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CONTENTS

1.1.	Foreword	4
1.2.	Manifesto	5
2.1.	Highlights and key data	6
2.2.	Strategy, vision, mission	10
2.2.1.	Mental Health and Psychosocial Support	11
2.3.	Our achievements in 2018	13
2.4.	Our programs in 2018	14
2.4.1.	Program quality and monitoring	26
2.5.	Research and Program Development	28
2.6.	Report of the Board of Directors - Financial policy and financial results	31
2.7.	Governance	33
2.8.	Communication with our stakeholders	38
2.8.1.	Our donors and partners	39
2.8.2.	Relevant networks	42
2.8.3.	List of research publications 2018	43
2.9.	Risks management	44
2.10.	Outlook 2019	45
3.	Financial statements 2018	46

1.1. Foreword

HealthNet TPO has offered an integrated approach to health, including mental health and psychosocial support, since its inception in 1992.

We have unique capabilities and a tremendous track-record.
Our teams and people operate in areas of significant risks: conflict, terrorism. Tragically, in 2018, we lost 3 valued team members in Afghanistan, due to a road accident and an attack on an election facility. Our colleagues are remembered for their courage and determination to serve people in need.

In 2018, we increased the number of projects implemented, thus reaching more people in need in fragile countries. We are the trusted implementation partner of several United Nations organisations, World Health Organisation, European Union, NL Ministry of Foreign Affairs and many others.

There is an increasing recognition from governments and multilateral organisations for the need for an integrated approach to prevent conflicts and improve safety in fragile countries. Poverty, conflict, terrorism, climate change, population growth and migration are interlinked.

An integrated approach will help to create opportunities for people to have a future with employment, health, education, equal opportunities and safety.
Part of this integrated approach is more attention for people who need mental health and psycho-social support to process their traumas and improve their wellbeing.

Early 2019, after extensive engagement and evaluation, we decided to revert from Health Works to the name HealthNet TPO. The key reason being that the country teams had increasingly concerns about their safety, as they are widely known as HealthNet TPO in the field. Thus, in this Annual Report, we refer to this organisation as HealthNet TPO.

For 2019 we continue to work on strengthening the organisation and its capabilities, so we can reach more people with our effective and scientifically proven interventions, and thus contribute to a more stable world.

Carin Beumer
Chair of the Board of Directors
HealthNet TPO

1.2. Manifesto

Yes, there has been a worldwide improvement in poverty reduction. Yes, people are getting healthier and, yes, they have better access to public services. But no, this does not include everyone!

There is one group left out, losing out, and even being pushed out. Billions of people at the bottom are excluded from such developments; they are 'disconnected' from all public services or basic security. Almost half of the world's population (45%) live on less than $4 per day. 10% survive on less than half of that. That's not just poverty, it's a brutal obscenity, a social problem, a security issue, and a moral disgrace.

We don't do charity. For 25 years we have been working with people in communities where the violence goes beyond weapons and visible repression. Where malnourished children have no chance to develop their natural potentials, and illegal abortions are safer than giving birth.

We have a deep understanding of how being 'disconnected' destroys the foundation of any society: trust and minimum confidence. We gain people's trust and help them to change their fate. We know health is not just the absence of disease, but an essential condition for a satisfying life.

Health is much more than health care. Health is about cure and care. Health is the opposite of illness, and individuals cannot be healed in a sick society. Health is required for building communities that enable a secure and safe life. We use health as an entry point into the worst situations.

We build health systems and provide health care, but any lasting effect must be built on healing the communities: health is a condition for change and working on change makes people healthy. We leave no one out. Our approach is aimed at the entire community. We identify the most competent and daring agents of change – usually young women – and work with them on change. Health is the driver, but integration makes it happen.

By working together on health, we re-connect individuals and groups. Old relationships are rediscovered, new ones are forged – and communities are mobilized against repression and exclusion. Together, we connect by building new trust and empathy.

Every day we prove that stronger relationships have a tangible, measurable positive impact on the health and well-being of everyone, everywhere. No one is excluded, no one is 'disconnected'!

2.1. Highlights and key data

In 2018, the field and the Amsterdam support office submitted substantial, multi-year project proposals with several institutional donors for all our project countries.

In Afghanistan, HealthNet TPO acquired the contracts for the Basic Package of Health Services and Essential Package of Hospital Services in the provinces of Kunar and Laghman and the Essential Package of Hospital Services in Nangarhar.

In Burundi, we submitted and acquired a three-year project "Resilience in Health" funded by the European Union.

In South Sudan, we submitted and acquired three new contracts as lead implementing partner, and one contract as subcontractor under the umbrella of the Health Pooled Fund.

As such, thanks to the hard work of our teams in the field and with the support of the office in Amsterdam, we have laid out a sound basis for the continuity of the organization for the coming years[...] .

In our efforts to decrease our overhead costs, we restructured the support office in Amsterdam with 5.8 fte, which leaves a total of 12,5 fte at the end of December 2018.

It was painful to say goodbye to valued colleagues as we streamlined our organization, but we realized this was necessary to return to a financial situation that will allow us to continue our work into the future. Further restructuring will take place in 2019, coinciding with a reorientation of the role of the Amsterdam support office.

For HealthNet TPO, 2018 was also a year of intensive collaboration. To be able to deliver programs with high quality, efficiency and scale, partnerships are essential for the future of our work.

In 2018, we sought out a single partner, potentially for merger, a partner with whom we shared the same basic values. This intensive process, which started as early as February 2018 and lasted until November, did unfortunately not materialize. We will continue our efforts to find new partners in 2019.

Key developments in our project countries

In **Afghanistan** over the past year, suicide attacks, airstrikes and pervasive threats to life, security and well-being have plunged the Afghan people into a deepening protection crisis.

Almost two-thirds of the Afghan population live in areas directly affected by conflict, many of them frequently exposed to violations of international humanitarian and human rights law, including the deliberate targeting of civilian infrastructure.

Population flows are now a permanent feature of the crisis, impacting the displaced and host communities alike, in turn compromising access to essential services.

At the same time, a severe drought has left up to 3.9 million people in rural parts of the country in need of emergency food and livelihoods assistance and sparked a significant displacement crisis in the Western region.
(source: Hum. Needs overview 2019)

Despite a significant improvement of the humanitarian situation in **Burundi**, just over 1.9 million people are affected by climate hazards, food insecurity, malnutrition, socio-economic background favorable or limited access to basic goods and services.

Among them, 1.77 million people need humanitarian assistance, twice as much as in 2018. This increase is mainly attributed to the 2017-2018 farming seasons as they were more efficient than in previous years, the absence of any form of epidemic for most of the year 2018, the reduction of security incidents recorded in the country as well as a slow, but still insufficient recovery of the economy. These factors have among other things, contributed to the return of more than 55,000 Burundian refugees mostly from Tanzania, as well as the decrease of more than 20% of the number of internally displaced people in the last 12 months.

The situation remains fragile though. In 2019, climatic factors such as the El Niño phenomenon, unfavorable socio-economic conditions or risks of epidemics such as cholera and malaria could contribute to increasing the vulnerability of certain populations. (source: Hum. Needs overview 2019)

In **Colombia** in 2018, in a change from earlier years, the humanitarian impact due to a convergence of emergencies related to the conflict, an increase in armed violence, and the occurrence of natural and man-made disasters, resulted in more than 5.1 million people in need in different sectors and regions of Colombia.

The regions of greatest concentration of humanitarian impact included the Northeastern border with Venezuela, the Southern border with Ecuador and the Pacific coast bordering Panama, as well as the Northwest region. As a result, a total of 268 municipalities were prioritized. This prioritization increases the visibility of needs for assistance and strengthening of humanitarian actors and protection and the need for

maintaining coordination spaces active in complementarity with the State. The persistence of armed actions and attacks against civilians continues to leave victims, along with human rights violations, resulting in humanitarian emergencies.

One of the major challenges of the new administration is to take measures and implement effective strategies in the areas of prevention, protection and durable solutions by the State for vulnerable populations.

(source: Hum. Needs overview 2019)

In **South Sudan**, even with the advent of the revitalized peace agreement in late 2018 and the promise of better times to come, the cumulative effects of the conflict have translated to sustained poverty and persistent humanitarian as well as protection needs for more than 7 million people in South Sudan.

This is particularly the case in the Equatorias, Western Bahr el Ghazal, Jonglei, Upper Nile and Unity, where drivers and multipliers of crisis have remained present over time.

These include insecurity and violence, local and intercommunal conflicts, ongoing displacement, sparse basic services, disease, climate shocks, economic instability and insecure access to food and livelihoods.

Yet, prospects for peace and development may improve and begin to generate some confidence for durable solutions, including returns, relocations or local integrations, although their scope, scale and flows remain difficult to project.

In 2018, the conflict continued to force people to remain on the move and undermine their access to assistance. Almost 4.2 million people have been displaced, often more than once, including nearly 2.2 million in neighboring countries and nearly 2 million internally.

(source: Hum. Needs overview 2019)

2.2. Strategy, vision and mission

Our vision: HealthNet TPO strives for a world in which people in fragile and conflict settings can actively contribute in rebuilding their own lives, health and wellbeing.

Our mission: building trust through health initiatives that lead to social inclusion and improved health and wellbeing.

HealthNet TPO builds healthy communities with people who have been abandoned. Marginalization, increasingly defined as 'expulsion' to better understand socioeconomic and environmental processes that go beyond simply poverty and injustice, happens when people are displaced, fleeing from violence and obscene poverty. Expulsion also happens to people who are not going anywhere – because they have no means to get out of a hopeless situation.

Coming from a healthcare background, HealthNet TPO found that improving health in extremely fragile situations requires a social – and not only medical – approach. HealthNet TPO developed a way to identify capacity and resources in fragile populations. People excluded from public services and any realistic development perspective have often lost the use of their own communal resources for change. These are hidden in the damaged social fabric of the community.

HealthNet TPO engages the whole community in a process of identifying local problems, the sometimes-hidden local resources, and local change agents. The latter, often young women, start tackling immediate and urgent problems as defined by people themselves. This starts a community dynamic that reunites people, strengthens social bonds, and restores healing relationships.

HealthNet TPO does this successfully based on cultural knowledge and therapeutic skills. We help to build new resources where needed. Healthcare is an outcome of a functioning community. HealthNet TPO builds healthy communities. HealthNet TPO studies the efficacy and efficiency of its work and publishes the results of its approach in peer-reviewed journals.

What we do

Core of our strategy is improving health in fragile settings through inclusive development. HealthNet TPO will address the social determinant for health.

The strategy focuses on factors that support human health and wellbeing, rather than factors that cause disease. HealthNet TPO's track record is in working with the most vulnerable people in fragile states. Public services such as health and education are often beyond reach in fragile settings.

Providing access to these services implies contributing to building public service provision systems. Working on the construction of these systems is part of an approach that precedes straightforward service provision.

Enabling people to rebuild social relations and 'mobilize resilience' helps families and groups to improve their own health and education, and sets up the common ground that is a condition for effective social services.

The experience HealthNet TPO has in working on Universal Health Coverage, inclusion of human rights, using a multisectoral approach based on evidence, is guiding for the programs and projects that will be developed in the coming years.

HealthNet TPO thus contributes to the 'Comprehensive Approach to Human Security', the social inclusion agenda in the Sustainable Development Goals and the World Health Organisation Comprehensive Mental Health Action Plan as adopted by the World Health Assembly in 2013.

