HEALTHNET TPO ANNUAL REPORT 2016

HEALTH WORKS

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PREFACE

A YEAR OF RENEWED HOPE

HealthNet/TPO is a specialist organisation aimed at improving the health and wellbeing of people and communities that have been severely traumatized by war and violence. HealthNet is unique in its strong focus on mental health, stemming from the conviction that the provision of physical health care alone is not enough to help traumatized communities to start functioning again.

The invisible, mental trauma of people in these communities, needs to be addressed in order to enable them to truly rebuild their communities. The effectiveness of HealthNet's intervention methods, in the areas of both physical and mental health, are furthermore continually monitored & evaluated and improved by HealthNet's uniquely strong research department.

For HealthNet as an organisation, 2016 was a year of renewed hope. At the beginning of the year, HealthNet's resources needed further strengthening. The consequences of the negative equity built up over the previous years were strongly felt. The unwavering dedication of HealthNet's local teams ensured that our projects in Afghanistan, South Sudan and Burundi, could continue. These colleagues are our heroes.

Donations by the Zaluvida Foundation (in total €2.8 million during late 2015 and 2016), allowed HealthNet to make the financial, organisational and strategical changes needed to ensure a stable organisation, which is fit-for-purpose, an organisation that is as relevant today as it was twenty-five years ago.

Carin Beumer
Chair of the Board of Directors

Fotografie: Edwin Venema, De Dikke Blauwe

YES, there's 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!

More than a billion people at the bottom are excluded from such developments. They are left out, losing out, and even being pushed out; they are 'disconnected' from public services and basic security. They are among the 10% of the world's population who have to survive on less than 2 USD per day. Let's be very clear: that's not just poverty, it's the most urgent social and moral problem, and an immediate security issue for all.

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 an illegal abortion is safer than giving birth. We have a deep understanding of how being 'disconnected' destroys the basic foundation of any society: trust and minimum confidence.

We gain people's trust and help them to change their fate themselves.

We know health is so much more than the absence of disease. Health is an essential condition for a satisfying life. Just as every person is more than a patient, health is about much more than health care. Health is about both cure and care, it is the opposite of illness, it is reflected in the caring and healing relations between people. Individuals cannot be healed in a sick society. Health is required for building communities that allow a secure and safe life for everyone.

10%

OF THE WORLD'S POPULATION HAVE TO SURVIVE ON LESS THAN 2 USD PER DAY

We use therefore health as an entry point into the worst situations. We build health systems and provide health care, but any lasting effect has to 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 total 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 mobilised 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. And no one is excluded, no one stays disconnected.

CHAPTER 02 PROGRAMMES

'Partnerships are key'

In 2016, the effects of HealthNet's financial problems were felt in our project portfolio. Our project income and expenditure dropped compared to the previous year. In 2015, a number of longer-running projects had ended, and due to the precarious financial situation of the organisation in 2014 and 2015, we had been unable to acquire substantial, new multi-year funding. In 2016, we developed a new strategy that will allow us to rebuild our project portfolio and make it even stronger than before.

HealthNet has run its projects on funding from institutional donors. These institutional donors are organisations (mostly governmental, inter-governmental or sometimes non-governmental) that give grants to other parties in order to carry out projects that correspond with their policy framework and mandate. The direct costs of projects are completely covered by these institutional donors. These donors, however, only cover part of the indirect costs, such as proposal development, monitoring and reporting on projects and all other activities at the organisation's headquarters in Amsterdam.

'OVER THE COURSE OF 2016, A NUMBER OF STRATEGIC DECISIONS HAVE BEEN MADE IN ORDER TO MAKE HEALTHNET FIT FOR PURPOSE AND FUTURE-PROOF'

NEGATIVE EFFECT

Because HealthNet, coming from Doctors Without Borders (MSF), was initially not expected to enter the private fundraising market and compete with MSF, these uncovered indirect costs and operational losses led to the build-up of negative equity over the years. This build-up of negative equity, in turn, started to have a negative effect on our success with institutional donors. Grants were denied to us, not on the basis of our operational quality or expertise, but on the basis of our precarious financial situation. We lost, for example, our FPA (Framework Partnership Agreement) status with ECHO (European Civil Protection and Humanitarian Aid Operations; the emergency aid desk of the European Union), which is also widely used as a benchmark for being awarded grants, both for emergency projects and structural development projects, by other institutional donors.

NEW STRATEGY

With the capital injection of the Zaluvida Foundation in December 2015, HealthNet's financial situation has changed considerably. This improves our position in the tender market, and we will once more be able to apply for funding from various institutional donors. Over the course of 2016, a number of strategic decisions have been made in order to make HealthNet fit for purpose and future-proof. These include starting up fundraising to cover our indirect costs and to set up our own projects rather than only execute projects outlined by institutional donors.

Gaining access to institutional funds, however, also requires a new strategy: over recent years, these funds have become ever harder to access if one is not member of a platform or coalition. Partnerships are key. For that purpose, substantial efforts have been made in 2016 to set up partnerships, become part of platforms/coalitions and so on. This has led to some first successful results: HealthNet was awarded a grant from the Health Pooled Fund in South Sudan (for a follow-up project on the one described below), in a consortium with Cordaid and AFOD. Also in 2016, we have joined the platform DCDD (Dutch Coalition on Disability and Development) and have joined the effort to set up a Dutch Alliance of Health Systems. This allows us to set up strategic partnerships with other members of these platforms.

PROJECTS EXAMPLES

Below, we have selected three project examples from 2016 that illustrate clearly what we do, how we do it and why. We have been organising projects in these three countries for many years now, and have built up considerable expertise and operational excellence in these areas.

CHAPTER 02

A. EXAMPLE PROGRAMME BURUNDI

Significant amount of success in family planning services

From 2012 until 2016, a HealthNet project ran that addressed sexual and reproductive health and rights in three provinces of Burundi. In this project, we implemented our community resource mapping and mobilisation method, in which we select, train and mobilise local community members to become local agents of change. This project addressed three important issues related to sexual and reproductive health and rights: family planning, sexual and reproductive health services for (young) Burundians and the reduction of sexual and gender-based violence.

Burundi is a small country with extremely high poverty levels. With an average of 5-6 children per family and very little knowledge of the possibilities for family planning, our intervention with regard to family planning was sorely needed. We selected and trained local community members to start approaching and educating their community members on various contraceptive methods. We have booked a significant amount of success in this regard:

- Before the start of the project the unmet need for family planning (women that don't use any form of anti-conception while indicating they don't want any more children) was estimated at some 49,9%. In 2016 this percentage was some 30%, which is a decrease of 19,9%.
- The percentage of people that use modern contraceptives increased from 24,5% in 2013 to 42% in 2016, which is an increase of 17,5%.
- The percentage of unwanted pregnancies among adolescents went down from 11% in 2013 to 3,5% in 2016.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Over 50% of the population of Burundi is under 18 years of age. Among these young Burundians, there is very little knowledge about their own bodies and, unaware of the dangers involved, they engage in a lot of risky sexual behaviour. Apart from pregnancy, sexually transmitted infections (STIs) constituted an important area of attention in which we have made an effort to educate Burundian youth. As part of these efforts, we addressed a wide variety of topics, from recognising STIs such as chlamydia, seeking medical treatment and the need for informing sexual partners. The results of our project are as follows:

- The percentage of youth that makes use of SRH related services went from 31,7% in 2013 to 74% in 2016 which is an increase of 42,3 %.
- The percentage of sexually transmitted infections (STIs) went from 8.5% to 5,13%.

