Universal Declaration of Human Rights

The right to health is expressly included in various charters and treaties, including the Universal Declaration of Human Rights. This means that the necessary conditions for a healthy and productive life, such as affordable care and good nutrition, should be available worldwide.

Millennium Development Goals

In 2000, the government leaders of the 189 United Nations member countries agreed that the time had come for change in the world. They formulated eight Millennium Development Goals stating that poverty, hunger and disease must be greatly reduced by the year 2015.

Wemos calls upon politicians and policymakers worldwide to ensure health for all

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ANNUAL REPORT

2007







Health wemos for all

Change and challenges

In 2007 Wemos continued to contribute towards the structural improvement of the living and health conditions of Joyce. For Wemos, she represents the millions of people in developing countries who are trapped in the vicious circle of poverty and ill health.

According to the Universal Declaration of Human Rights and the Millennium Development Goals, which form the basis of our work at Wemos, Joyce has the right to the highest attainable standard of health. Together with our allies in the South and North, Wemos strives to improve people's health, particularly through our advocacy for effective and equitable health systems.

Wemos helps to build strong health systems that deliver.

The year 2007 was one of changes and challenges for Wemos. Nina Tellegen left the organization after six years of service as its highly-regarded Director. The year also highlighted the need to find additional and new ways of funding our mission. Wemos continued to shift its focus towards the South, whilst also intensifying its collaboration with partner organizations. Through our advocacy activities and awareness-raising examples from the South we convinced stake-holders, including Dutch Members of Parliament and representatives of development organizations, of the importance to invest in better and stronger health systems.

Advocating for structural improvements takes time, endurance and perseverance. Results are not instantly visible. Nevertheless, our structural approach remains essential to succeed in our mission of giving Joyce and her family a better and healthier life. It is with great enthusiasm and commitment that I commence my duties at Wemos.

Cily Keizer
Wemos Director

Wemos contributes to the structural improvement of people's health in developing countries through advocacy.

Wemos' themes

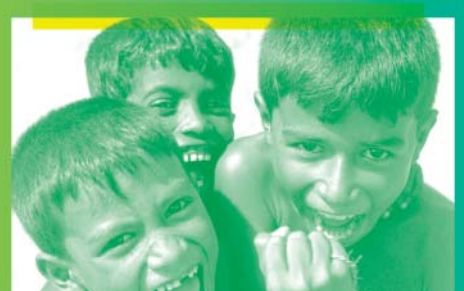
Medicines
Health Budgets
Human Resources for Health
Nutrition

Wemos' strategies

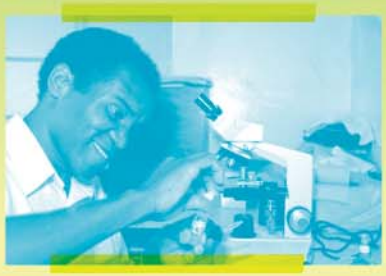
Advocacy
Cooperation with organizations in developing countries
Communications and campaigning

Wemos' partners

AIS, Acción Internacional por la Salud, Bolivia
CHESSORE, Centre for Health, Science and Social Research, Zambia
CIN, Consumer Information Network, Kenya
CSTNZ, Civil Society Trade Network Zambia, Zambia
DORP, Development Organisation of the Rural Poor, Bangladesh
VOICE, Voluntary Organization in Interest of Consumer Education, India



To enjoy the best possible health is a universal human right



Strengthening health systems that are accessible, available and sustainable for all men, women and children forms the heart of the work of Wemos.

The World Health Organization defines a health system as including all the activities whose primary purpose is to promote, restore or maintain health.

This includes **formal** and **informal health services**, **health promotion**, **disease prevention** and other health enhancing interventions, such as the development of **national nutrition plans**, **education programmes on healthy diets**, **sanitation projects** and **ensuring access to safe drinking water**.

Research shows that 69% of Dutch citizens want their government to pay more attention to health care in its future development aid policy.