Social inclusion and better health are achieved through a special approach in Sexual and Reproductive Health and Rights (SRHR) programmes, gender-based violence (GBV), mental health and access to basic health and social services for the most vulnerable populations (Health Systems Development).

2.2.1. Mental Health and Psychosocial Support

The mental wounds of war and conflict are most of the time less noticeable and detectable than the destruction of homes. However, it often takes far longer to recover from mental impact than to overcome material losses. Mental health and psychosocial disabilities can present significant barriers when it comes to rebuilding both individual and family life, as well as communities and societies as a whole.

Although mental health has been rarely seen as a priority when it comes to health in fragile states in the past, it is now increasingly recognized by countries, international humanitarian and development agencies.

A recent systematic review by World Health Organisation revealed new prevalence estimates of mental disorders in conflict setting to be 22.1 % at any point in time in the assessed conflict-affected populations.[1]

This reiterates that there is an urgent need to implement scalable mental health interventions throughout fragile settings. When health professionals talk about 'mental health and psychosocial support' (MHPSS), they refer to any kind of local or external support that aims to prevent or take care of mental disorders but also to the support that protect or promote psychosocial wellbeing.

[1] Fiona Charlson, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, Shekhar Saxena, 2019. New WHO prevalence estimates of mental disorders inconflict settings: a systematic review and meta-analysis. The Lancet: http://dx.doi.org/10.1016/S0140-6736(19)30934-1

HealthNet TPO’s long standing experience in mental health and psychosocial support in fragile settings has shown that there is not one size fits all solution and that it is important not to describe a whole population as “traumatized”.

Most people cope with difficult experiences and may become even more resilient provided that a safe environment has been re-established. Others are more vulnerable to distress, especially those who have lost, or been separated from, family members, or who are survivors of violence.

HealthNet TPO considers MHPSS services not to be a ‘stand alone' sector. In addition, its programmes address mental health as well as psychosocial problems in a combined approach. HealthNet TPO integrates MHPSS services into their broader community and health programmes in Afghanistan, South Sudan and Burundi.

As psychosocial problems may lead to the onset of mental disorders, such as depression and anxiety disorders, a reduction of psychosocial problems and stressors is therefore a focus in our programmes, to prevent the onset of mental disorders.

HealthNet TPO strengthens the community-based psychosocial support mechanism in order to make best use of existing resources at community level for many MHPSS problems and to facilitate referrals for various social and clinical mental health services – if needed.

Within the framework of the MHPSS activities, HealthNet TPO aims to revive and strengthen family and community support systems, promote positive coping mechanisms and change people into active survivors rather than passive victims. In addition, HealthNet TPO aims to build knowledge in health systems on mental health, working with governments, local health authorities and local health providers.

The programmes seek to raise awareness on the necessity of integrating mental health treatments into primary health care. HealthNet TPO supports governments in implementing their mental health policies in health systems approaches.

2.3. Our Achievements in 2018

In 2018 we have reached a total of 3.4 million beneficiaries by implementing 40 projects in 5 countries: Afghanistan, Burundi, Colombia, Lesotho and South Sudan.

A more detailed description of our results per project country are described in Chapter 2.4: Our Programmes in 2018.

Our financial results are specified in Chapter 2.6: Financial Policy and Results.

2.4. Our Programs in 2018

AFGHANISTAN

- Total population: 35.7 million
- Population affected by conflict: 17 million people live in the 106 highest conflict-affected districts. 6.3 million people have acute humanitarian needs
- Number of HealthNet TPO projects in 2018: 25
- Number of implementing partner organizations: 4
- Number of institutional partners providing funding: 11
- Number of beneficiaries in 2018: 2,490,539

WHY WE ARE HERE

Afghanistan is facing a complex chronic security situation for the last 40 years which has worsened during the last few years. Civilian casualties are at their highest since 2002, with an unprecedented level of conflict-induced displacement. Since 2007, the number of injuries and deaths has increased five-fold, and in 2016 and 2017, more than 1.1 million Afghans were internally displaced due to conflict.

At the end of 2018 there are signs of a peace process, but the humanitarian crisis is still as present as ever. The return of almost 1.7 million Afghan refugees, primarily from Pakistan and Iran during 2016-2017 remains a huge pressure on the country's economy and institutions. Internal displacement and large-scale return within a difficult economic and security context poses risks to welfare,

not only for the displaced, but also for host communities and the population at large, putting pressure on service delivery systems and increasing competition for already scarce public services and economic opportunities. Access to essential services in health care and the quality of healthcare services are still lacking behind. Ongoing drought in many provinces affect around 4 million people with widespread malnutrition amongst children. (World bank)

WHAT WE DO

HealthNet TPO is an active partner of the Ministry of Public Health in providing and supporting health care, nutrition, mental health, psychosocial services, health promotion, gender, women empowerment, elimination of violence against women, control of communicable diseases, and capacity building healthcare providers since 1992. Apart from being a service provider, we have developed curricula and innovative approaches that were accredited and integrated into the healthcare system of Afghanistan.

We take part in many working groups of the Ministry of Public Health and work on increasing access to quality health services. Our implementation approaches consist of enabling communities, ensuring participation, professional capacity building and evidence-based decision making. An integrated approach to healthcare improves the well-being of the Afghan population.

OUR PROJECTS

Hospital services

In 2018, HealthNet TPO delivered hospital services through Nangarhar Regional Hospital (NRH) and Paktia Provincial Hospital (PPH). The NRH is a hospital providing high-quality tertiary healthcare services for the population of the four eastern provinces and emergency care for many victims from traffic accidents on the main highway. In these 2 hospitals of 568 and 105 beds respectively, we provided a range of services such as general surgery, orthopedic surgery, neurosurgery, ophthalmology, gynecology/ obstetric, pediatrics, internal medicine, dermatology and dentistry.

Primary healthcare services

HealthNet TPO continued the implementation of the Kabul Urban Health project which consists in improving the access to and utilization of primary and secondary healthcare services through proper availability and quality of health services in 47 Kabul urban health facilities. These are 11 Basic Health Centers, 32 Comprehensive Health Centers and 3 District Hospitals. 4,227,261 people of Kabul province benefited either directly or indirectly. We also increased the access of nomadic population (Kuchis's) to primary healthcare services by provision of healthcare services to nomads through 15 mobile health teams in 12 provinces of the country.

We provided essential reproductive, maternal, newborn, child health services to underserved population of Herat and Ghor provinces through 7 active family health houses and 2 mobile health teams.

Life-saving Emergency Health, Nutrition and Protection Services

HealthNet TPO, with funding from UNOCHA, provided emergency primary health, nutrition, and protection services to people living in remote and hard to reach areas (internally displaced persons due to conflict or drought, refugees, underserved population). We ran 26 mobile health and nutrition teams, 2 family protection centers, 3 first aid trauma posts, and one static clinic in Kunduz, Urozgan, Laghman, Herat, Ghor and Khost provinces.

We provided services to 245,640 individuals, antenatal care to 11,163 pregnant women, postnatal care to 6,184 women, vaccination to 4,320 children and 3,365 women, nutrition to 60,599 children and 2,658 women, managed 7,008 gender-based violence cases, and 21,935 children received psychosocial support.

In addition, we provided basic and reproductive health, as well as psychosocial services to returnees and deportees from Pakistan and Iran and to drought-affected internally displaced persons in Kandahar and Herat provinces through 3 mobile health teams, zero-point clinic, and transaction centers.

Communicable Diseases Treatment and Control

HealthNet TPO is one of the sub-recipients of the Global Fund fighting Aids Tuberculosis and Malaria for their tuberculosis program in Afghanistan. 2,630 patients directly benefited from this project. Through this project, we improved access to tuberculosis care and control services, for example, quality of laboratory services. We also improved management in all health facilities of the targeted provinces, such as active case finding management of pediatric tuberculosis cases, and reduced stigma associated with the tuberculosis.

Mental Health and Psychosocial care

HealthNet TPO continued its support to the Kabul Mental Health Hospital until mid-2018 through the implementation of strengthening the provision of quality mental health care by increasing the access, coverage, utilization and quality of mental health care services. The number of patients treated increased by 20% on average. We provided refresher training to 216 psychosocial counselors in 3 regions: Kabul, Mazar and Heart. 51 students enrolled in the one-year psychosocial training program, so as did 51 medical doctors and 2 provincial mental health focal points. 89 midwives were also trained on working at comprehensive health centers on basic mental health services.

Health Sector Response to Gender-Based Violence

HealthNet TPO has been implementing a “health sector response to gender-based violence” project since 2016. In 2018, we provided services through 8 Family Protection Centers (FPS) located in Farah, Herat, Kandahar, Parwan, Kapisa, Paktia, and Nangarhar provinces. 6,005 gender-based violence cases were registered and as a result, medical and psychosocial counseling services were provided. We organized 26 community dialogues with religious leaders, community elders, health shura members and women shura members. 269 healthcare providers were trained on gender-based violence procedures and psychosocial counseling.

Eye care

Funded by the Fred Hollows Foundation, HealthNet TPO has been implementing an “eye system integration in Afghanistan”project since November 2016. In 2018, we conducted a rapid assessment of avoidable blindness survey in Kabul. As a result, we tested the vision of 114,198 students, provided 1,742 spectacles to needy school students, supported 2,104 cataract surgeries performed by eye outreach camps and Kabul Medical University Eye Hospital as well as trained 130 school teachers on vision testing.

Public Private Partnerships

This innovative approach was implemented for the first time by HealthNet TPO in 2008 to improve access of the community to health services in areas highly volatile and insecure. We train and support staff of private health facilities to provide a range of health services to the population free of charge. In 2018, we provided reproductive health, vaccinations and basic health services through 60 private health facilities in Paktia province. Out of the 82 852 visiting the clinics, 2,967 children and 1,595 women (including pregnant women) received vaccination and 3,552 women received reproductive health services.

Capacity Building of Healthcare Providers

HealthNet TPO implemented a children vaccination program, funded by the World Health Organization in partnership with local health workers and school teachers. Awareness programs were developed in 20 provinces of the country. We trained 2,768 health workers and 2,501 school teachers to implement the developed tools as well as 324 nurses/midwives working on health facilities on emergency counseling and 791 community health workers and community health supervisors on psychological first aid in 17 provinces. Furthermore, we provided training to 35 community midwives through the Ministry of Public Health standard two-year community midwifery education program in Herat province.

BURUNDI

- Total population: 11.8 million
- Population affected by conflict: 1.77 million people have humanitarian needs
- Number of HealthNet TPO projects in 2018: 3
- Number of implementing partner organizations: 2
- Number of institutional partners providing funding: 3
- Number of beneficiaries in 2018: 358, 944

WHY WE ARE HERE

Burundi is one of the poorest countries in the world: close to 74.7% of its population live below the poverty line. It is also the second most densely populated country in Africa with about 470 inhabitants per square kilometer. Burundi's economy is heavily reliant on the agricultural sector which, despite the extreme paucity of arable land, employs 80% of the population. Poverty overwhelmingly affects small rural farmers. The reelection of President Pierre Nkurunziza in 2015, however, triggered a political crisis that claimed hundreds of lives and sent tens of thousands of Burundians into exile.

Burundi's efforts at poverty reduction are constrained by a myriad of challenges, such as a weak rural economy; a heavy reliance on development aid, economic policy that does not allow for the equitable distribution of resources; vulnerability to environmental events; and strong population growth. The only positive trend is the fertility rate, which decreased from an average of 6.4 to 5.5 children per woman between 2010 and 2017. (World Bank).