This result is somewhat disappointing. The problem of STIs turned out to be larger than it had seemed at the beginning and STIs were more prevalent among Burundians than we initially thought. Many Burundians simply did not recognise that they were suffering from an STI or were so ashamed or mistrustful that they did not dare turn to health care workers for help.

The results of our sociotherapy intervention are impressive

SEXUAL AND GENDER-BASED VIOLENCE

One of the interventions that appeared to be successful when addressing the mechanisms associated with the violation of sexual and reproductive health and rights, was by means of (group) sociotherapy for couples that had serious conflicts. Local community members, trained and supported by us, organised and led these sessions. Over the course of the sessions, issues such as empathy, mutual understanding and conversational techniques were addressed. Both organisers and participants were very enthusiastic about this particular intervention method, which resulted in improved social, mental and physical wellbeing on part of the participants. In order to find the evidence base for the effects of our sociotherapy group interventions, our research department conducted a Randomized Control Trial. The results of our sociotherapy intervention are impressive and show significant differences on the decline of physical, mental health complaints compared to a control group.

The number of Sexual and gender-based violence cases that require medical and/or legal attention decreased with some 10% during the implementation period.

B. EXAMPLE PROGRAMME AFGHANISTAN

Training of doctors, nurses, psychologists, social workers and therapists in Kabul Mental Health Hospital

From 2015 until 2018, a HealthNet project is running in Afghanistan in which we are responsible for the implementation of services that are delivered in Kabul Mental Health Hospital, which is the only tertiary, highly specialised, psychiatric hospital in the country.

For the last 35 years, Afghanistan has been facing a chronic and complex conflict that has caused the displacement of people, both to other countries and domestically, which has resulted in poverty and has damaged social and cultural norms and values. Among Afghans, epidemiological studies have consistently found high rates of self-reported symptoms of depression, anxiety and posttraumatic stress, particularly among women and girls.

Since 2010, mental health care, including psychosocial counselling services, has been integrated into the Basic Package of Health Services (BPHS; primary health care) and the Essential Package of Hospital Services (EPHS; secondary and tertiary health care) in Afghanistan. On paper, this system is well-structured. In practice, however, many are not receiving the mental health care that they need; those who deliver health care are often insufficiently trained in the field of mental health and mental health problems among Afghans are still highly stigmatized.

THE KABUL MENTAL HEALTH HOSPITAL

The Kabul Mental Health Hospital, in which our project runs, has 100 beds. Of these beds, sixty are used for mentally ill patients and forty beds are the treatment of (opium) addicts. The hospital has a work force of 130 staff. We work with some psychiatrists, whom we have hired from abroad (mainly Pakistan), who train fifteen Afghan doctors, nineteen nurses and who are part of a team that consists of psychologists, social workers and occupational therapists. In close collaboration with the Afghan Ministry of Health, we have identified a number of priority areas to be addressed by our project:

- **Forensic psychiatric services** for prison inmates are in place, but utilisation of this ward needs to be increased. Also, the coordination with prison authorities and the Ministry of Interior Affairs needs to be improved.

- **Emergency services** are still in their infancy and most emergency cases are not properly recorded and reported. Within the project, we are developing a minimum quality standard for the provision of emergency services.

- **Care for children** and adolescents; young patients are currently treated together with, and in the same way as adults. We will establish a separate child and adolescent unit of 5-7 beds, supervised by trained and skilled staff.

- **Nursing care** is an important part of mental health services. In order to build the skills of the hospital's nurses, we organise a number of class room-based and on-the-job training sessions as well as exposure visits.

- **Standard operation procedures** and guidelines have to be developed to meet basic needs and

We will establish a separate child and adolescent unit of 5-7 beds, supervised by trained and skilled staff

standards. We will seek the collaboration with experts in the area of mental health services in order to deliver services that are up to international standards.

- **The hospital's laboratory** is understaffed. HealthNet will reorganise this department while ensuring round-the-clock service.

- **The hospital space** is limited and this is compromising the quality of services. Together with the hospital management, we have developed a comprehensive plan for proper space management, which includes the expansion and renovation of wards.

- **Supportive services** such as laundry, catering, tailoring and administration are currently scattered over different wards. This limits the effectiveness and quality of service provision. Together with the hospital management, we plan to reorganise these supportive services.

- **Recreational activities** for patients are currently not provided due to a lack of space and facilities. HealthNet will ensure that the hospital has space and facilities for the organisation of recreational activities for patients.

- **Referral system**; there is currently no proper two-way referral mechanism between the Kabul Mental health Hospital and provincial BPHS (Basic Package of Health Services) and EPHS (Essential Package of Hospital Services) health facilities. HealthNet will develop a referral system in close collaboration with the staff of relevant facilities.

- **Medical products and pharmaceutical management**; the hospital is responsible for ensuring the availability of all drugs to patients. HealthNet is currently working to set up a system in order to make drug procurement and stock management more efficient.

- **Infection prevention and waste management** are areas that need attention in the hospital. Health risks need to be minimised by improving the segregation and disposal of waste and the use of personnel protection equipment.

C. EXAMPLE PROGRAMME SOUTH SUDAN

Involve and commit local people to the health care in their own area

From 2012 to 2016, HealthNet was selected and funded by the Health Pooled Fund to run a services implementation project in the Jur River and Raja counties of Western Bar el Ghazal and in North Aweil of Northern Bar el Ghazal. Through the Health Pooled Fund (HPF), a group of institutional donors – mainly countries such as the UK, Canada, Sweden and the Netherlands – coordinate their developmental aid efforts with regard to health care in South Sudan. The HPF contracts NGO partners to:

- **support primary health care services** and increase the involvement of communities;
- **provide technical support** to county health departments;
- **support secondary** (more specialised) health care, with a focus on enhancing the level of reproductive, maternal and paediatric health care.

South Sudan is one of the most underdeveloped countries in the world. The country's independence in 2011 followed years of violent conflict that severely damaged the physical as well as the social infrastructure of the country, caused the deaths of tens of thousands and the displacement of an estimated 1.6 million people. The country is sparsely populated, its population extremely poor and among the citizens, the need for educational and health care services is pressing. Independence has unfortunately not led to stability: the situation in the country is still very fragile, political unrest is still escalating and violent fighting still erupts from time to time.

MAIN GOAL

Within the HPF project, we mainly worked on improving the systems and the delivery of health care and nutritional services that are part of the Basic Package of Primary Health care (BPPH) in South Sudan. For this purpose, we selected, educated and mobilised local community members in order to build up a health care network in which the community is involved. Over the course of four years, we have managed to set up a system that is strong enough to ensure a continuing delivery of basic health care services to the most vulnerable irrespective of ongoing conflicts.

FOCUS ON FAMILY PLANNING

Apart from this main goal, we identified a number of gaps and priorities that needed our attention. Family planning was one of these priorities: currently, there are a lot of child marriages and child pregnancies in South Sudan and the maternal and infant death rate, especially during childbirth, is very high. Among the inhabitants of South Sudan, traditional and ineffective methods of contraception are still widely used and knowledge of modern contraceptives is virtually absent. We have therefore trained two health care workers per health centre in family planning. Furthermore, we have organised a media campaign to inform the public on the dangers of giving birth in squalid, unhygienic circumstances, and we have made sure that modern contraceptives are continually available in local health facilities.

We trained two health care workers per health centre in family planning

NUTRITION

Another priority was educating the South Sudanese on nutrition and the importance of a varied diet. Malnutrition is a significant problem in South Sudan, especially among women and children. Therefore we have implemented highly effective interventions to address some of these problems, such as iron/folate supplementation during pregnancy, vitamin A supplementation, and the provision of complementary feeding for children from 6-9 months of age.

