Annual Report 2009

HEALTH FOR ALL

wemos HEALTH FOR ALL

Contents

Our mission

WE ADVOCATE FOR THE RIGHT TO HEALTH OF PEOPLE IN DEVELOPING COUNTRIES

WE AIM AT HEALTH FOR ALL

Countless women, men, and children cannot visit a doctor when they fall ill, millions of young children are seriously undernourished, while a great many ignorant people run severe risks during clinical trials. Wemos is concerned about the health of these people, mostly poor inhabitants of developing countries.

Wemos advocates for a just world in which every human being can realize her or his right to health. Being aware that ill-health is often caused by scarce financial means and inadequate use of resources, we advocate for strong health systems in developing countries.

Our advocacy projects, Medicines, Nutrition and Human Resources for Health, jointly contribute to **Health for All**. We push for adherence to rules that protect test subjects in clinical trials, we lobby for approaches that efficiently reduce malnutrition, and we advocate for sufficient health workers in developing countries. Wemos' lobby work focuses on the Dutch, European and global level, while our partner organizations in Bangladesh, Bolivia, Kenya, and Zambia advocate for improvements at the national level.

We strongly believe in partnerships, within and across borders. In our continuous quest for **Health for All**, we will deepen and expand partnerships with like-minded organizations. Wemos also encourages and facilitates the establishment of civil society alliances which aim at finding long-term solutions for bottlenecks in the health sector.

Our global context is changing rapidly. The global food and energy crises have taken a dramatic toll on the poor and some predictions show that the financial crisis will have an even deeper and more damaging effect on the situation of millions of poor people. In this context, Wemos' plea to give the poor a voice, the fight for more effective use of resources, and the elaboration of coherent and inclusive policies that aim at strong health systems, are more urgent than ever. We, therefore, call on policymakers and politicians to advocate, jointly with us, for **Health for All**.

Cily Keizer
Director

WE BELIEVE IN PARTNERSHIPS ACROSS BORDERS

Our work

We watch, we inform, we lobby

At a global level, Wemos pushes for the right to health of people in developing countries. Wemos' core business as a **Global Health Advocate** is to influence, in close collaboration with Southern and Northern partners, national and international health policies through advocacy work. The organization's Southern partners direct their attention to national governments and international organizations.

Wemos' lobby work focuses on topics that demonstrate the bottlenecks in health systems of developing countries: Resources for Health, Nutrition, and Medicines.

Being a **Global Health Advocate**, Wemos fulfills three roles:

Watchdog

Wemos conscientiously follows policy planning and implementation and, when necessary, sounds the alarm. Wemos confronts governments and international organizations with the gap between the 'realities on the ground' and the hoped-for health situation.

Expert-informant

Wemos provides policymakers and decision makers with technical advice and information in case of an obvious knowledge gap that hampers a solution of the problem.

Lobbyist

Wemos fully participates in policy processes and actively influences policies. This includes formulating positions and presenting them to policymakers.

Advocacy

We lobby for strong health systems

Wemos aims at strengthening national health systems that contribute to the structural improvement of people's health in developing countries. To provoke structural changes, Wemos links local health circumstances with national and international decision making processes.

Wemos' advocacy work centres on **Human Resources for Health, Nutrition, and Medicines.** These topics are included in the four focus countries' advocacy work as far as prioritized by the Southern partners and/or taken up in close consultation with organizations in other developing countries.

WE SUPPORT CIVIL SOCIETY MOVEMENTS

In all efforts, Wemos aims at forming alliances with like-minded organizations and networks. Wemos also supports and facilitates movements of national civil society organizations that advocate in their own countries for adequate health services and policies.

Advocacy projects

- Human Resources for Health > retention of health personnel
- Medicines > ethical clinical trials
- Nutrition > solutions for malnutrition

Our objective

We aim at strong national health systems that contribute to the structural improvement of people's health in developing countries

Human Resources for Health

We want greener grass for health workers

Millions of people in developing countries have no access to health care. One of the problems is that numerous health workers leave their countries as soon as they have finished their studies. They are faced with low salaries, limited training options, and out-of-date equipment. Many opt for a career switch or migrate to the rich Western world, because the grass is much greener there.

In 2009, Wemos lobbied for retention of health staff in developing countries. The advocacy work focused on encouraging governments of Western nations, including the Netherlands, to increase investments in health staff in developing countries and to train sufficient numbers of personnel, and on stimulating developing countries to upgrade local circumstances for health workers. In 2010, Wemos continues to push for solutions for the health staff shortages.

Wemos sounds the alarm

In 2009, Wemos successfully urged Members of Dutch Parliament (MPs) to motivate the Dutch Minister of Health to introduce a national code of conduct to govern ethical international recruitment of health personnel. The Minister proved himself a public supporter of such a code. The MPs were motivated by an event organized by Wemos, Cordaid and others, on the occasion of World Health Day (April 7). Later in 2009, Wemos voiced its opinion in Dutch media, when several medical centres of universities in the Netherlands recruited health workers in India. Wemos stated that it is unethical to actively recruit health staff in countries that lack sufficient, trained personnel.