Report of National Committee for International Cooperation and Sustainable Development in the Netherlands, June 2006

In the coming years I really intend [...] to focus more emphatically on health systems. [...] Strengthening health systems is not a goal in itself, but a means to provide better services and improve the health of poor people.

Dutch Minister for Development Cooperation Bert Koenders, October 2007

The so-called Primary Health Care concept serves as the guiding principle in building health systems. It entails:

- **universal access to quality care**,
- **coverage on the basis of need**,
- **availability of health services**,
- **conditions for leading a healthy life**, and
- commitment to **health equity as part of development** that is oriented towards social **justice**, **community participation** in defining and implementing **health agendas** and **intersectoral approaches** to health.

‘Time to stop using the world’s poor as guinea pigs’

Wemos in *European Voice*, October 2007

Medicines are increasingly being tested in developing countries - unfortunately not always in an ethical manner. For poor people, taking part in clinical research is often the only way to get medical treatment. The information and aftercare they receive generally leaves much to be desired. The medicines authorities of the European member countries have the task of checking whether new medicines have been ethically tested, but that hardly happens. The European Union is failing in its task of overseeing the enforcement of existing laws.

Reason enough for Wemos to organize a meeting together with Dutch socialist Euro parliamentarian Dorette Corbey in Brussels. The list of participants included representatives of the pharmaceutical industry, civil society and research organizations, the medicines authorities and experts from countries like Peru and India. Everyone agrees on one thing: compliance with the rules for ethical testing of medicines in developing countries must be placed higher on the European agenda. Representatives of the central European medicines authority say they need more funds and staff to properly carry out their tasks.

Both in Europe and the world at large, organizations pressed for stricter compliance with the rules. In Latin America Wemos worked closely with RELEM, a network dedicated to ethics and medicines. In India, which after China is the country where the most clinical tests are performed, Wemos also entered into new partnerships. At a conference on bioethics in Bangalore Wemos told about its lobby work and discussed the opportunities for setting up a Clinical Trial Watch together with Indian organizations.

In the Netherlands a growing number of people became aware of the risks of testing in developing countries. Wemos completed an information booklet outlining the risks as well as the solutions. In 2008 Wemos is continuing to advocate for ‘fair’ drugs.

Dorette Corbey,
Member of the European Parliament (Labour):

‘Patients who are badly informed or poor are easily won to take part in clinical tests, particularly in countries where the health system is not optimal. Unethical testing of medicines is really unacceptable and we must go all out to end this practice.’

‘Staff shortages in focus’

Medisch Contact about Wemos documentary, October 2007

Health workers are the engine behind an efficient and effective health system. They treat patients, dispense medicines and provide information. In Kenya and Zambia the shortage of health workers is so serious that the quality of service is suffering.

The documentary entitled *Putting the finger on the sore spot* is a joint production of Wemos, Consumer Information Network (CIN) from Kenya and Centre for Health Science and Social Research (CHESSORE) from Zambia. In this documentary they set out to find the causes of the health worker shortages and highlight the role of foreign donors.
The making of the documentary was a positive experience for everyone involved. The camera opened many doors, including that of the US aids relief programme PEPFAR whose budget for Kenya equals the entire health budget of the Kenyan government. Some foreign donors are paying higher salaries than is normal in public services, which is tempting many health workers to leave the public sector.

The trend where externally funded health programmes are causing strong competition for the services of scarce health workers led to a closer investigation. CHESSORE, CIN, the Great Lakes University of Kisumu (GLUK) from Kenya, Cordaid and Wemos looked at the impact of these programmes on staff policy at district level. It transpired that the Zambian and Kenyan district authorities do not have a sufficient mandate and funding to pursue an effective staff policy. Wemos is seeking a solution to this complex problem in cooperation with local organizations, donors and the government. One positive example is the Clinton Foundation in Kenya which provides the Ministry of Health with funds for recruiting health staff. In 2008 Wemos will bring such positive examples to the attention of policy makers.