RESULT

Within this project, there was little room for the mental health aspect that is part of our other programmes. This has to do with the extremely difficult and unstable situation of the country. What we have managed to achieve, however, is to involve and commit local people to the health care in their own area. The HPF project will be continued in a second HPF project on a smaller scale, which will be aimed at making the current basic health care system stronger and more sustainable.

CHAPTER 03 RESEARCH

Clear insights into what works, to what extent and why, and what does not

The strong focus on scientific research is one of the things that makes HealthNet truly unique in the NGO-world. Whereas other NGOs can generally only show that they have made an effort with donor money, our research enables us to show not only that we have made an effort, but also what the impact and quality of our efforts have been exactly.

Research serves two purposes for HealthNet. Firstly, research helps us to identify clearly 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.

RESEARCH DOMAINS

Our research is guided by an agenda and covers activities within three domains:

- **Systems and delivery**: within this domain, we gather information on the effectiveness and feasibility of interventions;
- **Research methods**: within this domain, we are concerned with the development of robust assessment methods in order to make sure that the data we gather is scientifically sound and trustworthy;
- **Context and health**: within this domain, we are concerned with the collection of evidence on the context in which we operate.

RESEARCH IN 2016

Unfortunately the amount of research conducted by the department is lower than in previous years because of lack of funding. Nevertheless, we are proud the following research activities took place in 2016:

- At the World Psychiatric Association (WPA) International Congress in Cape Town, HealthNet presented a model for the sustainable integration of community mental health services in Congo. The model was shared with the Congolese government and accepted as the way forward;
- HealthNet implemented a Naturalistic Cluster Randomized Trial to determine the efficacy of a sociotherapy group intervention aimed at dealing with the negative consequences of violations of Sexual Reproductive Health and Rights (SRHR);
- HealthNet participated in the large international academic research consortia PRIME (Dfid) and EMERALD (EU), both research projects contribute to the global initiative of closing the mental health service delivery gap in low-income countries.
- HealthNet co-lead a Post-Research Ethics Audit research initiative (PREA, R2HC) that is proposed to define a framework for post hoc assessment of ethical aspects of health research in humanitarian crises.

FOCUS

In 2016, HealthNet made the decision to shift the priorities of the thematic focus of our research more on the quality and impact that our interventions have on health, wellbeing and functioning of both individuals and groups.

AMBITION FOR THE FUTURE

In 2017, we aim to strengthen the Research & Development department. Also, we intend to optimize the collaboration and exchange of knowledge and expertise with our teams in Afghanistan, Burundi and South Sudan. 2017 will be a year of scaling up activities in order to achieve an overall ambition that, by 2021, HealthNet is again regarded as a leading organisation with a flourishing research department.

CHAPTER 03

EXAMPLE: THE SRHR PROGRAMME IN BURUNDI

'The social fabric in these communities is often destroyed by violence and its aftermath'

The importance of our research in determining the effectiveness of our interventions is clearly illustrated by the example of Burundi. We conducted a Naturalistic Cluster Randomized Trial (NCRT) to determine the efficacy of sociotherapy group intervention in the SRHR program in Burundi. The results of this research do not only show that our intervention has been effective, but also provides a strong evidence base for this type of intervention for SRHR related problems of individuals and communities in similar post-conflict areas.

Communities in post-conflict areas have specific but also shared characteristics. The social fabric in these communities is often destroyed by (political related) violence and its aftermath. Families no longer serve as a safe environment for their individual members and there is a significant lack of trust and bonding among the members of a community. On the level of the community as a whole, this deterioration of the social fabric is often associated with an increase of health problems, social exclusion, poverty and other socio-economic problems. On the level of the individual member of the community, the deterioration of the social fabric may lead to a range of diseases and problems associated with a decline in physical and mental health, psychosocial problems, distress and (social) dysfunctioning.

BURUNDI

In Burundi, violations of sexual and reproductive health rights (SRHR) are persistent problems and are associated with the loss of 'social fabric'. Earlier research has shown that the concrete problems of individual Burundians experience in their daily life often originate from the lost of social structures and increase of dysfunctional social mechanisms in the community.. This means that the problems of individuals and groups of vulnerable individuals are difficult to manage on an individual level and that it is much more effective to combine care for individuals and groups with the reconstruction and restoration of the social fabric of their communities.

COMMUNITY-BASED SOCIOTHERAPY

In general sociotherapy had been implemented as an intervention method to address either problems on the individual level or problems that are defined on a communal level. In our program in Burundi, HealthNet provided our community-based sociotherapy intervention on multiple levels thus address negative consequences of violations of SRHR for the individual, families and the community as a whole at the same time.

RESEARCH STUDY

Our community trail of the impact of our SRHR focused sociotherapy group intervention shows a statistically significant impact of sociotherapy and confirms the findings of two earlier pilot community intervention studies (2014 and 2015) on the effects of sociotherapy. This research study contributes to the evidence base that justifies the implementation of sociotherapy as a community-oriented intervention for a wide range of interrelated individual and communal problems characteristic for humanitarian crisis settings like Burundi. Compared to other studies on the effects of community-oriented sociotherapy, this study is the only study that shows that sociotherapy is an effective community practice to deal with the complex and interrelated health, social and economic problems faced by individuals as well as their social environment.

CHAPTER 04 POSITIONING HEALTHNET

'Increasing our brand awareness'

2016 was a year of making the organisation future-proof. In order to achieve this, it quickly became clear, we had to develop a new fundraising strategy. The first step in doing so consisted of the creation of a new, sharper positioning for HealthNet. This clear positioning will enable us to convey clearly, to potential donors as well as to the general public, what HealthNet is about.

Although HealthNet has existed for almost 25 years now, the organisation is virtually unknown outside of the institutional donor sector. This stems from the organisation's origins, as it came from Doctors Without Borders in 1992. That meant that the organisation had a clear goal and an important agreement. The goal was to build an institutionally-funded project portfolio to follow up on the emergency aid of Doctors Without Borders. The restriction was that HealthNet would not enter the fundraising market and compete with Doctors Without Borders. Therefore, the agreement was made that Doctors Without Borders would cover any financial deficits that HealthNet would encounter.

This removed any need for fundraising or publicity, at least until around the year 2000, when the collaboration with Doctors Without Borders came to an end and HealthNet had to fend for itself. Depending and relying on funding from institutional donors only proved to be unsustainable in the long term and nearly led to the collapse of HealthNet in 2015. After the donation from the Zaluvida Foundation at the end of 2015, it was clear that we had to change our strategy drastically and to get fundraising started. The first step towards this consisted of a fresh and clear positioning of HealthNet.

POSITIONING PROCESS

The process of positioning HealthNet started in spring 2016 with our strategic away-days. Over the course of these days, we realised that we needed professional help to help redefine and position HealthNet for the future. In fall 2016, an external marketing team started with an extensive survey of the organisation, including both the Amsterdam headquarters and the field offices in Afghanistan, Burundi and South Sudan. After this survey, we worked on sharpening HealthNet's position and defined our why-how-what in'Sharing knowledge, Strenghtening Communities'. The work with this external team continues in 2017 and includes the definition of target groups for fundraising, the development of a brand campaign and the creation of a marketing and communications plan.

EXPECTATIONS

We aim to launch the 'new' HealthNet in September 2017. In the short term, we expect that this new positioning will result in an increase in brand awareness. Also, we hope to book our first fundraising results with family foundations and corporate social responsibility (CSR) programs. In the long term, we expect that HealthNet will become a financially stable organisation that can rely on a sound donor base consisting of major private donors and corporate donors.