'Hospitals in several Western countries actively recruit staff in developing countries. In both poor and rich countries too few health workers are trained, while the job vacancies in the Western world attract many applicants. Consequently, the global lack of health workers disproportionately affects developing countries.
For instance, fourteen persons from India accepted a job in Groningen, The Netherlands, while India invested money in their training. As a result, many patients in India will not receive medical care from these health workers. We believe that it is unethical to look for a quick solution in a developing country, to solve a personnel shortage here.'

Anke Tijtsma, Project Coordinator Human Resources for Health at Wemos

Dutch actors join forces

In 2009, non-governmental organizations, academic and health institutions joined forces and expertise in the multisectoral Dutch Human Resources for Health (HRH) Alliance. The Alliance links activities in the North to the work in the South, in order to make a difference for human resources for health in developing countries. The Alliance sent a joint position letter on the international recruitment of health staff to the Minister of Health and the Minister for Development Cooperation in the Netherlands. The letter was used by the Dutch delegation during the WHO-EURO Regional Committee meeting in Copenhagen. Wemos takes the lead in many of the activities of the Alliance.

Partners

Cordaid, the Netherlands
Dutch Human Resources for Health (HRH) Alliance, the Netherlands
EQUINET, Zimbabwe
Global Health Workforce Alliance (GHWA), Switzerland
Health Workforce Advocacy Initiative (HWAI), US
Medicus Mundi International Network (MMI), Switzerland

Medicines

We advocate for fair medicines

Pharmaceutical companies do not always act in compliance with the guidelines for testing medicines and take advantage of the vulnerable position of people in developing countries. Often, test subjects are poor, illiterate and hardly have access to health services.

In 2009, Wemos intensified its advocacy work for ethics in clinical trials. It pushed for adherence to the rules that protect people in developing countries against unethical practices. Wemos also advocated for stricter checks of new drugs by the European Medicines Agency (EMA) and the national registration authorities of EU member states, so that only ethically tested medicines are marketed in Europe. The European Parliament declared its commitment, after Wemos gave a presentation on the subject. In 2010, Wemos' Medicines work continues to encourage the European Commission and Members of the European Parliament to take responsibility for fair drugs.

Campaign for fair drugs

On 5 February 2009, Wemos launched the global online campaign FairDrugs.org. The campaign centres on the 'Call for Ethical Clinical Trials in Developing Countries' and appeals to policymakers, regulators and pharmaceutical companies to respect the rights of test subjects. The supporters of the Call include leading figures in the field of medicines and ethics, and numerous health and human rights organizations. Their support along with the abundant media attention continues to lend enormous weight to the campaign and motivates politicians and policymakers to pay attention to ethics.

'I have been acquainted with Wemos and the campaign only recently, but I have found quite a number of common aims and visions. Over 40 years, the Mario Negri Institute is dedicated to supporting ethical research at experimental and clinical levels. The protection of patient rights, through independent trials and information, is among our major objectives. It is, therefore, not surprising that dozens of researchers of Mario Negri have given their support to the campaign.'
Professor Silvio Garattini, director Mario Negri Institute for Pharmacological Research, Italy, and member of the Committee of Recommendation of Wemos' FairDrugs.org campaign

Lobbying is paying off

Ethics are finally becoming part and parcel of the European procedure for granting market authorization for new drugs. In 2009, thanks to Wemos' excellent lobby work, the EMA announced that it would improve supervision of compliance with ethical guidelines in clinical trials conducted outside the European Union. In short, EMA will work harder to make sure that only fair drugs enter the European Union.

'The working methods of pharmaceutical companies are frequently questionable. For instance, people are offered drugs they do not actually need, while there are other diseases for which no drugs are being developed whatsoever. Particularly, inhabitants of developing countries are victimized. The pharmaceutical industry does not carry out enough research in communicable diseases and other health problems for which they do not have a market. Often clinical trial participants in developing countries are not aware that they are included in a research protocol, and are unable to understand the informed consent forms. In some cases they have not even seen the forms.'

Núria Homedes, coordinator Latin American Network on Ethics and Pharmaceuticals (RELEM)

Partners

Centre for Research on Multinational Corporations (SOMO), the Netherlands
Centre for Studies in Ethics and Rights (CSER), India
Latin American Network on Ethics and Pharmaceuticals (RELEM), Latin America

Nutrition

We want well-fed children

Around the world, millions of people do not get enough to eat, and what they do get is of poor quality. Every year, malnutrition claims the lives of 3.5 million children, most of them in developing countries.

In 2009, Wemos focused on finding support to address malnutrition in donor policies. Donors in general mainly address malnutrition in agricultural policies in response to the food crisis, but fail to include integrated malnutrition interventions that have proven to work. Wemos worked on convincing policymakers of the Dutch Ministry of Foreign Affairs and other international actors of the effectiveness of comprehensive multisectoral approaches to malnutrition.