Samuel Ochieng, Chief Executive of CIN:

‘This is the first time I took part in a documentary. The camera opens doors and the interviews with health workers have given me a better understanding of the problems they face in their daily work. I hope that the film contributes towards finding a structural solution to the shortage of health staff.’

‘Wemos and partners gather momentum in Bangladesh’

Wemos Newsletter, December 2007

In many developing countries the health sector is suffering from a structural lack of funding. Large sections of the population have no access to health services. In four countries Wemos works together with organizations who analyse the national health budgets and expenditures and use their findings to formulate proposals and build support for new policies. They also involve the local communities in these efforts.
The partner organizations seek to influence their own authorities and local implementing organizations. Wemos, together with its partners, focuses on donors and international institutions who are involved in the co-funding of health care in the four countries.
In this manner both governments and donors are held accountable for their commitment to fulfilling everyone’s right to health.

In Bangladesh Wemos supports the Development Organization of the Rural Poor (DORP) with the implementation of a health budget advocacy programme. DORP helps small civil society organizations to keep track of health budget spending and to communicate their recommendations to the government. During the budget talks last year, DORP argued on their behalf for a doubling of the amount earmarked for food for patients in clinics at subdistrict level.
The Director-General of the Bengal Ministry of Health promptly requested the Minister of Finance to adopt this recommendation.

In 2007 the four organizations Acción International por la Salud (AIS), DORP, CIN and CHESSORE attended a Budget Tracking training programme of the International Budget Project (IBP). In 2008 these organizations are employing this method to monitor the health budget in their country and make their government aware of alternative allocation and spending methods.

Merel Mattousch, Project Coordinator Health Budgets and Human Resources for Health at Wemos:
‘Thanks to the health budget club of DORP, people are now more aware of the right to health and are helping to draw up the budget of their local health centre.’

‘Does the IMF constrain health spending in poor countries?’

Report Center for Global Development, June 2007

One consequence of the programmes of the International Monetary Fund (IMF) in low-income countries is a structural shortage of investments in the public sector, such as health.

This is the conclusion of a working group of experts that looked into the question whether IMF programmes impede extra health spending. The working group, in which Wemos participated, was an initiative of the Center for Global Development in Washington. June saw the publication of a critical final report in which the working group argued for a flexible implementation of the IMF programmes. The IMF must take account of the circumstances in each specific country and formulate its programmes in consultation with civil society organizations. The report is partly based on country studies. In Zambia CHESSORE made a contribution in collaboration with the University of Zambia (UNZA).

When the report appeared, the IMF was already in the process of reforming its policy. However, the report stepped up the pressure to implement genuine changes. One example concerns the IMF’s decision to abolish health spending ceilings in Africa. Unfortunately, many ceilings remain intact because African governments have elevated the IMF norms to national policy in order to guarantee the fiscal stability which, in their eyes, is necessary to achieve economic growth and reduce poverty.

The IMF, one of the obstacles to raising public health spending, has made several important policy changes. This, however, has led to new challenges. In Zambia, for instance, the government has earmarked more money for health but has no trained staff to spend it on. Wemos is working with its partner organizations to ensure the money is spent well.

David Goldsbrough, chairman of the working group of the Center for Global Development:

‘The influence of the IMF on public health spending is indirect but substantial. The activities of the IMF often have important consequences for the health sector, particularly in those countries that have a macroeconomic agreement with the IMF.’

‘Reduce by half the proportion of people who suffer from hunger’

Millennium Development Goal 1

The growing problems in the field of nutrition security has put nutrition back on the political agenda. In Bolivia a multi-sector nutrition programme got underway in 2007. Zambia has a food and nutrition plan ready for implementation, while Kenya has a similar plan that is awaiting parliamentary approval. CIN was closely involved in the preparation of the plan. For one thing, it advocated successfully for the inclusion of the subject of nutrition security, thus broadening the scope of the plan to include healthcare.