FIRST SUCCESS: NATIONALE POSTCODE LOTERIJ

In our transition year 2016, we invested significant time and energy in writing a funding bid for the Nationale Postcode Loterij (Dutch National Postcode Lottery). Our efforts were rewarded in 2017, when we received a one-off grant of €1 million euros.

CHAPTER 05 ORGANISATIONAL STRUCTURES

'Renewed energy, ambition and organisational focus'

For Healthnet, 2016 was a year of redefining the organisation and making it future-proof. This also meant that organisational changes were needed in order to make sure that the right people were on the bus. There were departures from and new additions to the supervisory board. Furthermore, with the departure of Willem van de Put as executive director, a change in leadership was initiated. During several strategic away-days, we determined which additional skills were needed in order to further professionalise the organisation.

CHANGES TO THE BOARD

In 2016, Jaap Gelderloos (treasurer), Lex Winkler (specialised in field operations) and Ellen van Dodewaard (specialised in HR) left the board. This gave us the opportunity to look for new, highly qualified professionals with relevant skills. Over the course of the year, we were able to get both Piet Roelse and Hans-Georg van Liempd interested and on board. A qualified replacement for Lex Winkler, with expertise in the area of field operations, proved difficult to find and this position remained vacant over the course of the year.

COMPOSITION OF THE BOARD

At the end of the year, the composition of the board was as follows:

Carin Beumer (chair) was appointed to the board on 29 October 2015. She is founder and chair of the Zaluvida Group, which consists of a number of cutting-edge life sciences companies. Carin started her professional career in the financial sector and arranged financing for large infrastructural projects in developing countries. In 2005, together with her husband Thomas Hafner, she founded the Zaluvida Group. The two also set up the Zaluvida Foundation. This foundation actively supports Healthnet and drives Community Care programs in all of Zaluvida's locations around the globe.

Kay de Gier-Formanek (vice chair) was appointed to the board on 2 December 2015. Kay is the founder and CEO of KAY Diversity & Performance, which helps both profit and non-profit organisations to develop effective diversity and inclusion programs. Prior to founding KAY Diversity & Performance in 2014, Kay worked at Accenture as managing director and industry lead for its Life Sciences Practice in Europe, Africa and Latin America. She has significant experience in transforming and strengthening organisations that need to adapt to changing environments.

Piet Roelse (treasurer) was only officially appointed in January 2017. Piet is a business-driven senior financial executive and interim professional with over 30 years of international experience in Europe, the USA and the Far East. He is a certified public accountant and has served as Audit Lead at PWC for about 10 years. Subsequently, he has held important positions in global and Dutch enterprises, including Sara Lee and Royal Wessanen.

Hans-Georg van Liempd (member) was appointed to the board on 5 October 2016. Hans-Georg is Managing Director at Tilburg University's School of Social and Behavioural Sciences. Apart from his career at Tilburg University, Hans-Georg has also been very active in the field of internationalisation of Higher Education and has held important positions within the European Association for International Education (EAIE). Furthermore, Hans-Georg is chair of the board of the Zanskar-Stongde Foundation, which aims to provide young people in India with opportunities for education.

Koos van der Velden (member) has been a member of the board since July 2013. Koos holds a professorship in Public Health at the department of Primary and Community Care at the Radboud University Medical Center Nijmegen. His main research topics are infectious disease control and health systems development. He received his medical training at Utrecht University and specialised in tropical medicine, family medicine and community medicine in London. He defended his PhD thesis, titled 'General practice at work', at the Erasmus University Rotterdam.

CHAPTER 05

STRATEGIC AWAY-DAYS

Over the course of 2016, it became clear that the financial injection by the Zaluvida Foundation alone was not enough to secure a strong future for Healthnet. It became clear that the organisation had been in a survival mode for so long that there had been no room for the development of a clear strategy. Furthermore, a lot of deferred maintenance had accumulated, which needed to be taken care of. Therefore, a number of strategic away-days were organised, in which the organization worked on different relevant topics, such as marketing, communications and funding, the importance and role of our research programmes, organisational structures and business systems. In the third quarter of 2016, we also started work on the strategic positioning of Healthnet within the ngo-world.

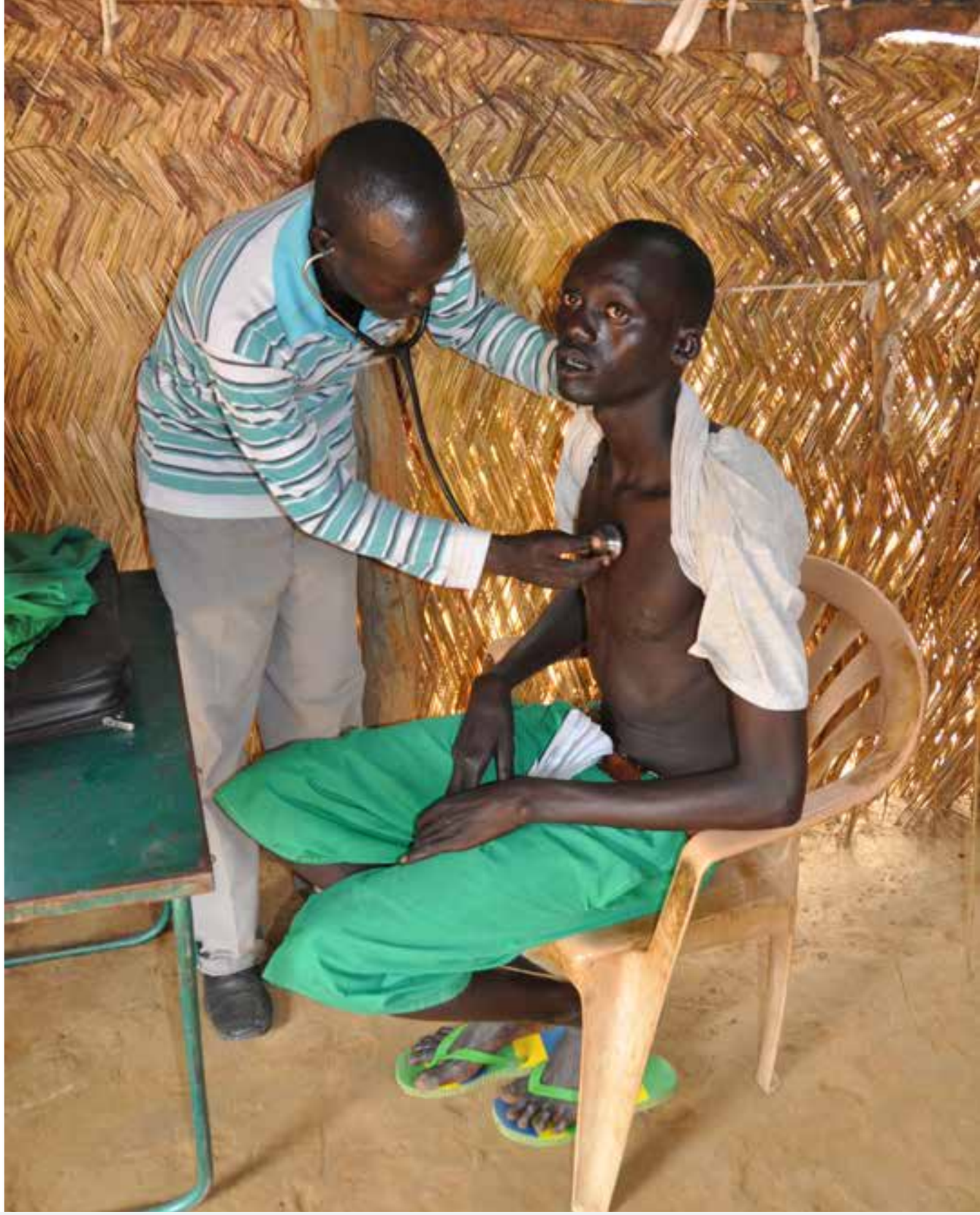
CHANGE IN MANAGEMENT

In 2016, the tough decision was made that new skills and a different management view were needed. Therefore, we had to say goodbye to our executive director Willem van de Put, who leaves an organisation that is widely praised for its operational excellence. After the departure of Willem van de Put, Hans Grootendorst served as interim executive director for the remainder of 2016. Meanwhile, the board looked for a new director with a different profile; someone with strong business acumen, proven skills in the field of marketing and communications and experience with NGOs as well as transition management. This led to the appointment of Marc Tijhuis as executive director in 2017.