WHAT WE DO

HealthNet TPO has been working in Burundi towards children and adolescents, by providing psychosocial assistance to young refugees from the Democratic Republic of Congo in the transit camps. Regarding women, HealthNet TPO worked on improving the economic empowerment of survivors of sexual and gender-based violence(SGBV). More than 344 women have seen their incomes increased and they became able to cover the main essential needs of their family.

OUR PROJECTS

PAPAB Project

Through a digital system, farmers living in remote areas could improve their financial development by taking part in a social and financial platform.
In addition to it, a specific community strengthening approach was used, groups of 50 families (G50) were brought together and equipped with tablets, computer software, internet connections to enable them to set up bank accounts and access credit schemes. 223.030 farmers were registered in the database and they constituted of 2200 G50-groups.

The project has also strengthened the capacity of 110.000 farmers in family planning, improvement of social skills as well as managing their own revenues and expenses.

World Bank Project

A guideline was set up to develop a saving and loan system for survivors of sexual and gender-based violence. The project has been implemented in 3 provinces: Cibitoke, Makamba and Muyinga. Trainings were provided on sexual and reproductive health and other topics related to sexual and gender-based violence, for instance management of conflicts.

344 groups have been established and they managed in the period from October to December to save about € 2000. 4300 survivors of SGBV received training on how to set up and manage a small business. They have been linked up with micro finance groups to apply for credits.

UNICEF Project

The project “Ndisanze" provided access to essential services for the protection and psychosocial support of Congolese refugees and vulnerable children and adolescents in the host communities of the communes Rumonge and Nyanza Lac. The project funded by UNICEF was implemented together with War Child Holland. The main objective of the project was to offer protection to the children through psychosocial activities, information about their health and rights, sensitization against violence, individual and family counseling to children suffering from trauma. 3765 children have been registered in the child friendly spaces. We held 75 group meetings with a psychosocial assistant and 107 sensitization sessions.

Out of 363 children and adolescents who showed signs of depression, 43 were referred for treatment, 9 received legal support and 22 received health care services.

COLOMBIA

- Total population: 49 million
- Population affected by conflict: 16.9% of the population direct victims of war
- Number of HealthNet TPO projects in 2018: 1
- Number of implementing partner organizations: 1
- Number of institutional partners providing funding: 1
- Number of beneficiaries in 2018: 1,083 direct beneficiaries + 351 families actively participating in community networks (1,700 individuals). Adding up to a total of 2,783.

WHY WE ARE HERE

In 2016, Colombia’s government signed a peace agreement with the FARC, marking an end to more than 50 years of civil war. An estimated 220,000 people died because of the conflict and more than five million civilians were forced to leave their homes. Despite the significance of the deal and the ceasefire agreement, Colombia is far from being at peace. Negotiations with the ELN have come to a halt and people continue to face risks and threats to their safety due to the ongoing violence perpetrated by various armed groups. According to Washington Office on Latin America, 123 human rights defenders and social leaders from indigenous and Afro-Colombian communities were assassinated in 2018.

Women and girls have had to bear the brunt of instability. Sexual and gender-based violence is still highly prevalent across territories in the form of abuse and/or physical violence. 2017 was recorded as the year with the highest incidence of sexual violence with an estimated 23,798 cases, representing an increase of 11% compared to 2016[1]. The climate of insecurity and political instability combined with a culture of impunity and patriarchal values constitutes a real challenge for women to access truth, justice, reparation and guarantees of non-repetition. Confronted with a damaged social fabric, women are still facing barriers for their equal participation and inclusion in the peace process and within their communities.

WHAT WE DO/OUR PROJECT

Following UN Security's Council's resolution 1325 calling for women's engagement in conflict resolution and peacebuilding, HealthNet TPO formed a consortium in 2016 with two other Dutch organizations, ICCO Cooperation and Mensen met een Missie for the project Women as Central Agents for Peacebuilding in Colombia'. We partnered up with LIMPAL, the sectional branch of the Women’s International League for Peace and Freedom, with the aim to change beliefs, values and norms in favor of women rights and promotion of equal participation.

Through concrete activities focused on community strengthening, conflict reduction, women’s empowerment, social inclusion, and psychosocial support, we aim to contribute to an environment where women and girls feel better protected, have increased awareness of their rights and have the appropriate tools to increase their political participation.

[1] Children Change Colombia (UK charity): http://www.medicinalegal.gov.co/documents/20143/262076/Forensis+2017+pdf+interactivo.pdf/e3786e81-8718-b8d5-2731-55758c8ac7ff

Women play an essential role in reconciliation processes. That is why one of the main components of the program focuses on psychosocial and emotional recuperation for women survivors of violence. LIMPAL has trained female facilitators in the provinces of Bolivar and Meta whose role is to empower women and their communities, promote the participation of men and young people and contribute to decreasing harmful gender norms.

In 2018, facilitators mobilized 351 families who have actively participated in community networks aiming at working together in reconciliation and peace building processes. As such, women are playing a central role in reactivating social ties and reconstructing the damaged social fabric that affected their communities.

LESOTHO

- Total population: 2.23 million
- Number of HealthNet TPO projects in 2018: 1
- Number of implementing partner organizations: 1
- Number of institutional partners providing funding: 1

WHAT WE DO/OUR PROJECT

The Lesotho Health Sector Performance Enhancement, funded by the World Bank became effective in February 2014 and was supported by a team formed by HealthNet TPO and 4 Medical Care Development International employees along with a Project Coordinator. The Performance Based Financing consisted of rewarding health facilities based on an agreed upon set of measurements. After piloting the project in Quthing and Leribe Districts, it was scaled up in July 2016 to four other districts: Mokhotlong, Thaba Tseka, Mafeteng and Mohale's Hoek. Medical Care Development International and HealthNet TPO worked together to provide technical assistance at central, district and community level: building capacity of key Ministry of Health officers, data verification of service delivery, contracting Community Based Organizations for quarterly client tracing and satisfaction surveys, performance payments of incentivized services as well as coaching health facilities in implementing the approach.

The model agreement was scaled up to four additional districts of Qacha's Nek, Beria, Butha-Buthe and Maseru at the end 2018. Early February 2018, a field visit to Lesotho was conducted, with visits to Mafeteng and Leribe districts, the Ministry of Health and health facilities. The Performance Based Financing promotes the Ministry of Health's ownership of programming and quality improvement. In September 2018, our joined venture with Medical Care Development International ended and the Ministry of Health took the steering role which finally will lead to the complete ownership of the Performance Based Finance program for Lesotho.

SOUTH SUDAN

- Total population: 12.4 million
- Number of HealthNet TPO projects in 2018: 10
- Number of implementing partner organizations: 7
- Number of institutional partners providing funding: 8
- Number of beneficiaries: 514.796

WHY WE ARE HERE

The Republic of South Sudan became the world's newest nation in July 2011. As a new country, South Sudan has the immense challenge of recovering from more than 50 years of war and continued instability. Despite the signing of the revitalized peace agreement in September 2018, opposition groups are still actively fighting in some parts of the country. The security situation therefore remains fragile and volatile. Years of protracted conflict and displacements, rights abuses, widespread violence – including sexual and gender-based violence – and sustained economic decline have diminished the capacity of people to face threats to their health, safety and livelihoods. Due to such harsh conditions, the number of people needing humanitarian assistance is estimated to be 7.1 million, representing over half the population.

WHAT WE DO

Since 1995, HealthNet TPO has been operational in South Sudan providing primary health care, hospital-based medical services and services for the prevention of malaria, HIV/AIDs, mental health and psychosocial problems, as well as sexual and gender-based violence. Our programs are designed to strengthen national health systems and to build the resilience of community systems.

These are developed in collaboration with local government authorities and through the active involvement of community-based leaders and structures. This approach allows us to tailor our services by directly addressing the needs identified by the population and to gain the trust of the communities we aim to serve.

OUR PROJECTS

Access to healthcare and illness prevention

Since 2016 and throughout 2018, we provided essential primary healthcare services and hospital services in five counties: Wau, Jur River, Aweil North, Aweil West and Raja. In addition to basic health services, in 2018 our health facilities offered maternal and child healthcare reaching 686,789 curative consultations, 6,696 deliveries with skilled birth attendants, while 29,589 and 13,455 pregnant mothers came for antenatal care 1st and 4th visits services respectively.

We also provided nutrition support to 7,198 malnourished children, family planning and community-based health promotion and also 17,671 children aged 0-11 months received immunization with Diphtheria-tetanus-pertussis.

In the county of Aweil, we implemented a program for women of reproductive age living with or at

risk of HIV/Aids to maintain their health and prevent their infants from acquiring the disease: as a result, 7,635 males and females were reached with awareness messages. In 2018, we distributed 432,552 long-lasting insecticides treated nets in ten counties of former Western Equatoria to curb the widespread risk of malaria.

Additionally, we facilitated clinical services in the town of Mundri to patients afflicted with nodding syndrome – a rare and neglected autoimmune disease found in South Sudan,Tanzania and Northern Uganda.

Prevention of sexual and gender-based violence

As a signatory of the Dutch National Action Plan for Women, Peace and Security, HealthNet TPO provided training on sexual and gender-based violence and psychosocial support to staff and community volunteers in the towns of Nimule, Torit and Ganyiel. Through on-site coaching and individual/group supervision, community members improved their knowledge on mental health distress and gained the tools for building a community-based support mechanism for women and girls.

In addition, we successfully established women and girls' friendly spaces in Raja county. Village chiefs, youth members, women associations, churches, mosques, school teachers and health workers were oriented on the impact of sexual and gender-based violence and coping strategies for psychosocial problems. Women from the community were directly in charge of building and running the spaces as well as selecting and implementing livelihood projects such as running restaurants, tea shops and goat-keeping.

Institutional capacity building

The capacity of the Country Coordination Mechanism was strengthened through fund management support as well as training of the staff on finance, procurement and logistics.

Community mobilization

In Jur River county, we supported local government structures in terms of county planning, formation and training of community users' groups, as well as identification and prioritization of community needs. Our community engagement activities offered a platform to restore confidence among community members.

Women whom had previously been excluded from community development projects now had the opportunity to participate in their design, planning and implementation. Examples of micro-projects included digging of bore holes, clearing rural roads, the construction of primary schools and health centers.

Research

Two research-related projects were implemented in 2018. The prevalence study on nodding disease aimed at identifying the number of cases from the community and referring them to the hospital for treatment.

We also took part in a qualitative research project exploring the perspectives of researchers, NGO staff, Ministry of Health representatives and members of Ethical Review Board on the ethical conduct of research during humanitarian emergencies.

2.4.1. Program Quality and Monitoring & Evaluation

Jointly with Afghanistan, the South Sudan health programs provided a base for the enhancement of quality and standards within HealthNet TPO's service delivery in the various countries. Within this plan, the organization set up a data collection system for donor independent monitoring and evaluating of priority health indicators, follow up of activities and progress in improvements of health services.

The initial draft for a complete database based on Health Pooled Fund project collection has been presented in 2018. It remained at the stage where it required to be transformed by HealthNet TPO into the development of an online database for countries actual utilization. However, due to limited resources, this did not lead to further progress, although a similar system for only project control has been introduced.

Next, a HealthNet TPO's information platform was scheduled to be launched to provide access to guidelines, protocols and global standards for the adherence, coaching and capacity building. This focus diverted for 2018 to the annual plan's priority work on mental health and people with disability.

The systematic support for country programs by the Amsterdam head office requires guidance by a Monitoring & Evaluation framework and monthly individual program reporting (currently weekly/monthly templates) against HealthNet TPO's defined priority indicators, also by the development of each country's track record as well as strategy papers.