In 2007 the first results of the Food Basket studies were announced. During two years partner organizations of Wemos and ICCO carried out complex studies in five countries to ascertain the impact of trade agreements on the content of consumers’ food baskets. Though the outcomes of the studies were not conclusive, it did become clear that free trade does not promote food security at the domestic level. This is the conclusion that the representatives of the participating organizations, the Food Trade and Nutrition coalition, drew together in December. The changed role of the World Trade Organization was also discussed. Whereas developing countries formerly negotiated with this multilateral giant, they now hold talks on a bilateral basis. In 2007, for instance, Kenya signed a provisional Economic Partnership Agreement with the European Union (EU). Zambia is still engaged in talks with the EU about a similar agreement.

In the coming period the Southern organizations will focus mainly on the food situation in their own countries. The Wemos Nutrition Team also sharpened its focus and, together with its partner organizations, will support the implementation of the nutrition and food security plans in Bolivia, Zambia and Kenya. Though the nutritional situation in these countries has not improved over the past decades, the new plans offer hope.

Irene Lausberg,
Project Coordinator Nutrition at Wemos:

‘In Zambia I asked why the nutrition problems in Africa had not changed in the past twenty years. Everyone said the same: ‘Our Ministry of Health is not strong enough in the negotiations with other ministries. And we are not strong enough to persuade our politicians.’ Wemos can help them to bring solutions for the nutrition problems to the attention of the right people.’

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(Planning and Monitoring Officer)

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Dieneke Schulting *(Secretary)*
Marga Sijmonsbergen *(Administrative Assistant)*
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Frédérique Kram
(Advisor Communications/ Coordinator Campaigns)
Brigitte Boswinkel
(Sr. Communications Officer)
Leontien Laterveer
(Communications Officer)

On 1 February 2008 Cily Keizer became the new director of Wemos. For the last few years Cily Keizer was Director of the Netherlands Development Organisation SNV in Laos, Cambodia and Bhutan.

Temporary staff
Mayke Smit, *Junior Communications Officer (May-August)*
Govert Buijze, *Junior Communications Officer (August-November)*
Marieke Colenberg, *Secretary (September-November)*
Erica Wortel, *Interim Director (October-January 2008)*

Moved on
Vera van den Nieuwenhof, *Secretary (June)*
Jordi van Scheijen, *Systems Administrator (September)*
Nina Tellegen, *Director (October)*
Anna Maria Doppenberg, *Team Manager Communications and Campaigning (December)*
Haregu Gebreyesus, *Secretary (December)*

Work experience trainees and students
Marlou Delhez *(February-July)*
Govert Buijze *(March-June)*
Christiaan Mulder *(May-August)*

Volunteer
Gracy Santos Heijblom

Board
Kick Visser *(Chair)*
Loes Valk *(Secretary)*
Kees Boot *(Treasurer until September)*
Oscar van Agthoven *(Treasurer since October)*
Ankie van den Broek *(Board Member)*
Jos Dusseljee *(Board Member)*
Janneke Molenkamp *(Board Member until September)*
Chris Knoet *(Board Member since October)*

Networking

Bangladesh Forum on Development Cooperation and Human Rights *(Bangladesh Overleg Ontwikkelingssamenwerking en Mensenrechten)* BOOM
Coalition for Trade Justice *(Coalitie voor Eerlijke Handel)*
Corporate Social Responsibility Platform *(Maatschappelijk Verantwoord Ondernemen Platform)*
Dutch Platform Millennium Development Goals (EEN)
European Food Security Group (EFSG)
European Network on Debt and Development (Eurodad)
Food Trade and Nutrition (FTN) coalition
Global Health Education Project (GHEP)
Health Action International (HAI)
Jubilee Netherlands
Co-financing programme related broad network on Bolivia *(Mede-financierings Programma Breed Netwerk Bolivia)* MBN Bolivia
Co-financing programme related broad network on Zambia *(Mede-financierings Programma Breed Netwerk Zambia)* MBN Zambia
Red Latina Americana de Ética y Medicamentos (RELEM)
Partos, umbrella association for Dutch non-governmental organizations in the international development cooperation sector
People's Health Movement (PHM)
Share-net, Netherlands Network on Sexual & Reproductive Health and Aids

