---------------------------------------------------|---------------------|-------------------|------------------|
|                                                   | <b>Funds</b>        | <b>Funds</b>      | <b>Funds</b>     |
|                                                   | <b>£</b>            | <b>£</b>          | <b>£</b>         |
| Fund balances at 31 March 2012 are represented by |                     |                   |                  |
| Current assets                                    | 854,184             | 4,004,611         | 4,858,795        |
| Current liabilities                               | (213,197)           | (925,538)         | (1,138,735)      |
|                                                   | -----               | -----             | -----            |
| Total Net Assets                                  | <b>640,987</b>      | <b>3,079,073</b>  | <b>3,720,060</b> |
|                                                   | =====               | =====             | =====            |

**HEALTH LIMITED  
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**NOTES TO THE FINANCIAL STATEMENTS**

**16. STATEMENT OF FUNDS**

|                               | <b>Funds at<br/>2011<br/>£</b> | <b>Income<br/>£</b> | <b>Expenditure<br/>£</b> | <b>Funds at<br/>2012<br/>£</b> |
|-------------------------------|--------------------------------|---------------------|--------------------------|--------------------------------|
| <b>Restricted Funds</b>       |                                |                     |                          |                                |
| Somaliland                    | 441,659                        | 1,785,960           | 1,855,055                | <b>372,564</b>                 |
| Rwanda                        | - 63,053                       | 290,515             | 104,102                  | <b>123,360</b>                 |
| Ethiopia                      | 226,831                        | 102,706             | 242,939                  | <b>86,598</b>                  |
| Namibia                       | 16,272                         | 170,434             | 167,936                  | <b>18,770</b>                  |
| Sierra Leone                  | 77,773                         | 339,974             | 356,055                  | <b>61,692</b>                  |
| Kenya                         | 11,658                         | 349,791             | 19,909                   | <b>341,540</b>                 |
| Cambodia                      | 201,901                        | 1,045,219           | 1,021,272                | <b>225,848</b>                 |
| Laos                          | 275,042                        | 800,124             | 914,237                  | <b>160,929</b>                 |
| Guatemala                     | 1,742                          | 325                 | 7,015                    | ( <b>4,948</b> )               |
| Peru                          | 1,663                          | 111,194             | 111,763                  | <b>1,094</b>                   |
| Nicaragua                     | - 92,750                       | 55,196              | 26,507                   | ( <b>64,061</b> )              |
| Burma&China                   | 890,730                        | 3,623,203           | 2,918,783                | <b>1,595,150</b>               |
| Global                        | 664,491                        | 129,285             | 633,239                  | <b>160,537</b>                 |
|                               | -----                          | -----               | -----                    | -----                          |
| <b>Total restricted funds</b> | <b>2,653,959</b>               | <b>8,803,926</b>    | <b>8,378,812</b>         | <b>3,079,073</b>               |
| <b>Unrestricted funds</b>     | 452,539                        | 591,785             | 403,337                  | <b>640,987</b>                 |
|                               | -----                          | -----               | -----                    | -----                          |
| <b>Total Funds</b>            | <b>3,106,498</b>               | <b>9,395,711</b>    | <b>8,782,149</b>         | <b>3,720,060</b>               |
|                               | -----                          | -----               | -----                    | -----                          |

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

**HEALTH LIMITED  
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**NOTES TO THE FINANCIAL STATEMENTS**

**16. STATEMENT OF FUNDS Continued**

**Oxfam Novib Fund balances as at 31 March 2012 (Restricted Funds) included Statement of Funds**

|                                                   | £             |
|---------------------------------------------------|---------------|
| Balance B/F                                       | 69,831        |
| Income                                            | 17,950        |
| Expenditure                                       | 66,764        |
|                                                   | -----         |
| <b>Oxfam Novib Fund balances at 31 March 2012</b> | <b>21,017</b> |
|                                                   | -----         |

**DFID CSCF funding in 2011-12**

|           | <b>DFID CSCF<br/>Receipts</b> | <b>DFID CSCF<br/>Expenditure</b> |
|-----------|-------------------------------|----------------------------------|
| CSCF 0432 | 123,360                       | 123,360                          |
| CSCF 0522 | 145,156                       | 160,598                          |
| CSCF 0545 | 92,189                        | 91,017                           |

**DFID Burma PHC Programme**

| <b>Receipts</b> | <b>Expenditure</b> |
|-----------------|--------------------|
| 921,175         | 944,718            |

**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 £94,000 to Health Poverty Action.