In 2010, the Nutrition work focuses on advocating for coherent actions by the international community, including the Dutch government, on proven and cost-effective malnutrition interventions.

Nutrition is the key to health

Malnutrition being an enormous health problem, Wemos supported a research into nutrition initiatives in development cooperation programmes, implemented by three students of Wageningen University, in 2009. The investigation made clear that, nowadays, nutrition plays a minor role in Dutch development programmes. To tackle the problem of malnutrition effectively, Wemos advocates for strong health systems, in which nutritional information and monitoring children's growth are incorporated.

'By participating in the Netherlands Working Group on International Nutrition, Wemos has made its first step towards collaborating with 'new' partners. The working group brings together knowledge institutes, civil society organizations and the business community in an effort to place malnutrition back on the Dutch development agenda.'
Rosemarijn de Jong, Communications and Fundraising Officer at Wemos

European lobby

In 2009, Wemos initiated the founding of the European Nutrition Action Group, in close collaboration with Save the Children (UK) and Action Contre la Faim (France). The Action Group sent several statements to European policymakers, such as to European Commissioner for Development and Humanitarian Aid Louis Michel. During the World Food Summit in Rome, it organized a side-event on 'The Missing Link in Food Security Policy & Action'.

Partners

European Nutrition Action Group
Netherlands Working Group on International Nutrition (NWGN)
Plan Nederland, the Netherlands

South-North Collaboration

We exchange know-how

Wemos' country-specific work centres on supporting advocacy activities of civil society organizations in four countries: **Bangladesh, Bolivia, Kenya, and Zambia**. The aim is to strengthen national health systems in order to improve the health of the people. At the same time, civil society organizations active in these countries provide Wemos with context data that is indispensable for the global advocacy work.

In 2009, country-specific activities centred on Wemos' three main issues: Human Resources for Health, Nutrition, and Medicines. Wemos supported and facilitated advocacy processes of its partners, preferably implemented in collaboration with other national organizations. Meetings of Wemos and its Southern partners, such as in February 2009, are great opportunities to share expertise on lobbying and campaigning for the right to health.

WE MONITOR HEALTH BUDGETS AND EXPENDITURES

Wemos and its partner organizations in Bangladesh, Bolivia, Kenya, and Zambia jointly implement a Budget Monitoring project (2007-2010), which focuses on encouraging governments to adequately invest money in the health sector. Project activities comprise mapping of policy development, budgeting and spending of funds for health in the four focus countries as well as training programmes, exchange of experience and lobby strategies, and empowerment of the organizations. The nature of Budget Monitoring varies for each country.

South-North Collaboration projects

- Bangladesh > health budget monitoring
- Bolivia > monitoring national nutrition programme
- Kenya > health budget monitoring
- Zambia > civil society advocacy development

Bangladesh

We follow health expenses in Bangladesh

In Bangladesh, about 50 percent of its 156 million inhabitants fall below the United Nations' poverty line of $1.25 a day. Many struggle with ill-health. Improvements in the public health system are desperately needed, but the government of Bangladesh reserves too little money for health and inadequately manages its resources. The country is faced with a severe shortage of health facilities and personnel, which particularly affects women, children, and people in rural areas.

In Bangladesh, Wemos collaborates with Development Organization of the Rural Poor (DORP) in the Budget Monitoring project. In 2009, DORP continued to closely follow the health budgets and expenditures of the national government, and advocated for more efficiency in planning and spending.

In 2010, Wemos supports a health monitoring and advocacy programme in different regions of Bangladesh, jointly implemented by DORP and four Bengal health organizations and supported by a research institute. To improve local service delivery, in particular for pregnant women and new-born children, the project concentrates on strengthening of monitoring and setting up a dialogue between the local population, health workers and authorities.

Successful lobby in Bangladesh

Over the years, DORP has been quite successful in encouraging local authorities to improve service delivery in Bangladesh. In 2009, in one subdistrict of Bangladesh, a budget for the repair of tube wells for a clinic was made available, while, in another subdistrict, long-standing vacancies for nurses were filled.

'A Union Health and Family Welfare Centre in Bangladesh had long had no running water, so patients were not being properly helped. We looked into how this could have happened, and discovered that the government had simply forgotten to include 'water' in the centre's budget. Once a request had been submitted, the centre got its running water. This is a good example of how budget monitoring works. The local community is faced with a problem; small local organizations work with DORP to find out more; they draw the government's attention to the gap in the budget, and eventually the government – hopefully – delivers the goods. Many poor people living in rural Bangladesh are unaware that they can improve their own living conditions simply by reminding the authorities of their responsibilities. We help them to do so.'