Financial statements

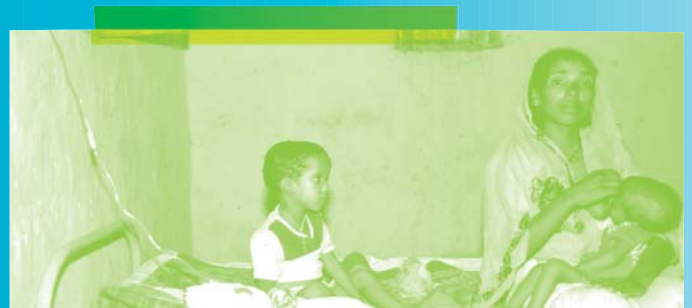
Abbreviated financial statements for the year 2007

Amounts in euros (EUR)

The unabridged financial statements 2007 (in Dutch) can be obtained or consulted at www.wemos.nl.

Balance sheet as at December 31, 2007

	31 December 2007		31 December 2006	
Assets				
Material fixed assets		66,343		81,847
Financial fixed assets				
- Subsidies		2,176,000		3,097,250
Current assets				
- Subsidies	1,302,547		1,396,349	
- Other receivables	57,670		69,040	
- Cash and cash equivalents	517,318		428,561	
		1,877,535		1,893,950
Total assets		4,119,878		5,072,687
Equity and liabilities				
Equity		486,302		508,585
Long term liabilities				
- Subsidies		2,176,001		3,097,251
Short term liabilities				
- Taxation	53,198		80,538	
- Subsidies payable	1,185,963		1,160,600	
- Debts to subcontractors	69,039		69,765	
- Other short term liabilities	149,375		155,948	
		1,457,575		1,466,851
Total equity and liabilities		4,119,878		5,072,687



Statement of income and expenses for the financial year 2007

	2007		2006	
Income on fund raising				
Contributions and donations	15,881		15,540	
Private funds	30,000		6,500	
		45,881		21,950
Fund raising expenses:				
Direct costs	-755		-890	
Allocated operational expenses	-1,146		-2,273	
		-1,902		-3,163
		43,980		18,787
Percentage fund raising expenses versus income on fund raising		4,1%		14,4%
Other income				
Subsidies	1,406,502		1,481,185	
Other income	172,841		135,119	
		1,579,343		1,616,304
Available for objective		1,623,323		1,635,091
Expenditures for objective				
To strengthen national health systems that contribute to the structural improvement of people's health in developing countries				
Collaboration with Southern partners, including capacity strengthening	374,690		379,058	
Campaigning to raise awareness in The Netherlands	101,481		162,701	
Lobbying and advocacy	50,778		39,487	
Activity costs		526,949		581,246
Operation expenditures		1,118,657		1,036,648
		1,645,606		1,617,894
Withdrawal of/Addition to general reserves		-22,283		17,197
		1,623,323		1,635,091

Explanatory notes to the abbreviated financial statements for the year 2007

Breakdown of operating expenses

	2007		2006	
Personnel expenses	908,443		846,179	
Housing expenses	95,890		97,536	
Office expenses	71,634		65,276	
Organization expenses	43,836		28,035	
Expenses for communication and further professionalization of the organization	-		1,895	
Total operating expenses		1,119,803		1,038,921
Allocation to fund raising		1,146		2,273
Allocation to objective		1,118,657		1,036,648

Valuation standards

General
The financial statements are prepared on the basis of the historical costs convention. Unless stated otherwise, all assets and liabilities are valued at their nominal value. Donations and gifts are recognized in the year in which they are received. Provided subsidies are recognized in the year they relate to. Costs are included in the year in which they are incurred and will be accrued if foreseeable. The report has been drawn up according to the "Directive 650 Fundraising Institutions" *(Richtlijn 650 Fondsenwervende Instellingen)* of the Council of Annual Reporting *(Raad voor de Jaarverslaggeving)*, in accordance with the recommendations of the Central Bureau Fundraising *(Centraal Bureau Fondsenwerving)* for fundraising institutions.

