Company Number: 4785712
Charity Number: 1099776

Malaria Consortium

Trustees' Report and Financial Statements
For the Year to 31 March 2016

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Reference and Administrative Details

Status

Malaria Consortium is a registered charity and is incorporated under the Companies Act as a company limited by guarantee not having a share capital. The company is governed by its Memorandum and Articles of Association dated 3 June 2003, under which each member has undertaken to contribute to the assets in the event of a winding-up a sum not exceeding £1.

Company Number 4785712

Charity Number 1099776

Registered Office

Development House, 56-64 Leonard Street, London, EC2A 4LT, U.K. The Consortium, during this period, also had offices in Uganda, Burkina Faso, Chad, Ethiopia, Mozambique, South Sudan, Nigeria, Thailand, Cambodia and Myanmar.

Patron

The Right Reverend Dinis S Sengulane, Anglican Bishop, Mozambique

The Trustees

The Trustees, who are also Directors under company law, who served during the year and up to the date of this report were as follows:

Chair	Dr Julian Lob-Levyt	
Treasurer	Canisius Anthony	
	Anthony Davy	(appointed 17 May 2016)
	Dr Allan Schapira	(appointed 20 November 2015)
	Dr Joanna Schellenberg	
	Dr Neil Squires	
	Dr Nermeen Varawalla	
	Dr Precious Lunga	(appointed 21 December 2015)
	Dr Simon Kay	(appointed 22 April 2016)
	Ian Boulton	(resigned 19 December 2015)
	Mark Clark	(appointed 17 May 2016)
	Peter Potter-Lesage	
	Professor Fred Binka	
	Professor Marcel Tanner	(appointed 17 March 2016)
	Professor Melissa Leach	(resigned 16 June 2016)
	Professor Sir Brian Greenwood	
	Robert Seabrook	(resigned 16 June 2016)
	Sarah Veilex	(appointed 22 April 2016)
	The Rt. Hon. Baroness Hayman	(resigned 17 May 2016)

Chief Executive Charles Nelson

Bankers

HSBC Bank PLC
Westminster Branch
22 Victoria Street, London SW1H ONJ, United Kingdom

Auditor

KPMG LLP
Chartered Accountants
15 Canada Square, London, E14 5GL, United Kingdom

Report of the Trustees

The Trustees present their report and the audited financial statements for the year ended 31 March 2016. The Trustees' Report also contains the information required in a Strategic Report as set out on pages 5 to 13.

Reference and administrative information set out on page 1 forms part of this report. The financial statements comply with the current statutory requirements, the Memorandum and Articles of Association and the Statement of Recommended Practice (2015) - Accounting and Reporting by Charities.

A copy of the Trustees Report and financial statements can be obtained by writing to the organisation at the registered address as detailed on page 1 of this report.

Structure, Governance and Management

Trustees and organisational structure

Malaria Consortium was established under a Memorandum of Association which established the objects and powers of the charitable company, and is governed under its Articles of Association. The charity is governed by a Board of Trustees, of whom there shall never be less than three, and the maximum number shall be eighteen. The Trustees meet quarterly for the Board of Trustees meeting, and for the Annual General Meeting (AGM), at which the audited accounts for the year are formally approved. At the AGM one third of the Trustees retire, and are eligible for re-election as long as they have not served for a continuous period exceeding six years. After six years Trustees must retire.

New trustees are recruited for their skills in areas relevant to the governance, aims or the changing nature of strategy and activities of Malaria Consortium. The trustees may at any time select a suitable person as a trustee, either to fill a vacancy or by way of addition to their number, who should be appointed in consultation with all existing trustees on the Board and preferably with unanimous support for the appointment. Trustees are sought in a variety of ways involving exploration of the field of potential candidates, including by recommendation from those working for or with Malaria Consortium, or from existing trustees. Potential trustees are scrutinised by the Officers of the Board of Trustees and by the Board as a whole. All new trustees receive an induction to the organisation by the Chief Executive and may be invited to attend a Board Meeting prior to election. During the year, four Board Meetings took place, including the AGM in July and a retreat held in November 2015. An average of nine trustees attended each meeting.

There are three sub-committees of the Board, the Governance Committee, the Finance, Audit and Risk Committee and the Compensation Committee. The purpose of the Governance Committee is to review and make recommendations regarding Board effectiveness, provide direction regarding on-going Board development and lead the process of Board renewal. Currently, the Committee comprises five members including the Chief Executive who is a non-voting member of the Committee. During the year there were four meetings of the Governance Committee; four trustees were at three meetings and two trustees at one meeting.