Zobair Hasan, researcher for Development Organization of the Rural Poor (DORP), Bangladesh

Partner

Development Organization of the Rural Poor (DORP), Bangladesh

Bolivia

We fight malnutrition in Bolivia

In Bolivia, 20 percent of the approximately nine million inhabitants fall below the poverty line. Indigenous people – two thirds of the population – are particularly affected by poverty and a malfunctioning health system. One of the challenges is the undernourishment of about 25 percent of Bolivian children under three years.

Since the start of the reorganization of the Bolivian health system, in the nineties, Bolivians have better access to health care. However, many more improvements are required. Challenges are ineffective budget allocation, specifically inadequate finances for promotion and prevention, as well as insufficient health staff and medical facilities, in particular in rural areas.

As part of Wemos' Budget Monitoring project, Acción International por la Salud (AIS Bolivia) closely follows the planning and implementation of a national programme that fight malnutrition in Bolivia. In 2009, the work in Bolivia focused on the implementation of the Malnutrition Zero Programme *(Programa Desnutrición Cero)*, a multisectoral and multiministerial programme that aims to eradicate malnutrition in Bolivia.

In 2010, AIS Bolivia, Plan Bolivia, Plan Nederland, and Wemos join forces in the project Strong and Healthy Children *(Niños Sanos y Fuertes)* in Bolivia, which works on adequate implementation of the Malnutrition Zero Programme in five poor Bolivian municipalities. Focus areas of the project include increasing agricultural production and informing the population about healthy food.

Breastfeeding law in Bolivia

In 2009, the Bolivian Breastfeeding law was approved, an important issue in the Malnutrition Zero Programme. The law aims to promote breastfeeding in Bolivia and states that all working women with nursing infants up to six months of age have the right to bring their babies to work or school with them, nurse them in a comfortable room and to continue their work or study with their infants for this period of time. The law also regulates marketing of breast milk substitutes and complementary feeding. During the law's formulation process, AIS Bolivia provided valuable input. AIS Bolivia was also invited to participate in the National Breastfeeding Committee, which is in charge of enforcing the breastfeeding encouragement law.

‘The starting point of all the work of AIS is the right to health of every human being on earth. Fortunately, Bolivian politicians more and more recognize the expertise of AIS Bolivia. For years, we have been pushing our government to incorporate the situation of the poor in their plans, for instance in the case of law-making. We are delighted that the authorities increasingly pay attention to our ideas and involve AIS in decision making processes.’
Rodrigo Urquieta Arias, Projects Officer Acción International por la Salud (AIS), Bolivia

Partners
Acción International por la Salud (AIS), Bolivia
Plan Bolivia, Bolivia
Plan Nederland, the Netherlands

Kenya

We keep a close eye on Kenya's health budget

Kenya is a relatively poor nation with a rapidly expanding population. In spite of the country's constant economic growth, most of the approximately 37 million inhabitants are still faced with scarcity and ill-health. Approximately 20 percent fall below the poverty line. The main challenges in the health sector of Kenya are the limited financial means and the division of the Ministry of Health into two ministries and two budgets, causing ineffective planning and implementation.

In Kenya, one of the obstacles on the road to good health is the lack of sufficient health staff, in particular in rural areas, because many trained health workers leave the country or opt for a career switch. The inadequate integration of nutrition interventions in Kenyan health policies is another issue that needs to be tackled.

In 2009, in Kenya, Wemos collaborated with Great Lakes University of Kisumu (GLUK) and with Health NGOs Network Kenya (HENNET), a strong health network that consists of 72 organizations. Wemos supported them in their efforts to encourage the government of Kenya to increase investments in the Community Health Strategy.

In 2010, HENNET intensifies the advocacy work for more resources for the Community Health Strategy and also develops clear-cut plans and recommendations. Since GLUK implements the Strategy in the Nyanza province, community experiences can be incorporated in the lobby for more resources for the Community Health Strategy.

Budget Monitoring strengthens lobby in Kenya

Wemos' Kenyan partner GLUK participates in the Budget Monitoring project. In 2009, GLUK made use of this lobby instrument while implementing the Community Health Strategy in the Kenyan districts Suba and Rarieda. Over 300 people were trained and tools were pilot tested. The Budget Monitoring work generated valuable data for communities and health workers at the district level to lobby for adequate resources for health services.

‘Many of those living in Kenya’s rural areas have no access to good health care. To help GLUK to keep the government aware of its responsibilities we will be using Budget Monitoring, as several other of Wemos’ partner organizations already do. Budget Monitoring is an instrument for keeping a close eye on whether the government actually achieves what its health budget is intended to bring about.
We compare government plans with the reality on the ground, and we research into the quality of the health care delivered. This factual documentation strengthens our case in lobbying for better access to health care.’
Charles Wafula, lecturer at Kenya’s Great Lakes University of Kisumu (GLUK)

Partners
Consumer Information Network (CIN), Kenya
Great Lake University of Kisumu (GLUK), Kenya
Health NGOs Network Kenya (HENNET), Kenya

Zambia

We lobby for more health workers in Zambia

In Zambia, economic growth cannot keep up with the rapid population growth. Sixty-four percent of the nearly 12 million people fall below the poverty line. Millions are trapped in the vicious circle of poverty and ill-health.