ORGANISATIONAL CHANGE IN 2017

Over the course of 2016, we also decided on further organisational changes. Over the course of 2017, with a new executive director on board, we plan to establish a strong management team and to fill some important positions within the organisation. We have decided to hire an international project manager to optimise and oversee the project management cycle. Furthermore, we expect to fill important positions in the field of marketing and communications and funding.

With regard to 2017, we foresee a year of renewed energy, ambition and organisational focus. We expect to further develop into a financially and operationally solid organisation with a clear identity and strategy.



6.1 FINANCIAL STATEMENTS 2016

1. STATEMENT OF INCOME AND EXPENDITURE FOR THE YEAR 2016

(IN EUROS)	NOTE	ACTUAL 2016	BUDGET 2016	ACTUAL 2015
Expenditure on objectives				
Reconstruction and development	4	10.937.087	13.500.000	17.312.362
Awareness raising and public information	5	224.969	190.000	181.724
		11.162.056	**13.690.000**	**17.494.086**
Expenditure income generation				
Own fundraising efforts	6	124.581	115.000	114.609
Securing government subsidies	7	89.547	85.000	81.220
		214.127	**200.000**	**195.829**
Expenditure management & administration	7	634.490	1.025.000	624.655
		12.010.672	**14.915.000**	**18.314.570**
Income institutional donors	10	10.965.879	13.854.000	18.038.777
Income from fundraising	11			
Donations and gifts		917.479	1.000.000	2.121.111
Local project income		-	5.579	39.794
Subsidies from non-governmental organizations		312.067	150.000	249.769
		1.229.546	**1.155.579**	**2.410.674**
Income third party campaigns	12	-	50.000	64.551
		12.195.425	**15.059.579**	**20.514.002**
Other results	13	(23.489)	-	15.961
Result		**161.264**	**144.579**	**2.215.393**
Percentage expenditure on objectives vs total income		91,5%	90,9%	85,3%
Percentage expenditure on objectives vs total expenditure		92,9%	91,8%	95,5%

For the fourth year in a row the result is positive. Project income and expenditures 2016 were lower than budgeted as two important projects in South Sudan started up later than expected and with less than usual volume. The result for 2016 is still in line with budget as the lower contribution from projects was compensated by lower expenditures for management & administration as a result of strict cost control. HealthNet was again supported by the Zaluvida foundation. In 2016 this foundation donated € 0,8 million.

2. BALANCE SHEET FOR YEAR ENDING 31 DECEMBER 2016

(IN EUROS)	NOTE	DECEMBER 31 2016	DECEMBER 31 2015
Intangible fixed assets	14	-	6.322
Tangible fixed assets	15	3.644	4.897
Receivables and accrued income			
Work In progress	22	1.923.795	2.731.767
Receivables	16	54.173	185.565
Cash and banks	17	2.901.660	1.809.663
Total Assets		**4.883.272**	**4.738.214**
Continuity reserves	19	368.073	206.809
Provisions	20	565.909	553.978
Short-term liabilities			
Project balances	22	2.670.238	2.998.676
Other short-term liabilities	23	1.279.051	978.751
Total reserves and liabilities		**4.883.272**	**4.738.214**

3. CASH FLOW STATEMENT

(IN EUROS)	2016 PROJECT COUNTRIES	2016 NETHERLANDS	2016 TOTAL	2015 PROJECT COUNTRIES	2015 NETHERLANDS	2015 TOTAL
Balance on 1 January	**363.177**	**1.446.486**	**1.809.663**	**1.692.861**	**536.109**	**2.228.970**
Donor instalments current projects	7.903.857	3.826.538	11.730.394	7.041.646	10.851.938	17.893.584
Repaid unspend subsidies to donor	(4.513)	-	(4.513)	(4.513)	(30.518)	(35.031)
Received final payments closed projects	-	-	-	-	-	-
Donations	34	803.381	803.415	(597)	2.013.000	2.012.403
Other income	(48.478)	2.574	(45.904)	66.459	1.350	67.809
	7.850.900	**4.632.492**	**12.483.393**	**7.102.995**	**12.835.770**	**19.938.765**
Transfers to the project countries	3.196.278	(3.196.278)	-	8.724.100	(8.724.100)	-
Expenditures on objectives in the field offices	(8.853.556)	-	(8.853.556)	(17.156.779)	-	(17.156.779)
Project expenses paid from the Netherlands	-	(438.159)	(438.159)	0	(1.159.449)	(1.159.449)
Expenditure on overhead in the Netherlands	-	(2.099.682)	(2.099.682)	-	(2.041.844)	(2.041.844)
Balance on 31 December	**2.556.800**	**344.860**	**2.901.660**	**363.177**	**1.446.486**	**1.809.663**

Donor instalments for project countries are the instalments received in Afghanistan. As the project volume Afghanistan in 2016 was similar to 2015 the locally received donor instalments in 2016 are also in line with 2015. For the other project countries the instalments are received in Amsterdam. These are lower in 2016 as a result of the overall lower project volume. The project expenses paid from the Netherlands in 2016 are significantly lower than in 2015 as no medical supplies were purchased by the head office in 2016. In 2015 these expenditures amounted €0.5 million.

6.2 NOTES TO THE FINANCIAL STATEMENTS

ACCOUNTING PRINCIPLES

The annual report has been prepared in accordance with the 'Guideline 650 for Fundraising Institutions', as published by the Dutch Council for Annual Reporting published in January 2012. The purpose of this guideline is to provide information about the costs of the organization and the expenditure of funds to further the objectives for which the funds were acquired. Execution of projects is the main objective of HealthNet. For this reason HealthNet has deviated from the prescribed model. In the statement of income and expenditure the expenditure is presented before the income. 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.

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 Profit and Loss Account.

ALLOCATION OF ORGANIZATIONAL COST

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

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 considered to be administrative expenses for 20%. Other costs are allocated on a pro rata basis based on the allocation of the direct costs.

INCOME THIRD PARTY CAMPAIGNS

Income from third party campaigns relates to the activities for which the foundation bears no risk. This income is accounted for in the year that the proceeds are received and/or allocated by the third party.

CASH FLOW STATEMENT

The consolidated cash flow statement was prepared using the direct method.

ASSETS

The assets shown on the balance sheet are all held for the purpose of 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

DEBTORS

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

RESERVES AND FUNDS

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

PROJECT BALANCE AND WORK IN PROGRESS

The project balance is presented according 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 taken into account.

6.3 NOTES TO THE STATEMENT OF INCOME AND EXPENDITURE

EXPENDITURE

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 is to spend at least 90% of the total expenditures directly on the objectives.