The purpose of the Finance, Audit and Risk Committee is to provide assurance to the Board that an effective internal control and risk management system is maintained and that Malaria Consortium's financial performance is being effectively managed. Currently, the Committee comprises six members, including two non-trustee members, and the Chief Executive and

Chief Finance Officer as non-voting members. During the year there were four meetings of the committee and an average of three trustees attended each meeting.

Malaria Consortium's policy is to provide inductions to new staff to enable a strong understanding of the organisation and an effective settling in period. Induction covers organisational structure, policies, procedures, teams and how they operate as well as role relevant information. Managers are also inducted on people management policies and procedures as well as budgeting and planning. Inductions for UK staff are managed in the UK by the HR team with support for planning from line managers and in Country Programmes by HR Focal Points and the Country Directors.

Separate to this Malaria Consortium utilises the annual performance appraisal to enable managers and staff to identify relevant learning initiatives to bridge skills or knowledge gaps. Staff also have the opportunity to request learning and development initiatives or support for professional development should such an opportunity arise outside of the annual performance appraisal period.

Malaria Consortium has developed and implemented (March 16) a job evaluation system which is used to evaluate roles and determine pay for all roles. Separate to the job evaluation system a salary benchmark exercise was conducted in the same period and as a result a global pay scale was developed. Pay scales where developed at the median of the job market for each country that we operate as Malaria Consortium's pay principle is to remunerate at the median of the job market.

The purpose of the Compensation Committee is to review and make recommendations on the Chief Executive's remuneration, the framework for the Global Management Group's remuneration and the organisation's human resources strategy and policies. Currently, the Committee comprises four trustee members, including the Chair of the Board of Trustees. The committee met once during the year at which four trustees were in attendance.

The Board of Trustees approves the major strategic decisions for the organisation. Each year, a number of trustees are invited to make field visits to be fully informed about Malaria Consortium's activities, thus enabling them to effectively support these strategic decisions. The Board of Trustees delegates day-to-day operational decision-making to the Chief Executive, who, with the Global Management Group (GMG), runs the organisation. The GMG is supported by Senior Management Teams at regional and country level responsible for technical, management and finance, as well as projects and programmes.

Malaria Consortium's head office is in London, United Kingdom. The regional offices for Africa, based in Kampala, Uganda and for Asia, based in Bangkok, Thailand coordinate and supervise programmes and projects at country level in the two regions. The Country Director of Nigeria reports directly to the Chief Executive. Global activities and any work in other parts of the world are directed through the head office in the UK. During this reporting period, country offices in Africa were operating in Kampala, Uganda; Juba, South Sudan; Addis Ababa, Ethiopia; Maputo, Mozambique; Ouagadougou, Burkina Faso; and Abuja, Nigeria. Additional provincial or sub-national offices were operational in Mbale, Hoima and Soroti in Uganda, Aweil in South Sudan, Inhambane, Niassa and Nampula provinces in Mozambique, Hawassa in Ethiopia and in Kano, Lagos, Anambra, Katsina, Niger, Ogun, Enugu, Jigawa, Zamfara, Sokoto and Kaduna states in Nigeria. Staff in Nigeria also support Yobe state from Jigawa, and have presence implementing programmes in nine other states. The Uganda Malaria Research Centre continues its activities in Kampala. In Asia offices were operational in Bangkok and Chiang Mai in Thailand and Phnom Penh, Ratnakiri and Pailin in Cambodia as well as in Yangon, Myanmar.

During this year Malaria Consortium's partners who have supported our work at the global and regional level include the Department for International Development/UK aid (DFID/UKaid), United States Agency for International Development and US President's Malaria Initiative (USAID/PMI), Bill & Melinda Gates Foundation (BMGF), Comic Relief, Global Malaria Programme of the World Health Organization (WHO), the Global Fund to Fight AIDS/HIV, Tuberculosis and Malaria (GFATM), Centers of Disease Control and Prevention, USA (CDC), UNICEF, UNITAID, the World Food Programme (WFP) and the James Percy Foundation.

At country level, our partners include National Malaria Control Programmes (NMCP) and Ministries of Health (MOH); local and regional UN offices; regional organisations in West, East, and Southern Africa, bilateral donors; international foundations; civil society organisations; development projects, private sector and most importantly communities suffering from malaria and other communicable diseases.

Close collaborations are maintained with academic institutions in UK including the Nuffield Centre for International Health and Development at Leeds University, the London School of Hygiene and Tropical Medicine and University College, London; Johns Hopkins University in the USA; Makerere University, Uganda; Kwame Nkrumah University of Science and Technology, Ghana; the University of Nigeria; Eduardo Mondlane University, Mozambique; Mahidol University, Thailand; and Pasteur Institute, Cambodia.

Malaria Consortium raises its income, which is predominantly restricted, through successful project contract and grant applications. The organisation currently receives a small amount of funding through fundraising efforts of public and private supporters to whom we are very grateful.