The main challenge is Zambia's malfunctioning health system, particularly the lack of financial means and the inadequate allocation of resources. Limited training opportunities for health workers exacerbate the lack of available human resources for health.

In 2009, Wemos focused on bringing together national organizations that push the Zambian government and its health donors to find solutions for the health staff crisis in Zambia. Wemos, Cordaid, the Zambian Centre for Health Science and Social Research (CHESSORE), and a range of other organizations collaborated to create a strong civil society.

In 2010, Wemos focuses on the impact of policies of international donors – World Bank, Global Fund, and European countries – on the Zambian health system. Activities comprise advocacy and exchange of expertise with Zambian organizations.

Lobby network

In 2009, Cordaid and Wemos contributed to the establishment of the Zambian Human Resources for Health Civil Society Network, an alliance of organizations that jointly develop plans for action and advocacy to solve the health staff crisis in Zambia. The advocacy work focuses on national and international actors. Wemos' Zambian partner CHESSORE coordinates the network.

'In Zambia, the working conditions for nurses are dreadful. In most health centres there is hardly any medical equipment available, salaries for nurses are quite minimal and many are not even qualified for their job. Many health workers leave Zambia. Trade union ZUNO intends to contribute to a solution of the human resources for health crisis. To make our lobby stronger, ZUNO joined the Human Resources for Health network. Wemos supports this network.'
Grace Mtonga Mwandila, vice chairperson of the Zambian Trade Union of Nurses Organization (ZUNO) for the Lusaka province and National Secretary for the Zambia Theatre Interest Group, Zambia

Fund attracts health workers

Wemos and CHESSORE together implemented a research into the effects of the work of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) on the availability of health workers. The Fund claims to work on health systems strengthening, but the research demonstrates another reality. The effect of investing enormous sums of money in disease-specific projects is that relatively less money is available for general health programmes. The Fund also pulls many health workers from the public health sector towards its programmes, which increases the existing personnel shortage.

Partners
Centre for Health Science and Social Research (CHESSORE), Zambia
Cordaid, the Netherlands
Human Resources for Health Civil Society Network of Zambia, Zambia

Communications

We are compaigners

To reinforce the global advocacy work, Wemos mobilizes public and political support. Campaigns, events and free publicity generate visibility and persuade policymakers to take action.

Campaigning

In 2009, Wemos launched the campaign FairDrugs.org. The site www.fairdrugs.org, the hub of the campaign, encouraged – and continues to do so in 2010 – persons and organizations to sign the 'Call for Ethical Clinical Trials in Developing Countries'.

Free publicity

Wemos' website and newsletters provide news and views on a regular basis. In 2009, Wemos frequently voiced its opinion on global health issues in the national and international press as well as in medical papers. Topics ranged from active recruitment of health workers in developing countries to fair drugs at the European market.