By taking control of the implementation, HealthNet TPO ensures its programmes are well-executed in collaboration with a locally recruited team. Indeed, monitoring and evaluation of the effectiveness and efficiency comply with the specific requirements and procedures from our various donors. The results are then reported periodically. Often, external audits are performed to verify the efficiency of expenditures or projects are evaluated as part of donors self-evaluations.

As the added value of HealthNet TPO includes the development of new intervention models, the information obtained through monitoring and evaluation is also used to improve other (future) projects and/or to support research projects. Results of research projects are then published in leading international academic journals so that they are made available to other NGOs, governments and research centers.

Apart from reporting to donors, the director of HealthNet TPO also reports to the Board of Directors on a monthly basis, with regular contacts in between. The Board of Directors monitors both the internal and external expenditures of the organization. In 2019, we will continue to improve our work on Monitoring and Evaluation.

ACTIVITIES OF THE RESEARCH AND PROGRAM DEVELOPMENT DEPARTMENT IN 2018

In the countries where HealthNet TPO is active, treatment and care for people with mental health and psychosocial issues are largely absent, especially in rural settings. To increase treatment coverage, integration of mental health services into community and primary healthcare settings is recommended (WHO Mental Health Gap Action Programme). Although this strategy is currently rolled out globally, rigorous evaluation of outcomes at each stage of the service delivery pathway (from detection for treatment to individual outcomes of care) has been missing.

The Department of Research and Program Development participates in several research consortia to develop, improve and upscale treatment and care services that are provided by our Basic Health Care centers in the different countries we are active. Research serves two purposes for HealthNet TPO. Firstly, research helps us to clearly identify the problems that our interventions need to address and important contextual factors that we need to take into account to obtain maximal results.

An example of this role of research in our work in the different countries is the development of the tool for 'participative community mapping', which facilitates the identification of local resources and practices that are present or absent in post-conflict communities.

Secondly, our research is used to test and evaluate the effectiveness of our intervention programs. This research also provides us clear insights into what works, to what extent and why, and what does not.

2.5. Research and Program Development

WHY RESEARCH AND PROGRAM DEVELOPMENT

Sexual and Reproductive Health and Rights Theory of Change

A theory of change is developed defining the vision, expected impact and outcome for Sexual and Reproductive Health and Rights (SRHR) with the three result areas of:
1. Risks reduction (preventing illness, disability and risk mitigation)
2. Response (addressing specific needs and access to tailored quality services)
3. Resilience (SRHR promotion and empowerment of vulnerable groups).
Thereafter, the output, input and inherent activities are clarified with a central approach to respond to individual life cycle needs.

In line with the Theory of Change, a number of documents to guide the process have been developed: SRHR policy and strategy, concept notes addressing diversity of topics. Mental Health and Psychosocial Support have often been delivered standalone and settled in developmental programming. Health Net TPO programs are however mostly engrained within the system of public health and also in SRHR. Therefore, the continued development and investments into the inherent quality of health service delivery, of new and up to date approaches remain vital and lead to joined, detailed topics.

Sexual and Gender-Based Violence

A summarized training on the clinical care has been developed and complemented with the required templates for documentation and the follow up. Generally, the level of SGBV programming is addressed, whereas the focus remains on components as protection,wellbeing and safety, and education on gender-based violence prevention. Working in fragile context, the public health needs seem often more dire and demand quality and complete response towards people’s addressing their urgent risks in health instantly. Country directed trainings, discussions and documents often lead to partial approaches and are often referral dependent.

Public Health - Mental, Psychosocial Support and Disability

Following the annual plan and development in 2018, the Research & Development department (technical advisors) worked to provide mental health technical support to increase qualitative global programs based on policies, guidelines and international standards, emphasizing holistic and an inclusive approach strengthening trough intersectional coordination. Core themes to achieve the annual goals, were focusing on monitoring and evaluation, good practices and on implementing selected and specific program activities and practices based on scientific evidence.

The sectors aimed to target the Mental Health Psychosocial Support and Sexual and Reproductive Health and Rights, disability, Gender-Based Violence and the strengthening of health systems. Hereby technically framing the development of programs cooperation between health and Mental Health Psychosocial Support, but as well with the interlinked areas of education, protection, livelihood, water sanitation and shelter. As for Sexual and Reproductive Health and Rights, we aim to reduce risks to disease and disability for girls, women and boys, as well as men while responding to the specific health needs, building resilience and lowering distress and at the same time empower individuals.

WHAT WE DO

As a partner from the Programme for Improving Mental Health Care (PRIME), we used a combination of methods to evaluate the impact of a district mental health- care plan for depression, psychosis, alcohol use disorder (AUD), and epilepsy in Chitwan District, Nepal[1].

TPO Nepal , PRIME collaborators and HealthNet TPO, evaluated 4 components of the service delivery chain:
(1) contact coverage of primary care mental health services, evaluated through a community study (N = 3,482) and community surveys on the service utilization (N = 727);
(2) detection of mental illness among participants visiting primary care facilities through a facility study (N = 3,627);
(3) initiation of minimally adequate treatment after diagnosis, through the same facility study; and
(4) treatment outcomes of patients receiving primary-care-based mental health services, through cohort studies (total N = 449 Depression, N = 137; AUD N = 175; Psychosis, N = 95; Epilepsy, N = 42).

[1] Plos Medicine, vol 16, 2, 1-20, e1002748.

WHAT WE FOUND

Contact coverage increased from 0% at baseline to 7.5% for AUD, from 0% at baseline to 12.2% for depression, from 1.3% at baseline to 11.7% for epilepsy, and from 3.2% at baseline to 50.2% for psychosis.
These changes of using Mental Health services were achieved over a 12 months period and community survey results did not showed significant prevalence changes over time.

Health worker detection of depression increased by 15.7% (from 8.9% to 24.6%) 6 months after training, and 10.3% (from 8.9% to 19.2%) 24 months after training; for AUD the increase was 58.9% (from 1.1% to 60.0%) and 11.0% (from 1.1% to 12.1%) for 6 months and 24 months, respectively.

Provision of minimal adequate treatment subsequent to diagnosis for depression was 93.9% at 6 months and 66.7% at 24 months; for AUD these values were 95.1% and 75.0%, respectively.

CONCLUSIONS

These combined results show that it is feasible to set up community- and primary-care-based Mental health services that are delivered through an integrated district mental healthcare system and that such a healthcare system has an evidence-based impact on reducing the treatment gap and increases effective coverage for Mental disorders.

The findings of this research contribute to the follow up of the WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health that was released recently.

2.6. Financial Policy and Financial Results in 2018

In 2018, 97.5% of total income was spent on the objectives of the organization, which is 3,5% point more than budgeted.
The policy of HealthNet TPO is to spend at least 90% of the total expenditures directly on the objectives.

The 2018 financial year ended with a loss of Euro 427,367 (budget 2018: a positive result of Euro 250,182). The main reasons for the negative balance, are the lower income (donations) from companies (budget 2018; Euro 375,000, realised; Euro 16,605) and subsidies through Institutional grants (budget 2018; Euro 14,2 million, realised; Euro 12,9 million).

The income (project volume) in Afghanistan was lower than expected because of a lower volume of projects funded through The Ministry of Health and no projects funded by USAID. Due to the lower project income, the coverage for organizational cost was Euro 259,000 below budget (budget 2018; Euro 1,2 million, realised; Euro 0,94 million). The subsidies from government grants are not of a structural nature.

Next to the mentioned lower institutional income, a reservation of Euro 50,000 for Long Term Illness had to be made which also influenced the result in 2018. The overall lower income in 2018 was partly compensated by lower expenditures for (private) fundraising efforts.

Because the prospects for donations from companies were not promising, the policy for income generation shifted during 2018 from own fundraising efforts towards securing government (institutional) subsidies. The budget for own fundraising efforts was firmly decreased (budget 2018; Euro 210,000, realised; Euro 73,690) and almost double as budgeted was spend on securing government subsidies (budget Euro 50,000, realised Euro 95,174). This resulted in a much lower income from donations and companies as indicated before, but a firm increase in the order portfolio for government grants. However, the impact of this increased order portfolio will only become visible in 2019.

In 2017, HealthNet TPO started changing the structure of the organization with the goal to reduce the operational cost of the Amsterdam head office. In 2018, this reorganization was continued, and the cost of the head office decreased with Euro 141,000 compared to 2017. Finalization of this reorganization took somewhat longer than planned and actual 2018 head office cost are above budget, partly because of high cost for temporarily outsourcing the HR activities.

In 2019, the financial impact of the reorganization will fully be realised. The Amsterdam office costs are reduced firmly, and the responsibilities of the field offices have increased. As the volume of the project portfolio increases, we expect a turning point in 2019 and the result to become positive during the year. Because of the reorganization and new long-lasting government grants in Afghanistan, South Sudan and Burundi, HealthNet TPO financial position will gradually improve in the years to come.

The 2018 loss decreased the equity position as per year-end to Euro 313,313. It is expected that the equity will somewhat decrease in the first half of 2019 but will remain positive. From the second half of 2019, the reserves will increase because of positive operational results.

HealthNet TPO operates in fragile states and to be able to cope with unexpected operational losses, strives to have a reserve of about Euro 1 million.

The income of HealthNet TPO is related to projects and in principle has a one-off character, although the projects can run for several years. The funds from institutional donors and sponsors made available for this purpose are specifically intended for these projects.

HealthNet TPO does not raise income through other forms of fundraising. Funds that do not have to be used immediately are deposited with bankers in the form of immediately redeemable funds. HealthNet TPO does not invest in any other way.

2.7. Governance

Board of Directors

HealthNet TPO has a Board of Directors.The managing director, monitored and regulated by the Board of Directors is responsible for organization-wide policy implementation and daily management.

The tasks, responsibilities and authorizations of the Board of Directors and the managing director are described in the HealthNet TPO articles of association and in the Management Charter. The Board of Directors of HealthNet TPO has the task of supervising the activities of the managing director and within the organization.

The various requirements of running an organization such as HealthNet TPO are represented in the Board of Directors. The members must be experienced in (public) health, management, finance, fundraising, human resource or communication.

The members of the Board are recruited according to pre-agreed profiles to ensure the board's composition encompasses diverse areas of expertise. Vacancies are publicly advertised.

The Board of Directors appoints new board members. Members of the Board of Directors are appointed for a period of four years (with possible renewal), resign according to a schedule determined by the Board of Directors and receive no remuneration; actual expenses can be reimbursed.

The Audit Committee

An Audit Committee is established that operates under the Audit Charter. The Audit Committee has convened once in 2018.

The Remuneration Committee

The Remuneration Committee, consisting of the Chair of the Board and one board member, evaluates the functioning and renumeration of the managing Director, and operates under the Remuneration charter.

Evaluation of the Board

In line with the Governance Code, the Board of Directors annually evaluates its performance.

Carin Beumer

is Chairman of the HealthNet TPO Board since 29 October 2015. Carin is the Founder and Chairman at the Zaluvida group. The Zaluvida group operates on a global level and consists of cutting-edge life science companies, active across the entire value chain. Their human health products range from market leading easy-to-use gastro-intestinal and weight management solutions, new ways to help cystic fibrosis patients, to stunning new complex wound cures and much more.

Furthermore, Zaluvida develops and distributes animal health and environmental health products. Some of them help to reduce the need of antibiotics to raise livestock and others are for the reduction of greenhouse gasses emitted by ruminants. All of them are big global health issues!