In 2016 92.9% (€ 11.2 million) of total expenditures (€ 12.0 million) were directly spent on the objectives. Main part of this (91.0%) is for Reconstruction and Development. It is the policy of HealthNet to work with own staff in the field as much as possible. Therefore salary cost are the main part of the reconstruction and development cost. Medical goods are another big part of the expenditures.

4. RECONSTRUCTION AND DEVELOPMENT

(IN EUROS)	AFGHANISTAN	BURUNDI	SOUTH SUDAN	OTHER COUNTRIES	TOTAL 2016	BUDGET 2016	ACTUALS 2015
Actuals 2016							
Expat staff	58.531 1%	7.149 1%	135.623 7%	75.940 31%	**277.243** 3%	514.614 4%	690.723 4%
HQ staff	164.970 2%	82.485 6%	63.630 3%	134.542 55%	**445.627** 4%	546.615 4%	708.236 4%
Local staff	3.521.935 49%	361.260 28%	888.766 46%	- 0%	**4.771.960** 45%	5.229.827 40%	7.019.555 40%
Field office cost	844.794 12%	108.463 9%	305.259 16%	(1.336) -1%	**1.257.180** 12%	960.489 7%	1.289.184 7%
Transportation	358.378 5%	126.930 10%	266.431 14%	7.619 3%	**759.358** 7%	1.075.836 8%	1.444.003 8%
Training and education	542.336 7%	446.030 35%	78.978 4%	2.348 1%	**1.069.692** 10%	1.474.306 11%	1.978.837 11%
Medical and other goods	1.738.180 24%	- 0%	109.018 6%	- 0%	**1.847.199** 17%	2.116.843 16%	2.691.610 15%
Consultancy	6.229 0%	143.021 11%	25.290 1%	27.109 11%	**201.649** 2%	171.810 1%	230.606 1%
Local partners	- 0%	- 0%	43.435 2%	- 0%	**43.435** 0%	1.018.096 8%	1.366.504 8%
	7.235.354	**1.275.338**	**1.916.431**	**246.220**	**10.673.343**	**13.108.437**	**17.419.257**
Local income	48.478	-	-	(2.574)	**45.904**	-	(28.015)
Total Expenditures	**7.283.831**	**1.275.338**	**1.916.431**	**243.647**	**10.719.247**	**13.108.437**	**17.391.243**
				Allocated organizational costs (Note 7)	298.871	325.000	163.391
				Exchange rate and post project results (Note 8)	(81.031)	66.563	(242.271)
					10.937.087	**13.500.000**	**17.312.362**

5. AWARENESS RAISING AND PUBLIC INFORMATION

(IN EURO)	ACTUALS 2016	BUDGET 2016	ACTUALS 2015
Website	116.405	105.000	110.296
Other activities	43.387	15.000	3.146
	159.792	**120.000**	**113.442**
Allocated organizational costs (Note 7)	65.177	70.000	68.282
	224.969	**190.000**	**181.724**

6. COST OWN FUNDRAISING EFFORTS

(IN EURO)	ACTUALS 2016	BUDGET 2016	ACTUALS 2015
Advertisement	303	5.000	5.270
Other fundraising cost	33.291	20.000	14.017
	33.594	**25.000**	**19.287**
Allocated organizational costs (Note 7)	90.987	90.000	95.322
	124.581	**115.000**	**114.609**

7. ALLOCATION OF ORGANIZATIONAL COST

EXPENDITURES	RECONSTRUCTION AND DEVELOPMENT	AWARENESS RAISING AND PUBLIC INFORMATION	TOTAL EXPENDITURE ON OBJECTIVES	OWN FUNDRAISING EFFORTS	SECURING GOVERNMENT SUBSIDIES	MANAGEMENT & ADMINISTRATION	ACTUAL 2016	BUDGET 2016	ACTUAL 2015
Average number FTEs	7,3	0,7	**8,0**	0,9	1,2	7,0	**17,0**	19,1	17,6
Personnel costs	608.239	60.898	**669.137**	85.014	97.048	580.379	**1.431.579**	1.620.681	1.456.563
Accommodation costs	48.500	4.452	**52.952**	6.215	7.558	45.711	**112.437**	112.563	136.799
Office and general costs	32.088	4.006	**36.093**	5.592	8.075	65.000	**114.760**	106.861	98.185
Depreciation and interest	3.879	402	**4.281**	561	540	2.630	**8.011**	9.684	43.529
	692.705	**69.758**	**762.463**	**97.382**	**113.221**	**693.721**	**1.666.787**	**1.849.789**	**1.735.077**
Recovered organizational cost	(393.834)	(4.582)	**(398.415)**	(6.396)	(23.674)	(62.547)	**(491.033)**	(546.615)	(708.236)
	298.871	**65.177**	**364.047**	**90.987**	**89.547**	**631.174**	**1.175.754**	**1.303.174**	**1.026.841**
Subsidies and contribution	10.592.312	159.792	**10.752.104**	33.593	-	3.316	**10.789.013**	13.320.000	17.315.746
Local income	45.904		**45.904**				**45.904**		(28.015)
Total allocation	**10.937.087**	**224.969**	**11.162.056**	**124.580**	**89.547**	**634.490**	**12.010.671**	**14.623.174**	**18.314.573**
percentage of expenditures on objectives				1,1%	0,8%	5,7%			
						Note: Coverage of indirect cost	**647.584**	**741.014**	**1.071.144**
						In % of total organizational cost (incl. Subsidies and contribution for Management and Administration)	51%	54%	84%

Costs securing government subsidies
The costs for securing government subsidies consist entirely of allocated organizational cost. Within HealthNet 1.2 FTE was engaged in securing government subsidies.

Management and Administration
The expenditures for Management and Administration consist as well entirely of allocated organizational cost. Staff of the departments finance, operational support, technical support and the directors spend a percentage of their time on Management and Administration. The average number of FTE's assigned for Management and Administration has stabilized in 2016 after a continuous decrease in the past years from 13.5 FTE in 2012.

8. EXCHANGE RATE AND POST PROJECT RESULTS, COMMUNICATION EXPENSES

(IN EUROS)	AFGHANISTAN	BURUNDI	DRC	SOUTH SUDAN	OTHER COUNTRIES	TOTAL 2016	BUDGET 2016	ACTUALS 2015
Actuals 2016								
Exchange rate results	40.088	(1.998)	8	(19.350)	7.340	**26.088**	-	162.429
Post-project results	65.068	(26.664)	(10)	33.611	(17.063)	**54.942**	66.563	79.843
	105.156	**(28.662)**	**(2)**	**14.261**	**(9.723)**	**81.031**	**66.563**	**242.271**
Communication expenses	-	-	-	-	3.316	**3.316**	-	6.031
Total	**105.156**	**(28.662)**	**(2)**	**14.261**	**(6.407)**	**84.347**	**66.563**	**248.302**

9. ORGANIZATIONAL COST HEAD OFFICE

(IN EUROS)	ACTUALS 2016	BUDGET 2016	ACTUALS 2015
Salary cost			
Gross salaries	1.049.189	1.182.365	1.095.320
Social security	156.230	181.508	148.277
Pension	164.281	202.735	167.959
Other personnel costs	61.879	54.072	45.008
Total salary cost	**1.431.579**	**1.620.681**	**1.456.563**
Average number of FTE's	*17,0*	*19,1*	*17,6*
Accommodation cost			
Rent	69.349	71.074	92.115
Service charges and move	36.689	35.039	37.689
Office maintenance	6.400	6.450	6.996
Total accommodation cost	**112.437**	**112.563**	**136.799**
Office and General cost			
Automation/Telecom	23.781	29.144	23.092
Office cost	7.651	9.555	6.929
Insurrance	7.207	5.850	2.811
Bank charges	2.189	1.050	1.261
Consultancy	11.148	7.470	11.455
Audit fees	48.222	33.600	42.753
Other general cost	14.562	20.191	9.884
Total office and general cost	**114.760**	**106.861**	**98.185**
Depreciation and interest			
Depreciation	10.051	9.684	47.617
Interest expense	-2.040	0	-4.088
Total depreciation and interest	**8.011**	**9.684**	**43.529**
Total organization cost head office	**1.666.787**	**1.849.788**	**1.735.077**

The actual 2016 number of FTE is 2.1 FTE lower than budgeted. This has a positive impact on all salary related cost. Other personnel cost are some higher because of a training event.