Collaboration

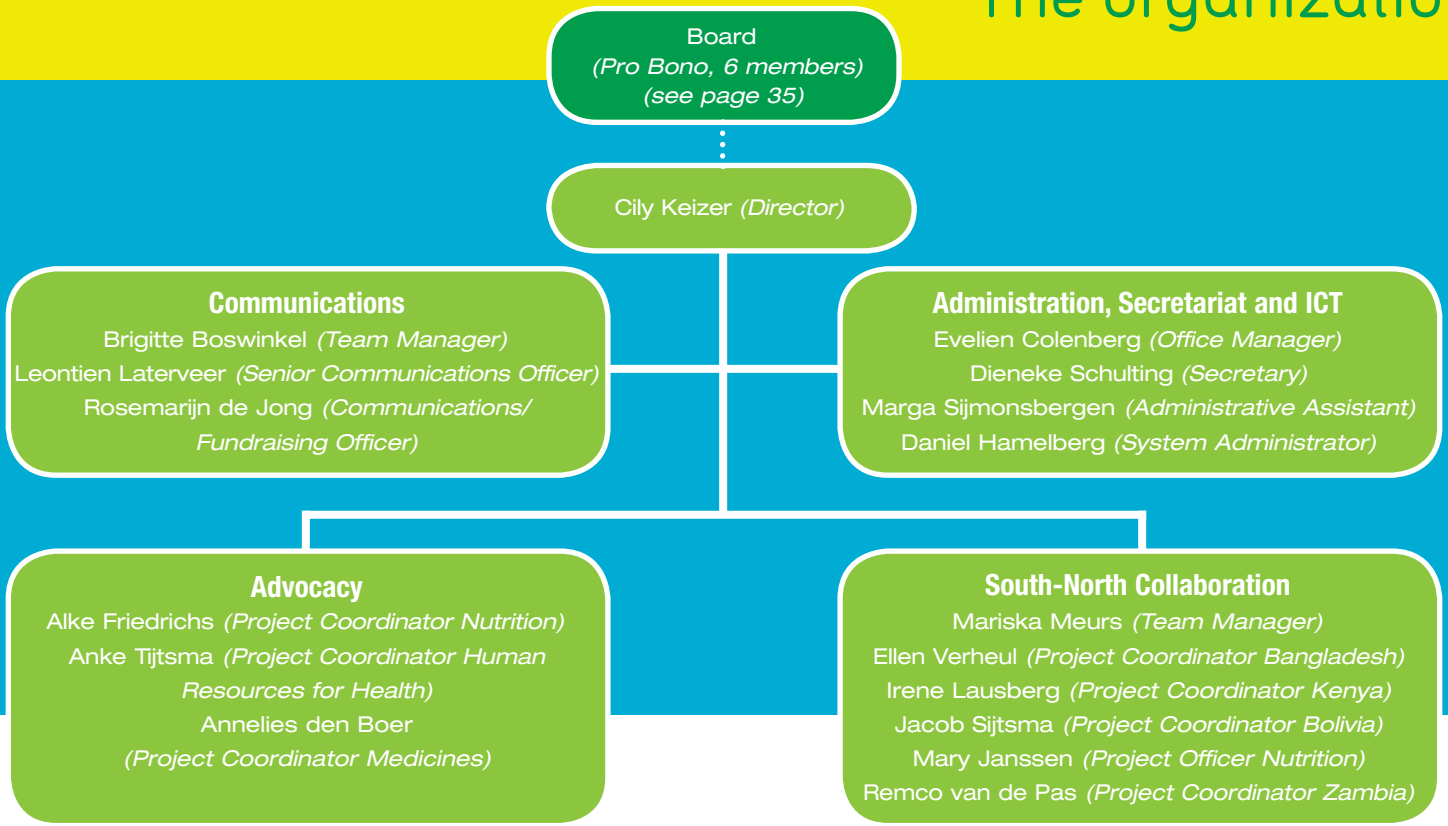
On the occasion of World Health Day (April 7), Wemos organized an event jointly with other development organizations. On International Clinical Trials' Day (May 20), Wemos gave interviews to the Dutch and international press. In collaboration with the International Federation of Medical Students' Associations – the Netherlands (IFMSA-NL), Wemos participated in the Millenniumtour 2009.

IFMSA-NL is part of Wemos' core support group, which consists of Dutch and European health workers, including medical students, and their associations.

Wemos gave 11 lectures, mostly on Dutch medical schools and faculties, which were good opportunities to provide future health workers with information on global health issues and to meet (potential) supporters.

‘There is a global shortage of as many as four million health workers, which means that huge numbers of people have no access to good health care. This was the reason behind IFMSA-NL, in conjunction with Wemos, holding presentations at Dutch university medical faculties in October. Our tour was part of the Millenniumtour 2009, initiated by NCDO, Move Your World and EEN, the aim of which was to involve more young people in the Millennium Development Goals.’
Hager Said, medical student, chairwoman Public Health working group of the International Federation of Medical Students’ Associations – the Netherlands (IFMSA-NL)

The organization



Temporary staff during maternity leave
Juliet van Oudenhoven (Fundraising Officer)
Sarah Los (Communications Officer)

Moved on
Maurits Reijnen
Merel Mattousch

Interns
Inger Janssen
Iris Bollemeijer
Maaike van Gameren
Tom Zwollo

Wemos' partner organizations in the South
Acción Internacional por la Salud (AIS), Bolivia
Centre for Health Science and Social Research (CHESSORE), Zambia
Centre for Studies in Ethics and Rights (CSER), India
Civil Society Trade Network Zambia (CSTNZ), Zambia
Consumer Information Network (CIN), Kenya
Development Organization of the Rural Poor (DORP), Bangladesh
Great Lakes University of Kisumu (GLUK), Kenya
Health NGOs Network (HENNET), Kenya
Latin American Network on Ethics and Medicines (RELEM), Latin America
Nutrition Association for Zambia (NAZ), Zambia

2010

Networking

Action for Global Health (AfGH)
Bangladesh Forum on Development Cooperation and Human Rights *(Bangladesh Overleg Ontwikkelingssamenwerking en Mensenrechten)*
BOOM
Co-financing Programme Related Broad Network on Bolivia *(Medefinancierings Programma Breed Netwerk Bolivia)* MBN Bolivia
Co-financing Programme Related Broad Network on Zambia *(Medefinancierings Programma Breed Netwerk Zambia)* MBN Zambia
Corporate Social Responsibility Platform *(Maatschappelijk Verantwoord Ondernemen Platform)*
Dutch Human Resources for Health (HRH) Alliance, the Netherlands *(Nederlandse HRH Alliantie)*
EEN, Dutch Platform Millennium Goals
EQUINET, Regional Network on Equity in Health in Southern Africa
European Food Security Group (EFSG)
European Network on Debt and Development (Eurodad)
European Nutrition Action Group (NAG)
Global Health Education Project (GHEP)
Global Health Workforce Alliance (GHWA)
Health Action International (HAI)
Health Workforce Advocacy Initiative (HWAI)
Human Resources for Health Civil Society Network of Zambia
Jubilee The Netherlands
Medicus Mundi International (MMI) Network
Netherlands Platform for Global Health Systems and Health Policy Research
Netherlands Working Group on International Nutrition (NWGN)
Partos, Association for Dutch NGOs in the International Development Cooperation Sector
People's Health Movement (PHM)