Carin's professional path started in banking: arranging financing for large infrastructural projects in developing countries. Years of professional experience helped her lay the strong ground work for her next step, and in 2005, together with her husband Thomas Hafner, she founded the Zaluvida group. To give back and support people beyond their products Zaluvida founded the Zaluvida Foundation, which actively supports HealthNet TPO and drives Community Care programs in all Zaluvida's locations around the globe.

Hans Georg van Liempd

is a member of the HealthNet TPO Board since 5 October 2016. Hans Georg is Managing Director at the Tilburg School of Social and Behavioral Sciences. Before this he held various functions with the same university, such as director of Strategy and director of the International Office.

Aside from that, he has been active for many years in the field of internationalization of Higher Education. He has been an active member of the European Association for International Education (EAIE) since 2001, first as Chair of IRM from 2002 until 2004 and as member of EAIE's Executive Board from 2002 to 2004. In 2010 he was elected as Vice President of the Association and he served as

President of the EAIE from 2012 until September 2014. As Immediate Past President he served until September 2016 on the General Council of the EAIE. Additionally, he is Senior Trainer for the EAIE.

Hans Georg is also Chair of the board of the Stichting Zanskar-Stongde Fonds in Amsterdam, which strives to give young people in India the opportunity to have an education. He is a member of the Advisory Board for the Stichting Gastatelier Leo XIII in Tilburg and a member of the Management Board of the Centre for Higher Education Internationalization (CHEI) of the Università Catolica del Sacro Cuore in Milan, Italy.

Koos van der Velden

is a member of the HealthNet TPO Board since 3 July 2013. Koos was professor of Public Health at Radboud University Nijmegen Medical Centre. His main research topics are infectious diseases control and health systems development. He received his medical training at Utrecht University and further specialized as tropical doctor, family physician and as community medicine specialist in London. His PhD thesis 'General practice at work' was defended at Erasmus Rotterdam University.

He started his career as Medical Officer of Health at Kola Ndoto Hospital in Shinyanga Tanzania, where he combined work in the hospital with the management of large primary health care programs. His career continued with a function as Family Medicine program leader at the Netherlands Institute of Health Services Research NIVEL during which he designed and coordinated the First Dutch National Survey of General Practice. During that period, he also managed many health sector reform programs in various EU and former CEE countries.

Later he was director of the Netherlands School of Public Health. He was for fifteen years chairman of the EC/WHO funded European Influenza Surveillance Scheme. He is (co)author of over 300 peer reviewed publications and several books. For the last ten years he was a leading person in health sector reforms in The Netherlands, first in perinatal health care, more recent in mental health care.

Guus Eskens

was appointed to the HealthNet TPO Board on the 20th of June 2017. Guus started his career in the pharmaceutical industry and since the early nineteen eighties, Guus has been involved in international development aid sector. Among other activities, he worked in the healthcare sector in Ghana (Africa), he was the Director Operations of IDA Foundation and Executive Director of the IDA Foundation's pharmaceutical production facility in Malta. The last 10 years of his career Guus was the CEO of CARE Netherlands and Board member of CARE International. During this period, CARE Netherlands developed into a solid organization focused on supporting fragile states and improving women's condition in these countries.

Prior to this experience with CARE International, Guus was member of the Executive Board of Cordaid and CEO of Memisa Foundation. During his career served on several Boards of NGO's among which: Medicus Mundi International (chair, Basel), Brooke Hospital for Animals (chair, Amsterdam), Nefkens Foundation and others. During fiscal year 2018 Guus Eskens served on the Boards mentioned here: -I+ Solutions, Woerden, (chair), VSO Netherlands, Utrecht (chair), VSO International, London (Trustee), Foundation Josephine Nefkens, Rotterdam (member), Nefkens Foundation Development Aid, Rotterdam (member).

Hans Moison (treasurer)

was appointed to the Board on the 3rd of July 2018. Hans is a Dutch chartered accountant and has worked for 35 years on behalf of EY and KMPG, both in the Netherlands and abroad as public accountant and advisor. He has been responsible for financial audits and advisory engagements for more than 70 banks, a number of insurance companies and pension funds, legislators and regulators. Hans fulfilled a leading role within the Royal Netherlands Institute of Chartered Accountants in developing professional rules for internal auditors and chartered accountants of financial enterprises in particular regarding prudential supervision and reporting to regulators.

From October 2014, he works as an independent senior advisor to executive boards in financial services. From March 2016 to February 2017 he was interim member of the executive board of the Surinaamsche Bank in Paramaribo. He currently is director Risk & Compliance a.i. at MN, the third-largest Dutch pension administration organization. Hans is also treasurer of two associations of owners.

Rotation and election procedure

Board members are appointed for a maximum of two-four-year terms. The Board's rotation schedule is as follows;

Board of Directors members	Appointed as of	End of 1st term	End of 2nd term
Carin Beumer	2015 (October)	2019	2023
Hans-Georg van Liempd	2016 (October)	2020	2024
Koos van der Velde	2013 (July)	2017	2021
Guus Eskens	2017 (June)	2021	2025
Hans Moison	2018 (July)	2022	2026

Board of Directors meetings in 2018

The Board convened 11 times in 2018, of which 3 times via Skype. The agenda items for the Board of Directors meetings are as follows:

- The annual plan and budget
- The annual report
- The programmes
- Formal audits, evaluations and risk assessments
- Self-evaluation
- Risk management and fraud prevention
- Progress on professionalizing the organization
- The evaluation of the Managing Director
- Approval of organizational policies

In addition to the standard agenda the board also discussed the following items this year:

- The Merger
- The Strategic re-orientation

2.8. Communication with our stakeholders

HealthNet TPO strives for optimal relations with its stakeholders through clear and accessible output of information and the opportunity to reach us with questions, suggestions or complaints.

Our website, social media channels and (local) newsletters are good examples of the ways in which we communicate with our stakeholders. These are: guests, volunteers, donors, staff, sponsors, partners, (local) governments.

Ideas, comments, suggestions and complaints are collected via our online channels or info@hntpo.org and then forwarded to the responsible departments or persons.

HealthNet TPO has worked throughout 2018 to maintain a close and constant dialogue with our stakeholders: institutional donors, governments & UN organizations on global and national (local) level. We strengthened the relationships we have with existing donors and developed new relationships with potential new partners.

On project country level, we make use of national and local media (radio, television) to bring our messages across. In all our project countries we closely work together with the Ministries of Health. We raised awareness for our mission and programs through online (website, Facebook) and offline communication.

2.8.1. Our donors and partners

Sponsor:

HealthNet TPO received in 2017 a one- off grant from the Dutch Postcode Lottery of 1 Million Euros. Thanks to the support of the NPL, HealthNet TPO has been able to increase its project portfolio and strengthen our organization.

Governments:

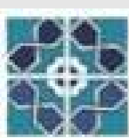
European Union:

UN organisations:

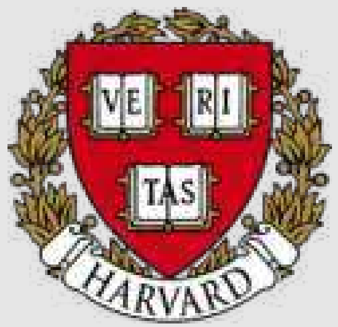
Other donors:

Foundation:

Partners :



Research partners:



2.8.2. Relevant networks

HealthNet TPO is part of several national and international networks and platforms aiming to share knowledge and have as much of an impact as possible.

Academic partners:

- Utrecht University, The Netherlands
- University of Amsterdam, The Netherlands
- Department of Public Health and Primary Care, School of Clinical Medicine, University of Cambridge, UK
- University of East London, United Kingdom
- Faculty of Health, Education, Medicine, and Social Care, Anglia Ruskin University, UK
- Institute of Psychiatry Psychology and Neuroscience, King's College London, UK
- Centre for Global Mental Health, London School of Hygiene and Tropical Medicine, UK
- School of Nursing & Human Sciences, Dublin City University, Ireland
- Alan J. Flisher Centre for Public Mental Health, Dep Psychiatry and MH, University of Cape Town, SA
- Addis Ababa University, Ethiopia
- Makarere University, Uganda
- Helene Fuld Health Trust National Institute for EBP in Nursing & Healthcare, Ohio State University, US
- Centre for Global Health, Johns Hopkins University, US
- Department of Social and Behavioral Sciences, Harvard School of Public Health, US

Platforms:

- Dutch Coalition Disability and Development (DCDD)
- Mental Health and Psychosocial Support Dutch coalition
- Inter-Agency Standing Committee (IASC), member of the MHPSS Reference Group
- Afghanistan Platform of Ministry of Foreign Affairs
- Burundi Platform of Ministry of Foreign Affairs
- Amsterdam Institute for Global Health and Development (AIGHD)
- Dutch Security Network (DSN)

2.8.2. List of research publications in 2018

· Luitel, N.P., Baron, E.C., Kohrt, B.A., Komproe, I.H., Jordans, M.J. (2018). Prevalence and correlates of depression and alcohol use disorder among adults attending primary health care services in Nepal: a cross sectional study. BMC Health Services Research, Vol 18, 215.

· Upadhaya, N., Jordans, M.J., Gurung, D., Pokhrel, R., Adhikari, R.A., Komproe, I.H. (2018). Psychotropic drugs in Nepal: perceptions on use and supply chain management. Globalization and Health, Volume: 14, 10.

· Wind, T.R. and I.H. Komproe (2018). Closing the gap between disaster mental health research and practice: evidence for socio-ecological mental health interventions through multilevel research. Intervention, 16 (1): 5-13.

· Adhikari, R. P., Upadhaya, N., Satinsky, E. N., Burkey, M. D., Kohrt, B. A., & Jordans, M. J. (2018). Feasibility study of a family- and school-based intervention for child behavior problems in Nepal. Child and adolescent psychiatry and mental health, 12(1), 20.

2.9. Risks management

HealthNet TPO's operations are conducted in volatile settings. We encounter severe safety and security issues during the implementation of our programs.

Operational, Safety and security risks

To reduce our risks, we identify, value and mitigate all potential risks to our operations and our field staff. HealthNet TPO has sound procedures, tailored security policies and controls in place in all project countries that help us to operate in areas with increased security risks.

Headquarters staff and visitors are obliged to follow a safety and security training. Our project managers, in the field and at the Amsterdam office alike, are recruited and selected on basis of their safety and security track record (training & experience).

In 2019, we will develop and implement an overall risk management register which will enable us to consolidate global risks and at the same time keep a keen eye on local risks and allowing us to follow up on individual action points.

We have put several internal controls and internal policies in place on fraud, selection of partners and compliance to mitigate the likelihood of risks occurring. In 2018, we have not encountered any incidents related to fraud.

In 2018, we encountered decreasing safety and security situation, especially in Afghanistan and South Sudan. Due to two incidents, a road accident and an attack on an election facility, we lost 3 Afghan team members.

Reputational risks and integrity

Integrity has been in the center of attention following the misconduct in the Humanitarian sector. We have recently reviewed all our policies and procedures on this subject and have revised our code of conduct as well as all our existing policies and guidelines.

Implementation in the field will take place in 2019. All these policies will be made available through our website.

Financial risks

Fluctuation in (institutional) income is a risk. HealthNet TPO continues to diversify and broaden its institutional donor base and invests in building strong relations with our institutional donors. In anticipation of and to mitigate the risk of possible disallowances from institutional donors, we have included a provision in our financial statements.

HealthNet TPO’s operations encounters currency risks. This risk is partly being mitigated by making use of a proprietary platform which gives us access to live rates and global payments.