Starting with the 2015 accounts, a local audit firm has been engaged to assist in the audit of our operation in Afghanistan resulting in higher auditing fees. This was not incorporated in the budget.

INCOME

The income of HealthNet 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 in the year that the subsidized expenditure took place. In this context, the expenditures by alliance partners, where HealthNet 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.

10. INCOME INSTITUTIONAL DONORS

(IN EUROS)	ACTUAL 2016	BUDGET 2016	ACTUAL 2015
Afghan Ministry of Health	5.059.803	6.000.000	3.040.278
Dutch Ministry of Foreign Affairs	1.363.807	1.100.000	5.968.778
European Commission	761.902	1.000.000	35.973
Gavi	-		-
Global Fund	(3.000)	-	1.187.497
Health Pooled Fund	1.090.198	2.000.000	2.543.854
USAID	8.391	-	2.473.698
United Nations organizations	966.108	1.000.000	382.364
WHO	268.647	350.000	784.400
World Bank	647.162	1.000.000	97.563
Other governments	155.277	662.986	453.228
Subtotal	**10.318.294**	**13.112.986**	**16.967.633**
Coverage for organizational cost	647.584	741.014	1.071.144
Total institutional subsidies	**10.965.879**	**13.854.000**	**18.038.777**

The actual 2016 income from institutional donors is lower than budget because in Afghanistan and South Sudan some projects started up later than expected, partly because the delayed signing of the contracts. Almost all of the 2016 projects for the Health Pooled fund were on temporary bridging budgets. Mid of November 2016 finally two new main projects for the Health Pooled fund started but this was too late to reach the budgeted income for 2016.

11. INCOME FROM FUNDRAISING

(IN EUROS)	ACTUAL 2016	BUDGET 2016	ACTUAL 2015
Donations			
Donations and gifts	917.479	1.000.000	2.121.111
	-	-	-
	917.479	**1.000.000**	**2.121.111**
Local project income	-	5.579	39.794
Subsidies from non-governmental organizations			
Achmea	312.067	150.000	248.869
Other donors	-	-	900
	312.067	**150.000**	**249.769**
Total income from fundraising	**1.229.546**	**1.155.579**	**2.410.674**

In 2016 HealthNet was again supported by the Zaluvida foundation. This party donated € 0.8 million.

12. INCOME FROM THIRD PARTY CAMPAIGNS

(IN EUROS)	ACTUAL 2016	BUDGET 2016	ACTUAL 2015
Cordaid	-	50.000	64.551
Total income from third party campaigns	**-**	**50.000**	**64.551**

13. OTHER RESULTS

(IN EUROS)	ACTUALS 2016	BUDGET 2016	ACTUALS 2015
Exchange rate gains/(losses)	(23.489)	-	15.961
Other results	-	-	-
Total other results	**(23.489)**	**-**	**15.961**

6.4 NOTES TO THE BALANCE SHEET 2016

14. INTANGIBLE ASSETS

(IN EUROS)	SOFTWARE	ERP SYSTEM	TOTAL
Purchase value			
Balance on 1 January	19.558	500.097	519.655
Investments 2016		-	-
Desinvestments 2016	-	-	-
	19.558	**500.097**	**519.655**
Depreciation			
Balance on 1 January	19.558	493.775	513.332
Depreciation 2016	-	6.322	6.322
	19.558	**500.097**	**519.655**
Balance 31 December	**-**	**-**	**-**

No main investments took place in 2016. In the cause of 2016 the ERP system was fully depreciated.

15. TANGIBLE ASSETS

(IN EUROS)	FURNITURE	OFFICE MACHINES	COMPUTERS	TOTAL
Purchase value				
Balance on 1 January	54.636	21.672	52.300	128.608
Investments 2016	-	-	2.476	2.476
Desinvestments 2016	-	-	-	-
	54.636	**21.672**	**54.776**	**131.084**
Depreciation				
Balance on 1 January	53.054	21.657	49.001	123.711
Depreciation 2016	1.353	-	2.376	3.728
Desinvestments 2016	-	-	-	-
	54.406	**21.657**	**51.377**	**127.440**
Balance 31 December	**229**	**15**	**3.399**	**3.644**

16. RECEIVABLES

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Debtors	24.034	117.196
VAT receivable		17.227
Donor receivables for final settlement	-	16.053
Provision donor receivables	-	(50.000)
Prepaid expenses	24.153	68.006
Prepayments to subcontractors	-	5.897
Accrued assets	5.986	11.186
Total receivables	**54.173**	**185.565**

Donor receivables for final settlement
This includes the final instalments/reimbursement by donors for completed projects. Some uncollectable final instalments were written of in 2016.

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

Prepayments to sub-contractors
For a number of projects HealthNet works with sub-contractors. Some of the sub-contractors are pre financed by HealthNet. Only when the sub-contractor reports the actual expenses HealthNet will book these expenses and charge them to the corresponding donor. When HealthNet is not pre-financing the sub-contractors, but reimburses the sub-contractor afterwards, the commitment is presented as short-term liability.

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

17. CASH AND BANKS

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Cash at bank and in hand in Amsterdam	344.860	1.446.486
Cash at bank and in hand in project countries	2.556.800	363.177
Total cash and bank	**2.901.660**	**1.809.663**

All the funds are repayable on demand except for a bank guarantee of € 43,785 for rental obligations.

18. CASH AND BANKS PER COUNTRY

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Afganistan	2.405.471	146.770
Burundi	13.468	18.605
DRC	-	0
South Sudan	137.860	197.801
Irak	-	(0)
Total cash and bank in countries	**2.556.800**	**363.177**

In the fourth quarter of 2016 several pre-financing donor instalments were received for projects in Afghanistan.

19. CONTINUITY RESERVES

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Continuity reserve		
Balance 1 January	206.809	(2.008.584)
Result current year	161.264	2.215.393
Total continuity reserve	**368.073**	**206.809**
Designated reserve		
Balance 1 January	-	-
Restricted reserve	-	-
Total designated reserve	**-**	**-**
Total reserves		
Balance 1 January	206.809	(2008.584)
Result current year	161.264	2.215.393
Total reserves	**368.073**	**206.809**

Due to the financially support from Zaluvida that HealthNet received in 2015 the equity turned positive by the end of 2015. In 2016 HealthNet worked on strengthening the organization and increasing the acquisition activities. Although the situation improved a lot in 2016 HealthNet still needed and received financially support albeit at a much lower level than in 2015. Also because of this support the result was positive further improving the equity position of HealthNet. HealthNet will continue the strategy started in 2016 and expects that the equity position will improve further in 2017.

20. PROVISIONS

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Balance 1 Januari	553.978	467.343
Allocation	91.522	104.917
Withdraw al	(79.591)	(18.282)
Release	-	-
Total provisions	**565.909**	**553.978**

Projects of HealthNet are regularly audited after the project has been finished and the financial report has been submitted. These project audits can take place until five years after a project has finished. Based on results of the project audits in the past, it was decided to form a provision of 0.25% on the yearly income out of government subsidies.
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. 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. The comparable figures for 2015 have also been adjusted accordingly.