Malaria Consortium US Inc. was established in 2009 to further the aim and objectives of Malaria Consortium in the USA. The directors of Malaria Consortium US Inc. are two ex–trustees of Malaria Consortium and are independent from the UK Board of Trustees. As Malaria Consortium does not control the activities of Malaria Consortium US Inc. Malaria Consortium does not consolidate its results within these accounts.

Mission and Objectives

The mission of Malaria Consortium is to improve lives in Africa and Asia through sustainable, evidence-based programmes that combat targeted diseases and promote child and maternal health. We have referred to the guidance in the Charity Commission's Charity Act 2011 general guidance on Public Benefit when reviewing our aims and objectives and in planning our future activities. In particular, the trustees consider how these activities will contribute to the aims and the objectives of the charity, as shown below, that guide all our work to serve those suffering from communicable diseases in Africa and Asia.

Objectives

This reporting period, reflects the first operating year of a new five year strategy 2015-2019, with four key business areas and five new strategic objectives. This strategy has been developed in light of the transition at a global level from the Millennium Development Goals (MDGs) to the new Sustainable Development Goals (SDGs) agreed at the United Nations General Assembly in 2015. The four key business areas are:

a) Preventive Treatment – looking at intervention through prophylaxis, mass drug administration and existing and emerging vaccines.
b) Vector Control – looking both at interventions to reduce the number of vectors present in the community and keeping beneficiaries apart from the vector.
c) Case management – covering both diagnosis and treatment, improving both access to and the quality of services available should an individual present with symptoms.

d) Health Service Effectiveness and Efficiency – recognising that there are many diverse elements to health system strengthening, we focus on the key interventions that deliver the functionality and data necessary for effective decision making and response to health needs.

We recognise that these business areas are not always found in isolation and the five strategic objectives aim to reflect this. Our first objective covers our overarching work to put in place the policies, mechanisms and resources necessary, at a national and international level, to ensure the right interventions are not hindered by lack of support at a political level. The remaining four objectives are directly linked to each of the business areas. We will measure the progress of our strategy against these objectives. The objectives are:

1. To guide international and national policies and strategies to enhance control and accelerate elimination of targeted diseases and malnutrition.

2. To reach at least 10 million people (in the strategy period) with preventive treatment, supporting the appropriate uptake of emerging vaccines and drug-based prevention approaches.

3. To engage in at-scale delivery of effective vector control interventions and develop, investigate, promote and implement novel, vector-focused approaches that reduce disease transmission.

4. To improve access to, and the quality of services for, the diagnosis and treatment of diseases and/or those that enhance child and maternal health.

5. To improve health system effectiveness and efficiency, through enhanced surveillance, outbreak response, referral, reporting, and capacity and market development.

Strategic Report

Achievements and Performance

At an operational level, Malaria Consortium has continued to expand our programmes to improve access to effective prevention and treatment of malaria, pneumonia and neglected tropical diseases to some of the poorest populations in Africa and Asia. We have launched in Burkina Faso, Chad and Sierra Leone and funded a pilot study in the Chittagong Hill Tract in Bangladesh. A selection of key achievements and challenges for the year, linked to our objectives, is presented below:

To guide international and national policies and strategies to enhance control and accelerate elimination of targeted diseases and malnutrition

Malaria Consortium, both at international and national level, has maintained presence in key partnerships and working groups linked to policy and advocacy – Internationally at the WHO's Malaria Policy Advisory Committee (MPAC) and Vector Control Working Group and have been actively engaged in the reformation of the Roll Back Malaria Partnership. In the UK, we work with the All Party Parliamentary Group for Malaria and Neglected Tropical Diseases. We partner with Ministries of Health in each country, and also work with local advocacy partners in endemic areas, aiming to change policy and practice so as to end malaria and neglected tropical diseases. For example, in Nigeria, we work with the Christian Health Association of Nigeria, the Federation of Muslim Women's Association of Nigeria, the Health Reform

Foundation of Nigeria, the Centre for Communication Programme Nigeria and the Health Policy and Research centre of the University of Nigeria. In Ethiopia, our partners include Coalition against Malaria in Ethiopia and the Carter Centre. In Mozambique, we work in conjunction with NAIMA +. Where appropriate we work to broker deals with the private sector to establish sustainable channels for delivery of public health and ensure clear, regulated, contributions. We also work with the commercial sector internationally especially to assess new public health products which may provide the next generation of interventions that need to be built into policy. We continue to serve on the WHO Drug Resistance Containment Technical Expert Group which is guiding global strategies on tackling the threat of artemisinin resistance.

The UKaid SuNMaP programme in Nigeria concluded after 7.5 years working directly alongside the National Malaria Elimination Programme (NMEP). Dissemination events were held in all supported states and at a national level and highlighted the significant contribution of the programme to the progress of the fight against malaria in Nigeria, and the harmonisation of policy and the key stakeholders.