Compliance

In all our project countries, we closely monitor and evaluate our compliance to national labor and financial (tax) laws. Each year we conduct a (written) compliance evaluation and follow developments closely by attending (I)NGO platforms and make use of in country available advisors on legal and tax issues.

Codes of conduct

We subscribe to the Code of Conduct of the International Committee of the Red Cross and as a member of Partos, we adhere to the Partos Code of Conduct (version Dec. 2018)

2.10. Our plans for 2019

2019 will be a year of further refining and implementing our strategy.

In 2019, we aim to accelerate our efforts to increase the reach of our programs. Due to the submission of high-quality proposals in 2018 and the appreciation of our efforts by institutional donors, our project portfolio will increase with an estimated amount of Euro 3 million. (see for more detail Chapter 3. Financial Statements, paragraph 3.5. Budget 2019)

Following the reorganization of the Head Office in Amsterdam in 2018 and early 2019, our overall functioning costs will decrease which is expected to lead to a modest positive result in 2019.

We will seek to enter new relations and partnerships with (inter)national NGO’s. We will continue our search for a potential partner for merger to deliver interventions of increasing reach and scale.

By the end of 2019, we will launch our new strategy (2019-2023) outlining our future challenges and opportunities.

3. Financial Statements

3.1. Statement of income and expenditure

(In euros)	*Note*	Actual 2018	Budget 2018	Actual 2017
Income				
Income from individuals	1	8.303	12.188	8.247
Income from companies	1	16.605	375.000	90.344
Income from lottery organizations	1	-	-	1.000.000
Subsidies from government grants	2	13.600.766	15.100.000	12.139.213
Income from non-profit organizations	2	4.225.722	4.550.000	3.455.938
Sum of income raised		**17.851.396**	**20.037.188**	**16.693.741**
Expenditure on objectives				
Reconstruction and development	3	17.352.657	18.780.560	14.592.189
Awareness raising and public information	4	54.111	50.000	59.989
	5	**17.406.768**	**18.830.560**	**14.652.178**
Expenditure income generation				
Own fundraising efforts	6	73.690	210.000	318.155
Securing government subsidies	5	95.174	50.000	106.162
		168.864	**260.000**	**424.317**
Expenditure management & administration	5	688.315	696.446	892.203
total expenditures		**18.263.948**	**19.787.006**	**15.968.698**
Financial income and expenditures	7	(14.816)	-	(352.437)
Result		**(427.367)**	**250.182**	**372.607**
Allocation of the result				
continuity reserve		(427.367)		372.607
		(427.367)		**372.607**
Percentage expenditure on objectives vs total income		97,5%	94,0%	87,8%
Percentage expenditure on objectives vs total expenditure		95,3%	95,2%	91,8%

3.2. Statement of financial position

(In euros)	Note	December 31 2018	December 31 2017
Intangible fixed assets	8	-	-
Tangible fixed assets	9	3.342	6.226
Receivables and accrued income			
Work in progress	10	2.372.208	2.458.897
Receivables	11	91.878	183.048
Cash and banks	12	3.516.385	4.862.166
Total Assets		**5.983.813**	**7.510.336**
Reserves	13	313.313	740.680
Provisions	14	656.194	742.440
Short-term liabilities			
Project balances	10	2.220.195	3.466.638
Other short-term liabilities	15	2.794.111	2.560.578
Total reserves and liabilities		**5.983.813**	**7.510.336**

3.3. Statement of cash flow

(in euros)	2018			2017		
	Project countries	Netherlands	Total	Project countries	Netherlands	Total
Balance on 1 January	3.782.760	1.079.406	4.862.166	2.556.800	344.860	2.901.660
Donor instalments current projects	9.424.192	7.392.320	16.816.513	9.063.082	6.681.062	15.744.143
Repaid unspend subsidies to donor	-	-	-	-	-	-
Received final payments closed projects	-	-	-	-	-	-
Donations	67	8.236	8.303	2.492	1.005.755	1.008.247
Other income	140.611	-	140.611	118.074	15	118.089
	9.564.870	7.400.557	16.965.426	9.183.648	7.686.831	16.870.479
Transfers to the project countries	3.233.849	(3.233.849)	-	3.143.570	(3.143.570)	-
Expenditures on objectives in the field offices	(14.142.538)		(14.142.538)	(11.101.258)		(11.101.258)
Project expenses paid from the Netherlands		(2.049.333)	(2.049.333)	0	(1.773.379)	(1.773.379)
Expenditure on overhead in the Netherlands		(1.519.337)	(1.519.337)	-	(2.035.337)	(2.035.337)
Balance on 31 December	2.438.941	1.077.444	3.516.385	3.782.760	1.079.406	4.862.166

3.4. Notes to the financial statement

3.4.1. Accounting principles

The annual report is prepared in accordance with the 'Guideline 650 for Fundraising Institutions'. The purpose of this guideline is to provide information about the costs of the organization and the expenditure of funds to meet the objectives for which the funds were acquired. Project execution is the main objective of HealthNet TPO. The financial year coincides with the calendar year.

Unless stated otherwise, items in the balance sheet are shown at nominal value and income and expenditures are allocated to the relevant year. Purchase of assets or stock (e.g. vehicles or medicines) in the program countries for projects are recognized on a cash basis.

3.4.1.1. Going concern basis

The financial statements have been prepared based on going concern.

3.4.1.2. Foreign currencies

Transactions denominated in foreign currencies are translated into Euros at the monthly exchange rate of the European Central Bank (ECB) prevailing on the transaction date. At the end of the financial year, all assets and liabilities in foreign currencies are translated into Euros at the exchange rate of the ECB on the balance sheet date. The resulting exchange rate gains/losses are included in the statement of income and expenditure.

3.4.1.3. Allocation of organizational costs

The administrative costs of own fundraising efforts, securing government subsidies, awareness raising and public information, and those of reconstruction and development are calculated based upon the costs of the full-time employees at the head office directly employed for these activities. The other, non-direct staff costs are allocated in proportion to these direct costs. Depreciation cost and interest expenses have been included.

3.4.1.4. Expenditure management & administration

This represents expenditures on managing the organization. These costs are calculated based on the guidance of the RJ650. Included are the direct costs of the human resources and administration departments and 50% of the director’s office. The costs of the operational department are administrative expenses for 20%. Other costs are allocated on a pro rata basis based on the allocation of the direct costs.

3.4.1.5. Cash flow statement

The cash flow statement was prepared using the direct method.

3.4.1.6. Assets

The assets shown on the balance sheet are all held for the activities of the organization.

Intangible fixed assets

The intangible fixed assets are stated at cost less depreciation. Depreciation is calculated at fixed percentages based upon the useful life. The following rates of depreciation are used:

ERP system	20.0% per annum
Computer software	33.3% per annum

Tangible fixed assets

The tangible fixed assets are stated at cost less depreciation. Depreciation is calculated at fixed percentages based upon the useful life. The following rates of depreciation are used:

Office furniture	14.3% per annum
Office equipment	20.0% per annum
Computer hardware	33.3% per annum

3.4.1.7. Debtors

Debtors are shown at face value. If necessary, a provision for bad and doubtful debts is deducted.

3.4.1.8. Reserves and funds

The organization currently only has a continuity reserve. All reserves will be used for its objectives.

3.4.1.9. Provisions

The provisions are valued based on the most recent information and probable expectation of possible future costs.

3.4.1.10. Project balance and work in progress

The project balance is presented according to the work in progress method. The balance for each project is determined based on project expenditures and received instalments/ reimbursements up to balance sheet date and realized income based on the progress of projects. In determining the realized project income losses due to budget overruns, ineligible costs or unsecured co-funding obligations are considered.

3.4.2. Notes to the statement of income and expenditure

3.4.2.1. Income fundraising

(In euros)	Actual 2018	Budget 2018	Actual 2017
Income from individuals			
Private donations	8.303	12.188	8.247
	8.303	**12.188**	**8.247**
Income from companies			
Google Adwords	8.782	95.000	90.858
Private Equity Funds	-	280.000	-
Local project income	7.823		(514)
	16.605	**375.000**	**90.344**
Income from lottery organizations			
Nationale Postcode Loterij	-	-	1.000.000
	-	-	**1.000.000**

3.4.2.2. Income institutional donors

The income of HealthNet TPO comes from subsidies from governments and non-governmental organizations, third-party campaigns and fundraising.

Subsidies that the donor allocated depending on project costs are accounted for in the year that the subsidized expenditure took place. In this context, the expenditures by alliance partners, where HealthNet TPO is lead agency, is equal to the amounts paid to these partners.

Differences in allocated and actual income from subsidies are accounted for in the statement of income and expenditure in the year in which these differences can be reliably estimated.

(In euros)	Actual 2018	Budget 2018	Actual 2017
Subsidies from government grants			
Afghan Ministry of Health	6.689.228	7.200.000	4.787.891
Dutch Ministry of Foreign Affairs	489.107	650.000	605.389
European Commission	711.167	950.000	802.978
Health Pooled Fund	4.682.372	4.200.000	4.524.923
USAID	-	650.000	-
Other governments	344.669	526.274	754.196
Coverage for organizational cost	684.222	923.726	663.836
	13.600.766	**15.100.000**	**12.139.213**
Income from non-profit organizations			
Gavi	625.698	750.000	267.146
Global Fund	466.991	550.000	-
United Nations organizations	1.428.825	1.500.000	1.244.592
WHO	141.531	171.659	31.982
World Bank	1.284.253	1.300.000	1.704.419
War Child	19.884		
Coverage for organizational cost	258.539	278.341	207.799
	4.225.722	**4.550.000**	**3.455.938**

3.4.2.3. Reconstruction and development

(in euro)	Afghanistan		Burundi		South Sudan		Other Countries		Total 2018		Budget 2018		Actuals 2017	
Actuals 2018														
Expat staff	56.448	1%	591	0%	349.794	6%	70.446	21%	477.279	3%	560.044	3%	442.387	3%
HQ staff	76.770	1%	6.120	2%	37.778	1%	134.012	40%	254.680	2%	381.337	2%	301.224	2%
Local staff	5.229.592	49%	146.502	40%	1.954.700	36%	-	0%	7.330.793	43%	7.124.664	40%	5.955.864	41%
Field office cost	1.501.633	14%	28.696	8%	429.337	8%	9.728	3%	1.969.393	12%	1.511.156	8%	1.193.663	8%
Transportation	628.426	6%	58.263	16%	481.691	9%	5.407	2%	1.173.787	7%	1.378.156	8%	1.089.415	7%
Training and education	805.676	7%	88.348	24%	90.509	2%	-	0%	984.534	6%	1.096.932	6%	866.462	6%
Medical and other goods	2.462.404	23%	-	0%	538.694	10%	-	0%	3.001.097	18%	3.956.921	22%	3.124.840	21%
Consultancy	13.635	0%	36.006	10%	34.213	1%	21.806	7%	105.661	1%	106.662	1%	84.254	1%
Local partners	-	0%	-	0%	1.564.068	29%	92.700	28%	1.656.769	10%	1.891.947	11%	1.494.477	10%
	10.774.585		**364.523**		**5.480.783**		**334.100**		**16.953.991**		**18.007.817**		**14.552.626**	
Local income	(3.626)		-		(129.162)		-		(132.787)		-		(118.603)	
Total Expenditures	**10.770.960**		**364.523**		**5.351.621**		**334.100**		**16.821.204**		**18.007.817**		**14.434.022**	
Allocated organizational costs									520.236		680.000		396.600	
Post project results									11.217		92.743		(238.434)	
									17.352.657		**18.780.560**		**14.592.189**	