Financial statements

Abbreviated financial statements for the year 2009

Amounts in Euros (EUR)

The unabridged financial statements 2009 (in Dutch) can be obtained or consulted at www.wemos.nl.

Balance sheet as at December 31, 2009

	31 December 2009		31 December 2008	
ASSETS				
Material fixed assets		39,803		46,530
Current assets				
Subsidies	156,316		309,719	
Other receivables	31,858		37,176	
Cash and cash equivalents	554,437		367,618	
		742,611		714,513
TOTAL ASSETS		**782,414**		**761,043**
EQUITY AND LIABILITIES				
Reserves and funds		490,956		488,718
Short term liabilities				
Taxation	17,529		36,788	
Subsidies payable	19,880		14,964	
Debts to subcontractors	99,211		69,197	
Other short term liabilities	154,838		151,376	
		291,458		272,325
TOTAL EQUITY AND LIABILITIES		**782,414**		**761,043**

Statement of income and expenses for the financial year 2009

	2009		2008	
INCOME				
Income own fund raising	90,116		24,855	
Share in actions by third parties	409,060		385,228	
Subsidies from government	1,019,101		929,256	
Investment income	9,031		10,214	
Other income	10,510		31,148	
TOTAL INCOME		**1,537,818**		**1,380,699**
EXPENDITURES				
Expenditures for objective				
To strengthen national health systems that contribute to the structural improvement of people's health through advocacy		1,346,405		1,178,860
Costs of generating income				
Own fund rasing expenses	5,112		19,090	
Expenses for share in actions by third parties	14,482		13,876	
Expenses for subsidies	32,186		23,128	
		51,780		56,094
Management and administration				
Expenses for management and administration		137,395		143,329
TOTAL EXPENDITURES		**1,535,580**		**1,378,283**
RESULT		**2,238**		**2,416**
ALLOCATION OF RESULT				
Addition to/withdrawal from	2,238		2,416	
- continuity reserve	**2,238**		**2,416**	

Explanatory notes to the abbreviated financial statements for the year 2009

Specification and breakdown of expenditures according to allocation

Allocation	Objective	Generating income			Management and administration	Realization 2009	Realization 2008
Expenditures	Advocacy for health	Own fund raising	Actions by third parties	Subsidies			
	EUR	EUR	EUR	EUR	EUR	EUR	EUR
Country advocacy	321,332					321,332	182,699
International advocacy	127,057					127,057	189,704
Joint project activities	65,397	357	1,936	27		67,717	44,886
Personnel	645,078	3,684	9,721	24,915	106,448	789,846	769,576
Housing	73,959	422	1,114	2,857	12,204	90,556	91,649
Office and organization costs	101,025	577	1,522	3,902	16,671	123,697	81,532
Depreciation and interest	12,557	72	189	485	2,072	15,375	18,237
Total	**1,346,405**	**5,112**	**14,482**	**32,186**	**137,395**	**1,535,580**	**1,378,283**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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.

Reserves and funds
The reserves and funds are designated to the Foundation's objectives. The part of the reserves which are not recognized as fixed reserves set apart for the Foundation's objectives, is presented as continuity reserve.

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

Only subsidies from governments, including the European Union and similar international institutions, governmental institutions and public bodies, are presented under the heading ‘Subsidies from governments’. Subsidies from others are presented under the heading ‘Share in actions by third parties’. 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.

Accountability statement 2009, summary

This is a summary of the Wemos Foundation's accountability statement for 2009. It provides details of how the Board has incorporated the principles of good governance within the organization. These principles are:

- to distinguish between the roles of supervision, governance and execution;
- to optimize the efficiency and effectiveness of expenditure;
- to optimize relations with stakeholders.

For the full version of this accountability statement (in Dutch), please contact the Wemos Foundation (+31 (0)20 4352050 or info@wemos.nl).