Fixed assets
The fixed assets are valued at the historical cost-price less a straight line depreciation charge for the year. The depreciation is based on the expected economic lifetime and is calculated according to a fixed percentage of the historical cost-price minus expected residual value. Fixed assets purchased during the year are depreciated proportional for the remaining period of the year.

- Inventory is valued at the historical cost-price less a straight line depreciation of 20% a year;
- Computer hard- and software are valued at cost-price less a straight line depreciation of 33.3% a year;
- Renovations building are valued at the historical cost-price less a straight line depreciation of 10% a year.

Current assets
The current assets are expected to mature within one year. They are valued at nominal value after deduction of necessary provisions for insolvency, based on the individual valuation of the receivables.

Foundation capital
The foundation capital is designated to the foundation's objectives. The part of the foundation capital, which is not recognized as fixed capital set apart for the foundation's objectives, is presented as expendable capital.

Foreign currency
Transactions arising in foreign currencies are translated into Euros at the exchange rate prevailing at the date of transaction. At year-end, assets and liabilities denominated in foreign currencies are translated into Euros at the exchange rate prevailing at balance sheet date. Resulting currency exchange results are included in the statement of income and expenditure.

Donations and gifts
Donations and gifts and subsidies are recognized as income in the year to which they relate.

Subsidies from governments and others
All subsidies from governments, companies and other institutions are presented under this heading. Subsidies consist of contributions which have been related to the costs of execution of the project by the supplier. All subsidies are recognized in the year of report as far as the subsidy is granted to the year of report. Subsidies which have been granted, but which are not allocated in the year of report are presented as assets.

Allocation of costs
Costs are allocated to the foundation's objectives on the basis of generally accepted principles on accounting. The costs of organization are allocated to the expenses made by the foundation for collecting funds and the expenses made for the realisation of the foundation's objectives. Allocation of the costs will take place according to a fixed percentage.
Direct costs related to the projects are recognized as costs related to the foundation's objectives. Direct costs accountable to the collection of funds are recognized as costs related to the collection of funds.

Auditor's report

Introduction

We have audited whether the accompanying abbreviated financial statements of Stichting Wemos, Amsterdam for the year 2007 (as set out on pages 16 to 17) have been derived consistently from the audited financial statements of Stichting Wemos, for the year 2007. In our auditors' report dated 25 March 2008 we expressed an unqualified opinion on these financial statements. The foundation's management is responsible for the preparation of the abbreviated financial statements in accordance with the accounting policies as applied in the 2007 financial statements of Stichting Wemos. Our responsibility is to express an opinion on these summarized financial statements.

Scope

We conducted our audit in accordance with Dutch law. This law requires that we plan and perform the audit to obtain reasonable assurance that the abbreviated financial statements have been derived consistently from the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, these abbreviated financial statements have been derived consistently, in all material respects, from the audited financial statements for the year 2007.

Emphasis of matter

For a better understanding of the foundation's financial position and results and the scope of the audit, we emphasize that the abbreviated financial statements should be read in conjunction with the unabridged financial statements for the year 2007, from which the abbreviated financial statements were derived and our unqualified auditors' report thereon dated 25 March 2008. Our opinion is not qualified in respect of this matter.

Amsterdam, 14 May 2008

MAZARS PAARDEKOOPER HOFFMAN N.V.
P.O. Box 7266 - 1007 JG Amsterdam, The Netherlands

L. van Garderen RA
(certified accountant)