3.4.2.4. Awareness raising and public information

(In euro)	Actuals 2018	Budget 2018	Actuals 2017
Website	10.963	9.000	13.044
Other activities	862	1.000	665
	11.825	***10.000***	***13.709***
Allocated organizational costs (Note 5)	42.286	40.000	46.280
	54.111	**50.000**	**59.989**

3.4.2.5. Allocation of organizational costs

Expenditures	Reconstruction and development	Awareness raising and public information	Total expenditure on objectives	Own fundraising efforts	Securing government subsidies	Management & administration	Actual 2018	Budget 2018	Actual 2017
Average number FTEs	6.1	0.4	**6.5**	0.6	1.0	6.6	**14.7**	14.3	17.6
Personnel costs	594.453	38.858	**633.311**	54.266	90.927	606.188	**1.384.631**	1.197.645	1.540.957
Accommodation costs	34.859	2.310	**37.169**	3.225	5.506	37.633	**83.533**	98.950	100.157
Office and general costs	53.806	4.901	**58.707**	6.772	13.671	118.684	**197.834**	108.166	167.398
Depreciation and interest	1.254	29	**1.283**	111	190	1.299	**2.884**	20.000	1.701
	684.371	**46.100**	**730.471**	**64.355**	**110.294**	**763.782**	**1.668.903**	**1.424.750**	**1.810.213**
Recovered organizational cost	(164.135)	(3.814)	**(167.949)**	(5.324)	(15.121)	(75.467)	**(263.860)**	(381.337)	(307.974)
	520.236	**42.286**	**562.522**	**59.031**	**95.174**	**688.315**	**1.405.043**	**1.043.453**	**1.502.239**
Subsidies and contribution	16.965.208	11.825	**16.977.033**	14.659	-	-	**16.991.692**	18.250.560	14.586.061
Local income	(132.787)		**(132.787)**				**(132.787)**		(118.603)
Total allocation	**17.352.657**	**54.111**	**17.406.768**	**73.691**	**95.174**	**688.315**	**18.263.548**	**19.294.015**	**15.968.697**
percentage of expenditures on objectives				0.4%	0.5%	4.0%			
Note: Coverage of indirect cost							**342.741**	-	**371.635**
In % of total organizational cost (incl. Subsidies and contribution for Management and Administration)							50%	2%	52%

Expenditures on objectives: The expenditures on objectives are divided into two groups, expenditure on (1) Reconstruction and Development, and (2) Awareness Raising and Public Information. The policy of HealthNet TPO is to spend at least 90% of the total expenditures directly on the objectives. In 2018 95,1% (€ 17.4 mln.) of total expenditures (€ 18.3 mln) was directly spent on the objectives. Almost all (99,7%) was for Reconstruction and Development.

It is the policy of HealthNet TPO to work with own staff in the field as often as possible. Therefore, salary costs are the main part of the reconstruction and development costs. Medical goods form another large part of the expenditures.

Costs securing government subsidies: The costs for securing government subsidies consist entirely of allocated organizational costs. Within HealthNet TPO 1.0 FTE was engaged in securing government subsidies.

Management and Administration: The expenditures for Management and Administration consist as well entirely of allocated organizational costs. Staff of the departments finance, operational support, technical support and the director spend a percentage of their time on Management and Administration. The average number of FTE's assigned for Management and Administration decreased in 2018 to 6,6 FTE.

Expenditures on objectives per region

	Budget 2018	Actual 2018	Actual 2017
Asia	52%	65%	65%
Africa	45%	34%	37%
Overige	3%	1%	-3%

3.4.2.6. Organizational head office costs

In table 3.4.2.5 Allocation of organizational cost the total of the Amsterdam head office costs (€1.668.903, -) is split up into the categories Personnel cost, Accommodation cost, Office & general cost and Depreciation & interest. The below table shows more details of these costs.

(In euro)	Actuals 2018	Budget 2018	Actuals 2017
Salary cost			
Gross salaries	1.038.562	853.058	1.136.309
Social security	133.951	125.147	158.148
Pension	164.552	146.459	182.016
Other personnel costs	47.586	72.981	64.483
Total salary cost	**1.384.651**	**1.197.645**	**1.540.957**
Average number of FTE's	*14,7*	*14,9*	*17,8*
Accommodation cost			
Rent	33.569	55.000	55.097
Service charges and move	43.245	35.500	36.689
Office maintenance	6.719	8.450	8.371
Total accommodation cost	**83.533**	**98.950**	**100.157**
Office and General cost			
Automation/Telecom	22.474	22.150	36.451
Office cost	6.911	7.705	7.736
Insurrance	1.488	11.655	3.460
Bank charges	1.774	1.250	2.195
Consultancy	91.271	7.720	49.030
Audit fees	58.061	35.000	51.809
Other general cost	15.854	22.715	16.718
Total office and general cost	**197.834**	**108.195**	**167.398**
Depreciation and interest			
Depreciation	2.884	20.000	2.208
Interest expense	0	0	-507
Total depreciation and interest	**2.884**	**20.000**	**1.701**
Total organization cost head office	**1.668.903**	**1.424.790**	**1.810.213**

The 2018 salary costs are less than in 2017 but above budget because a few employees were longer in service than budgeted. Also, a provision of € 54.000 was booked for long term illness costs.

Because we decided to move to another office and not to extend the current rental contract we received the contractual arranged discount on rental cost amounting € 19.000.

In 2018 the field visits by Amsterdam staff was at a very low level what caused low insurance costs.

Consultancy costs are high because the HR activities were temporarily taken care of by an external consultant.

Due to stricter regulations the annual account audits takes longer than previous years. And this translates into higher costs.
The upgrade of our ERP system has been postponed and therefore depreciation costs are lower than budget.

Board and Director's remunerations

The board members are not employed by the organization. Board members and former board members do not (nor did) receive any remuneration during the financial year. No loans or advances were made, and no guarantees were issued to the board members.The board has determined the remuneration policy, the height of the executive benefits and the amount of remuneration components. The remuneration policy is updated periodically.

As of February 2017, HealthNet TPO has one director, Marc Tijhuis. HealthNet TPOs has no bonuses, year-end bonuses or gratuities. Expenses are refunded on a claim basis.

(in euro)	2018	2017
Marc Tijhuis, Director		
Contract	indefinite	definite
Hours per week	40	40
Parttime percentage	100%	100%
Period	01/01-31/12	01/02-31/12
Gross wage/salary	91.200	85.705
Holiday allowance	7.296	6.856
Pension	17.080	15.692
	115.576	**108.253**

Staff overview

	Budget 2018	Actual 2018	Actual 2017
Staff at Amsterdam office			
1 January	18,3	18,3	18,3
31 December	12,5	12,3	18,3
Number of volunteers during the year	3	1	6
Average number of staff at headquarters	14,9	14,7	17,8
Personnel cost per FTE at headquarters (euro)	80.244	90.520	86.571
Other cost per FTE at headquarters(euro)	15.219	19.337	15.127
Hourly rate staff Amsterdam office (budget only, euro)	90,00	90,00	90,00
Field staff per 31 December			
Afghanistan - Local staff	1.400,0	1.450,0	1.272,0
Afghanistan - Expat staff	7,0	4,0	6,0
Burundi - Local staff	35,0	16,0	27,0
Burundi - Expat staff	-	-	-
lesotho - Local staff	-	-	-
lesotho - Expat staff	1,0	1,0	1,0
South Sudan - Local staff	35,0	31,8	31,0
South Sudan - Expat staff	3,0	5,0	4,0
Total field staff	**1.481,0**	**1.507,8**	**1.341,0**

3.4.2.7. Own fundraising efforts costs

(In euro)	Actuals 2018	Budget 2018	Actuals 2017
Advertisement	1.863	60.000	140.022
Other fundraising cost	12.796	80.000	113.526
	14.659	140.000	*253.548*
Allocated organizational costs (Note 5)	59.031	70.000	64.607
	73.690	210.000	318.155
Cost percentage own fundraising efforts vs income	*6,7%*	*19,0%*	*29,0%*

3.4.2.8. Other results

(In euros)	Actuals 2018	Budget 2018	Actuals 2017
Exchange rate gains/(losses) HQ Amsterdam	16.635	-	(14.105)
Exchange rate results project countries	(31.451)	-	(338.332)
Total other results	**(14.816)**	-	**(352.437)**

3.4.3. Notes to the statement of financial position

3.4.3.1. Intangible fixed assets

(In euros)	Software	ERP System	Total
Purchase value			
Balance on 1 January	19.558	500.097	519.655
Investments 2018		-	-
Divestments 2018	-	-	-
	19.558	**500.097**	**519.655**
Depreciation			
Balance on 1 January	19.558	500.097	519.655
Depreciation 2018	-	-	-
	19.558	**500.097**	**519.655**
Balance 31 December	-	-	-

No main investments took place in 2018. In 2017 we worked on the preparation of the ERP system upgrade but the execution of this project, planned for 2018, has been postponed. Our current system is from 2010, an upgrade is not possible anymore. Therefore, we will implement new Navision software. Because the Microsoft license fees have been paid all past years, we don’t need to invest in new software.

3.4.3.2. Tangible fixed assets

(In euros)	Furniture	Office machines	Computers	Total
Purchase value				
Balance on 1 January	54.636	15.215	56.580	126.430
Investments 2018	-	-	-	-
Divestments 2018	(32.295)	(13.966)	(4.276)	(50.537)
	22.341	**1.249**	**52.304**	**75.893**
Depreciation				
Balance on 1 January	54.636	15.214	50.368	120.218
Depreciation 2018	0	0	2.884	2.885
Divestments 2018	(32.295)	(13.966)	(4.291)	(50.552)
	22.341	**1.248**	**48.962**	**72.551**
Balance 31 December	**(0)**	**0**	**3.342**	**3.342**

3.4.3.3. Receivables

(In euros)	Actual 2018	Actual 2017
Debtors	6.899	81.176
Prepaid expenses	32.609	57.083
Prepayments to subcontractors	9.303	20.236
Accrued assets	43.067	24.554
Total receivables	**91.878**	**183.048**

Pre-paid expenses: This includes the deposits and pre-paid expenses at headquarters and in the field offices.

Prepayments to sub-contractors: For several projects, HealthNet TPO cooperates with sub-contractors. Some of the sub-contractors are pre-financed by HealthNet TPO. Because no unconditional commitments have been made, we book and charge the expenses of sub-contractors only when the sub-contractor reports the actual expenses. When HealthNet TPO is not pre-financing the sub-contractors, the sub-contractors are reimbursed afterwards. The commitment is presented as short-term liability.

Accrued assets: This includes the balance of advances that are given to HealthNet TPO staff to carry out activities in the field. HealthNet TPO carries out projects in areas where the (financial) infrastructure is sometimes lacking. To be able to do all the activities in these areas, cash advances are occasionally given to HealthNet TPO staff. These advances are accounted for within one month.