The Board

The Wemos Board is the Foundation's highest authority and bears ultimate responsibility for the Foundation's work. Its role is to set the policy of the Foundation. The Board has delegated the development and implementation of policy to the Director. The distribution of roles between the Board and the Director is regulated in the Articles and in the Management Regulations.
The Wemos Board is made up of a minimum of five members, appointed for a four-year term with possible reappointment for a further four years. No close family or comparable relationships are permitted within the Board. Board members are unsalaried and receive an expenses allowance of €75 for each meeting they attend. In 2009, the Board met six times. For the purposes of financial supervision, the Board appoints an Auditing Committee from among its number, which applies the Auditing Regulations established by the Board. The Board evaluates its performance annually.
At the end of 2009, the Board included the following members:

Name	Portfolio	In office until	Positions/Additional positions
G.R. (Kick) Visser	Chair (second term)	01-05-2011	*Positions*: Advisor to the National Register Non-Executive Directors & Regulators Chair of the Supervisory Board Fonds NutsOhra Chair of the Rehabilitation Innovation Programme at the Netherlands Organization for Health Research *(ZonMw)* Member of the Supervisory Board, Comprehensive Cancer Centre North East Chair of the Board, Library Foundation Zwolle Secretary of the Supervisory Board ROC Deltion College
A.L. (Loes) Valk	Secretary (second term)	01-11-2012	*Position*: Director/owner Menea BV
O. (Oscar) van Agthoven	Treasurer (first term)	30-09-2011	*Position:* Partner, BDO Accountants & Adviseurs
C.G.J. (Chris) Knoet	General board member (first term)	30-09-2011	*Positions*: Director, Office for Catholic Education *(Bureau Katholiek Onderwijs)* Director/owner Knoet Consult *Additional positions:* Member of the Supervisory Board, Comprehensive Cancer Centre West Member Auditing Committee, Association of Comprehensive Cancer Centres Board member, Foundation for the Promotion of Special Primary and Secondary Education *(SBfBO)*
A.A.L.J. (Ankie) van den Broek	General board member (second term)	31-08-2010	*Position*: Senior Public Health Advisor, Royal Tropical Institute *(Koninklijk Instituut voor de Tropen - KIT)* *Additional positions:* Physician, Stichting Kruispost
J.H.J. (Jos) Dusseljee	General board member (second term)	30-04-2012	*Position*: Consultant, ETC Crystal *Additional positions:* Board member, Foundation Doctors for Developing Countries *(Stichting Artsen naar Ontwikkelingslanden – SANO)* Board Member, Josephine Nefkens Foundation

Director

The role of the Director is to develop and implement policy within the framework of the multi-year plans, annual plans and budgets set by the Board. The Director, Ms Cily Keizer, works in accordance with her job description and the Management Regulations. The Board evaluates the Director's performance on an annual basis.

Planning, monitoring and evaluation

Wemos' planning is based on context analyses. These are updated annually and focus on the health care sector and the Wemos themes. They are used as a basis for setting the multi-year strategy plan (five years) and the annual plans and budgets. The plans clearly reflect the logical relationship between the Foundation's vision, objective, results and activities. Much attention is given to establishment of measurable SMART [1] performance indicators in order to gauge the results achieved.

Progress in the projects is monitored on the basis of the annual plans. In addition to the progress made in activities and the achievement of planned results, the use of resources (human and financial) is also subjected to regular monitoring. Where necessary, the management team will make adjustments based on this monitoring.
During the implementation of the five-year strategy plan, there is at least one external evaluation, the results of which are applied in the subsequent policy cycle.

Wemos places great emphasis on the need for continuous learning within the organization and this is included as a regular point on the agenda in the theme and strategy meetings. During the meetings with the Southern partners, the alliance's capacity for continuous learning is also a key agenda issue.

Relations with stakeholders

Health care providers (medical students and specialists in (tropical) medicine, including health care institutions and professional associations) constitute Wemos' longstanding target group with a view to reinforcing the lobbying message and generating support for the Wemos themes across Dutch society. When communicating with the different target groups, Wemos always aims to highlight the results of its work as clearly as possible.

Support network

Wemos has a small core of loyal donors and a larger group of other parties with an interest in the subjects on which Wemos focuses its work. These parties receive regular information about the projects in the quarterly digital newsletter. The annual report is another valuable source of information for the support network.

[1] *Specific, Measurable, Acceptable, Realistic and Time-related*

Funding bodies

Wemos updates those who fund its work on the results achieved by issuing annual general and financial reports. All funding bodies also receive the annual report including the financial statement and auditor's statement.

Partner organizations

Alliances with partner organizations are essential for the achievement of Wemos' lobbying objective. Project staff communicate intensively with partner organizations in the South, in Europe and in the Netherlands by means of e-mail and regular visits.

Complaints regulations

In 2009, Wemos established Complaints Regulations, which are published on the website.

Adopted by the Board on 2 February 2010, in Amsterdam.

MAZARS

Auditor's report

Introduction

We have audited whether the accompanying abbreviated financial statements of Stichting Wemos, Amsterdam for the year 2009 have been derived consistently from the audited financial statements of Stichting Wemos, for the year 2009. In our auditors' report dated April 1, 2010 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 2009 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 2009.

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 2009, from which the abbreviated financial statements were derived and our unqualified auditors' report thereon dated April 1, 2010. Our opinion is not qualified in respect of this matter.

Amsterdam, May 4, 2010

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