21. OVERVIEW PROJECT BALANCES

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Balance on 1 Januari	(266.909)	(1.037.592)
Received subsidies	(11.640.483)	(17.729.338)
Subsidies spent	10.952.271	18.437.663
Subsidies to be refunded to donor	208.679	62.357
Total project balance	**746.441**	**266.909**

22. SPECIFICATION PROJECT BALANCE PER DONOR

(IN EUROS)	2016 TO BE RECEIVED FROM DONOR	2016 UNSPENT PROJECT SUBSIDIES	2015 TO BE RECEIVED FROM DONOR	2015 UNSPENT PROJECT SUBSIDIES
Achmea	29.876	(0)	14.160	(2.327)
Afghan Ministry of Health	258.352	(290.333)	336.566	(414.593)
BSF	0	-	-	-
Cordaid	0	(0)	-	(4.518)
Dutch Ministry of Foreign Affairs	425.092	(52.846)	442.051	(13.590)
European Commission	64.366	(284.564)	32.178	(1.017.320)
GAVI	0	(0)	-	-
Global Fund	0	(0)	543.180	(492.123)
United Nations organizations	304.823	(1.028.404)	555.795	(639.682)
USAID	26.714	-	243.302	(201.111)
World Bank	303.313	(996.535)	122.645	(143.879)
Health Pooled Fund	469.155		429.791	-
Other donors	42.104	(17.555)	12.099	(18.873)
Subsidies to be refunded	-	-	-	(50.660)
	1.923.795	**(2.670.237)**	**2.731.767**	**(2.998.676)**
Total project balance	**-746.441**		**-266.909**	

The table above includes the balance of all running projects. This balance 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 taken into account.

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

23. SHORT-TERM LIABILITIES

(IN EUROS)	ACTUAL 2016	ACTUAL 2015
Creditors	69.947	26.837
Invoices to be received	113.536	123.784
Provision holiday allowance and holiday hours	101.113	103.080
Accrued personnel costs headquarters	11.574	30.777
Accrued tax and social security headquarters	38.733	42.597
Accrued personnel costs in project countries	150.555	50.784
Accrued social security project countries	2.745	88.015
Accrued subcontractors	56.014	64.275
Accrued other cost in project countries	734.834	448.602
Total short-term liabilities	**1.279.051**	**978.751**

Accrued personnel cost headquarter:
This includes the salary and insurance commitments for staff at headquarters per December 31st 2016.

Accrued tax and social security headquarter:
This includes the tax payables and social security, per December 31st 2016, for the staff at headquarters.

Accrued personnel cost in project countries:
This includes the salary and tax commitments for staff at field offices per December 31st 2016 in Afghanistan, Burundi and 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. About 20% of this amount relates to a subcontractor in Afghanistan. The remaining part is mainly for the partners Cordaid and Afod that we work with on Health Pooled Fund projects in South Sudan.

Accrued other cost 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 is subletting part of her office to Zoombim BV. The contract is for one year with a tacit renewal and a notice period of one month. The revenue from this rental agreement amounted €68.224 in 2016.
Already since February 2014, another small part of the office has been 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 €7.140.

Liabilities not included in the balance sheet

- The rental agreement for the office in Amsterdam, which runs from 01/16/2012 until 01/15/2019, has a total commitment €1.167.447. This requires a bank guarantee of €43.785. For 2016 the total rental cost including service charges amounted to €181.500.
- As of October 2011 HealthNet has signed a lease contract with Canon Business Center for three printers. This agreement runs until May 2016. This contract has been renewed for a period of 1 year. HealthNet pays €1.811 per 3 months for using the printers.
- For the Emerald project HealthNet is paying a contribution. The Emerald project is funded by the EC, but the EC will reimburse 75% of the expenses. The Emerald project started in November 2012 and will end in November 2017. The maximum contribution of HealthNet for 2013 until 2017 will be €53.660. For 2016 this contribution is €15.000.

6.5 BUDGET 2017

24. BUDGET 2017

(IN EUROS)	BUDGET 2017	ACTUAL 2016
Expenditure on objectives		
Reconstruction and development	20.879.950	10.937.087
Awareness raising and public information	285.420	224.969
	21.165.370	**11.162.056**
Expenditure income generation		
Own fundraising efforts	411.000	124.581
Securing government subsidies	95.000	89.547
	506.000	**214.127**
Expenditure management & administration	1.100.000	634.490
	22.771.370	**12.010.672**
Income institutional donors	**21.712.000**	**10.965.879**
Income from fundraising		
Donations and gifts	1.164.000	917.479
Local project income	-	-
Subsidies from non-governmental organizations	-	312.067
	1.164.000	**1.229.546**
Income third party campaigns	-	-
	22.876.000	12.195.425
Other results		
Exchange rate gains/(losses)	-	(23.489)
Other results	-	-
	-	**(23.489)**
Result	**104.630**	**161.264**
Percentage expenditure on objectives vs total income	*92,5%*	*91,5%*
Percentage expenditure on objectives vs total expenditure	*92,9%*	*92,9%*

6.6 OTHER INFORMATION

25. EXPENDITURE ON OBJECTIVES PER REGION

	BUDGET 2016	ACTUAL 2016	ACTUAL 2015
Asia	52%	69%	48%
Africa	47%	30%	45%
Overige	1%	1%	7%

26. STAFF OVERVIEW

	BUDGET 2017	ACTUAL 2016	ACTUAL 2015
Staff at Amsterdam office			
1 January	16,1	18,2	15,7
31 December	25,7	16,1	18,2
Number of volunteers during the year	10	9	10
Average number of staff at headquarters	21,0	17,4	17,5
Personnel cost per FTE at headquarters (euro)	88.042	82.098	83.292
Other cost per FTE at headquarters(euro)	10.982	13.489	15.926
Hourly rate staff Amsterdam office (budget only, euro)	92,00	90,00	90,00
Field staff per 31 December			
Afghanistan - Local staff	1.055,0	1.130,0	1.199,7
Afghanistan - Expat staff	2,6	2,3	-
Burundi - Local staff	23,0	58,4	110,0
Burundi - Expat staff	-	-	-
Congo - Local staff	-	2,0	2,0
Congo - Expat staff	-	-	-
South Sudan - Local staff	35,0	26,3	57,6
South Sudan - Expat staff	1,0	1,0	7,0
Total field staff	**1.116,6**	**1.220,0**	**1.376,3**

CHAPTER 06

BOARD AND DIRECTORS

The members of the board are not employed by the organization. The members of the board and former members of the board did not receive any remuneration during the financial year. No loans or advances were made and no guarantees were issued to the members of the board.

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.

HealthNet started the year 2016 with a director of operations (internal affairs) and a director of external affairs. But in the course of 2016 the organizational structure has changed. After a period working on a 50% basis from July 2016 onward the director of external affairs left the organisation in December 2016. HealthNet has no bonuses, year-end bonuses or gratuities. Expenses are refunded on a claim basis.

27. REMUNERATION DIRECTORS

(IN EURO)	2016	2015
Hans Grootendorst, Internal Director		
Gross wage/salary	105.099	103.089
Holiday allowance	8.314	8.223
Social security - employer's part	9.671	9.449
Pension	19.158	18.810
	142.242	**139.571**
Willem van de Put, External Director		
Gross wage/salary	78.825	103.089
Holiday allowance	8.314	8.223
Social security - employer's part	9.672	9.453
Pension	16.821	21.978
	113.632	**142.743**