3.4.3.4. Cash and bank

(In euros)	Actual 2018	Actual 2017
Cash at bank and in hand in Amsterdam	1.077.444	1.079.406
Cash at bank and in hand in project countries	2.438.941	3.782.760
Total cash and bank	**3.516.385**	**4.862.166**

(In euros)	Actual 2018	Actual 2017
Afghanistan	2.287.510	3.759.432
Burundi	30.035	1.826
DRC	-	-
South Sudan	121.397	21.501
Irak	-	-
Total cash and bank in countries	**2.438.941**	**3.782.760**

3.4.3.5. Reserves

(In euros)	Actual 2018	Actual 2017
Continuity reserve		
Balance 1 January	740.680	368.073
Result current year	(427.367)	372.607
Total continuity reserve	**313.313**	**740.680**
Designated reserve		
Balance 1 January	-	-
Result current year	-	-
Total designated reserve	-	-
Total reserves		
Balance 1 January	740.680	368.073
Result current year	(427.367)	372.607
Total reserves	**313.313**	**740.680**

3.4.3.6. Provisions

(In euros)	Actual 2018	Actual 2017
Balance 1 January	742.440	565.909
Allocation	438.200	465.889
Withdrawal	(438.272)	2.450
Release	(86.174)	(291.808)
Total provisions	**656.194**	**742.440**
post project provision	179.756	163.752
social securities	453.688	520.938
court cases Burundi	22.750	57.750
Total provisions	**656.194**	**742.440**

(In euros)	post project provision	social securities	court cases
Balance 1 January 2018	163.752	520.938	57.750
Allocation	42.717	395.483	-
Withdrawal	(26.713)	(411.559)	-
Release	-	(51.174)	(35.000)
Balance 31 December 2018	**179.756**	**453.688**	**22.750**

HealthNet TPO projects are regularly audited after they finish, and the financial report has been submitted. These project audits can take place until five years after a project finished. Based on results of the project audits in the past, it was decided to form a provision. Every year 0.25% of the yearly income out of government subsidies is added to this provision.

For two USAID projects from 2014 there is a claim from the Afghan Ministry of Health amounting USD 175K. Part of these cost are for sub contractors we worked with and they have confirmed that they will take care of their part.

In some of our project countries, social security contributions are not paid to the government but directly to the employees at the end of their employment period. Because of the nature of these obligations, it was decided to record these long-term obligations as of 2016 as a provision instead of short-term liabilities. Because of the strong devaluation in South Sudan monthly exchange rates, as used by the national bank, are used for the obligations.

3.4.3.7. Overview project balances

(in euros)	Actual 2018	Actual 2017
Balance on 1 January	(1.007.737)	(746.441)
Received subsidies	(16.715.955)	(15.617.844)
Subsidies spent	17.875.707	15.356.548
Subsidies to be refunded to donor	-	-
Total project balance	**152.016**	**(1.007.737)**

(in euros)	2018		2017	
	To be received from donor	Unspent project subsidies	To be received from donor	Unspent project subsidies
Achmea	0	(3.366)	0	(3.366)
Afghan Ministry of Health	225.899	(686.581)	96.638	(1.585.271)
BSF	0	-	0	-
Cordaid	0	(0)	0	(0)
Dutch Ministry of Foreign Affairs	257.397	(437.584)	185.053	(245.358)
European Commission	0	(0)	88.438	(54.000)
GAVI	352.570	(709.163)	187.313	(503.565)
Global Fund	268.081	(36.606)	0	(0)
United Nations organizations	470.894	(251.761)	363.917	(554.692)
USAID	0	(0)	26.714	(0)
World Bank	31.361	(0)	185.683	(419.416)
Health Pooled Fund	758.158	(0)	1.307.185	(0)
Other donors	7.850	(95.134)	17.959	(100.968)
Subsidies to be refunded	-	-	-	-
	2.372.210	(2.220.195)	2.458.899	(3.466.637)
Total project balance	152.015		-1.007.737	

The table above includes the balance of all running projects. This balance is determined based on project expenditures and received instalments/reimbursements up to the balance sheet date and realized income, based on the progress of projects. In determining the realized project income losses due to budget overruns, ineligible costs or unsecured co-funding obligations are considered.

Based on the project progress and received instalments, HealthNet TPO can have a receivable from or a payable to a donor. In the specification project balance per donor the individual position for each donor is explained.

3.4.3.8. Short-term liabilities

(In euros)	Actual 2018	Actual 2017
Creditors	42.942	246.553
Payable to project partners	995.435	798.940
Payable to donors	54.709	-
Invoices to be received	121.552	64.453
Provision holiday allowance and holiday hours	95.863	104.350
Accrued personnel costs headquarters	64.643	942
Accrued tax and social security headquarters	31.448	42.576
Accrued personnel costs in project countries	178.368	176.026
Accrued social securty project countries	22.444	8.369
Accrued subcontractors	19.492	85.513
Accrued other cost in project countries	1.167.216	978.906
Total short-term liabilities	**2.794.111**	**2.506.627**

Accrued personnel costs headquarters: This includes the salary and insurance commitments for staff at headquarters per December 31st, 2018.

Accrued tax and social security headquarters: This includes the tax payables and social security, per December 31st, 2018, for the staff at headquarters.

Accrued personnel costs in project countries: This includes the salary and tax commitments for staff at field offices per December 31st, 2018 in Afghanistan, Burundi and South Sudan.

Accrued social security project countries: This includes reservations for paying social security and 'end of contract payments' in Burundi.

Accrued sub-contractors: These are commitments to local partners for services they have provided, mainly in Afghanistan.

Accrued other costs in project countries: This includes all, non-salary related, project commitments in the project countries.
These commitments include received invoices and made commitments for medicine, constructions of health facilities, fuel and other contracts.

Rights not included in the balance sheet: since August 2015 HealthNet TPO is subletting part of his office to Zoombim BV. The contract is for one year with a tacit renewal and a notice period of one month. More office space was sublet to Zoombim BV in 2017 and the total revenue from this rental agreement amounted €90.277 in 2018.

Since February 2014, another small part of the office is being sublet to Stichting Antares for the period of one year with a tacit renewal and a notice period of one month. The yearly income from this agreement amounts €7,041.

Liabilities not included in the balance sheet:

· The rental agreement for the office in Amsterdam, which runs from 16 January 2012until 15 January 2019, has a total commitment of €1,167,447. This requires a bank guarantee of €43,785. For 2018 the total rental cost including service charges amounted to €167,576. At the beginning of 2018, the rental agreement for the office at the Lizzy Ansinghstraat was terminated. At the end of 2018 we moved to an office at the Singel in Amsterdam. We can use this office for 11 months at most.

· As of October 2011, HealthNet TPO has signed a lease contract with Canon Business Center for three printers. This agreement runs until October 2019. HealthNet TPO pays €1,811 per 3 months for using the printers. In December 2018 the lease contract has been adjusted. After moving to the new office, we only have one printer. The new contract runs for 3 years and we pay €1.433,34 per 3 months.

3.5. Budget 2019

(In euros)	Budget 2019	Actual 2018
Income		
Income from individuals	12.000	8.303
Income from companies	12.562	16.605
Income from lottery organizations	-	-
Subsidies from government grants	15.000.000	13.600.766
Income from non-profit organizations	5.320.000	4.225.722
Sum of income raised	**20.344.562**	**17.851.396**
Expenditure on objectives		
Reconstruction and development	19.573.748	17.318.297
Awareness raising and public information	50.000	54.111
	19.623.748	**17.372.408**
Expenditure income generation		
Own fundraising efforts	25.000	73.690
Securing government subsidies	95.000	96.401
	120.000	**170.091**
Expenditure management & administration	550.000	721.449
total expenditures	**20.293.748**	**18.263.948**
Financial income and expenditures	-	(14.816)
Result	**50.814**	**(427.367)**
Percentage expenditure on objectives vs total income	96,5%	97,3%
Percentage expenditure on objectives vs total expenditure	96,7%	95,1%

INDEPENDENT AUDITOR'S REPORT

To: the Management Board of Stichting Health Works in Amsterdam,
The Netherlands.

A. Report on the audit of the financial statements 2018 included in the annual report

Our opinion
We have audited the financial statements 2018 of Stichting Health Works based in Amsterdam, The Netherlands.

In our opinion the accompanying financial statements give a true and fair view of the financial position of Stichting Health Works as at 31 December 2018 and of its result for 2018 in accordance with the Guidelines for annual reporting 650 "Fundraising Organisations" of the Dutch Accounting Standards Board.

The financial statements comprise:
1. the balance sheet as at 31 December 2018;
2. the statement of income and expenditure for 2018; and
3. the notes comprising a summary of the accounting policies and other explanatory information.

Basis for our opinion
We conducted our audit in accordance with Dutch law, including the Dutch Standards on Auditing. Our responsibilities under those standards are further described in the 'Our responsibilities for the audit of the financial statements' section of our report.

We are independent of Stichting Health Works in accordance with the Verordening inzake de onafhankelijkheid van accountants bij assurance-opdrachten (ViO, Code of Ethics for Professional Accountants, a regulation with respect to independence) and other relevant independence regulations in the Netherlands. Furthermore we have complied with the Verordening gedrags- en beroepsregels accountants (VGBA, Dutch Code of Ethics).

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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Dubois & Co. Registeraccountants is een maatschap van praktijkvennootschappen. Op alle opdrachten die aan ons kantoor worden verstrekt zijn onze algemene voorwaarden van toepassing. Deze voorwaarden, waarvan de tekst is opgenomen op de website www.dubois.nl, bevatten een aansprakelijkheidsbeperking.

B. Report on the other information included in the annual report

In addition to the financial statements and our auditor's report thereon, the annual report contains other information that consists of the management board's report.

Based on the following procedures performed, we conclude that the other information is consistent with the financial statements and does not contain material misstatements.

We have read the other information. Based on our knowledge and understanding obtained through our audit of the financial statements or otherwise, we have considered whether the other information contains material misstatements.

By performing these procedures, we comply with the requirements of the Dutch Standard 720. The scope of the procedures performed is substantially less than the scope of those performed in our audit of the financial statements.

Management is responsible for the preparation of the other information, including the management board's report, in accordance with the Guidelines for annual reporting 650 "Fundraising Organisations" of the Dutch Accounting Standards Board.

C. Description of responsibilities regarding the financial statements

Responsibilities of management for the financial statements
Management is responsible for the preparation and fair presentation of the financial statements, in accordance with the Guidelines for annual reporting 650 "Fundraising Organisations" of the Dutch Accounting Standards Board. Furthermore, management is responsible for such internal control as management determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

As part of the preparation of the financial statements, management is responsible for assessing the organization's ability to continue as a going concern. Based on the financial reporting framework mentioned, management should prepare the financial statements using the going concern basis of accounting unless management either intends to dissolve the foundation or to cease operations, or has no realistic alternative but to do so.

Management should disclose events and circumstances that may cast significant doubt on the organization's ability to continue as a going concern in the financial statements.

Our responsibilities for the audit of the financial statements
Our objective is to plan and perform the audit assignment in a manner that allows us to obtain sufficient and appropriate audit evidence for our opinion.

Our audit has been performed with a high, but not absolute, level of assurance, which means we may not detect all material errors and fraud during our audit.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. The materiality affects the nature, timing and extent of our audit procedures and the evaluation of the effect of identified misstatements on our opinion.

We have exercised professional judgement and have maintained professional scepticism throughout the audit, in accordance with Dutch Standards on Auditing, ethical requirements and independence requirements.

Our audit included e.g.:

- identifying and assessing the risks of material misstatement of the financial statements, whether due to fraud or error, designing and performing audit procedures responsive to those risks, and obtaining audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control;
- evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management;
- concluding on the appropriateness of management's use of the going concern basis of accounting, and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the organization's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause an organization to cease to continue as a going concern;
- evaluating the overall presentation, structure and content of the financial statements, including the disclosures; and
- evaluating whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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

Amsterdam, 23 July 2019

Dubois & Co. Registeraccountants

Signed on original by:
G. Visser RA and K. Ait Boukdir RA

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