To reach at least 10 million people (in the strategy period) with preventive treatment, supporting the appropriate uptake of emerging vaccines and drug-based prevention approaches

The primary intervention that has contributed to this objective has been seasonal malaria chemoprevention for children of 3-59 months in the Sahel Region of Sub-Saharan Africa. This intervention is approved by WHO for this age-group for regions where malaria transmission is at a peak during a period of no more than four months, and where the available drugs (Sulphadoxine Pyrimethamine & Amodiaquine (SPAQ)) are still effective. The total eligible group for this intervention is about 25 million children. Funded by UNITAID, Malaria Consortium is leading a partnership of Catholic Relief Services (CRS), London School of Hygiene & Tropical Medicine (LSHTM), Medicines for Malaria Venture (MMV), Management Sciences for Health (MSH) and Speak Up Africa to develop the market for child friendly dispersible products across seven countries (Nigeria, Chad, Burkina Faso, Mali, Niger, Guinea and The Gambia). In the 2015 rainy season we reached over 3.2 million children with the requisite 4 monthly doses and saw presentation of fever at clinics drop by a dramatic 65+%. This is the first programme of its type, going to scale in this way across 7 countries and, although we did not reach of the initial target (twice the achieved level) this was due to non-availability of appropriately qualified product – an issue which has been resolved for the 2016 season, it represented a significant step forward and has resulted in strong domestic uptake and the interest of other major international donors.

Malaria Consortium has continued to seek funding opportunities to expand mass drug administration for various neglected tropical diseases, but limited additional funding has been realised. However, work funded through our Programme Partnership agreement has allowed us to push ahead with research work on the effect of community dialogues on the uptake of available treatment for schistosomiasis in Mozambique and the roll-out of treatment for worm infections in nearly 170 thousand children in Central Equatoria, South Sudan. Also, in Ethiopia we have worked in 4 districts, to pilot an integrated malaria, schistosomiasis and soil-transmitted helminth approach in schools.

Malaria Consortium is experienced in conducting field trials of vaccines and has been exploring the chance to run scaled-up trials for the recently registered RTSS vaccine for Malaria from GlaxoSmithKline. This has been recommended as an additional tool in high transmission areas but programmes have not yet been finalised. A dengue vaccine is also awaited.

To engage in at-scale delivery of effective vector control interventions and develop, investigate, promote and implement novel, vector-focused approaches that reduce disease transmission

Malaria Consortium has continued to be involved in large scale distribution of long-lasting insecticide-treated nets (LLINs), which remain one of the key, high-value interventions against malaria. In Nigeria, with both UKaid and USAID funding, we were engaged in campaigns to deliver 5.5 million nets in 3 states reaching a target population of 11 million people, and 0.65 million nets delivered through continuous distribution channels such as schools and antenatal care. Though getting significant interest from the private sector, it has proved a challenge to get consistent uptake of nets through commercial channels, as leakage of free nets and price diminution distort the market. In northern Mozambique, supported by Global Fund, Malaria Consortium delivered 1.4 million nets in Niassa and Nampula provinces to a target population of 2.6 million. The total value of gifts in kind was lower than the previous years both because the sum of the nets needed for campaigns was less than the prior year, and where nets were utilised in Nigeria, they did not meet the necessary criteria to be categorised as gifts in kind (e.g. Malaria Consortium was not required to take ownership of the nets at any point).

Results from some Malaria Consortium research, in partnership with London School of Hygiene and Tropical Medicine, showed that, although resistance is growing in mosquitos to the pyrethroid used as the insecticide, there was still a significant effect on the ability of the parasite to develop in the mosquito before transmission. While new insecticides are being developed, and even as the efficacy of the net reduces to control the mosquito population, this research suggests that ongoing use of currently available LLINs is highly valuable as transmission rates will continue to be reduced.

We are implementing an integrated vector management programme for dengue control in Cambodia, particularly seeing how well accepted a variety of approaches are to the community, and field testing tools. This will provide significant insight on a number of diseases as the vector, Aedes aegypti, is the one responsible for the transmission of the Zika virus and yellow fever. It has been a challenge to solidify donor interest in direct funding.

There has been significant activity looking at insecticide treated clothing in Southeast Asia, as many migrant and mobile populations are night/forest workers and particularly vulnerable to being bitten. The products have been well received in principle, but there are still some issues to resolve on price-point, acceptability of design for younger people, and the willingness of employers to fund such products as 'uniform'.

To improve access to, and the quality of services for the diagnosis and treatment of diseases and/or those that enhance child and maternal health

In the unfortunate event that transmission of any of the diseases or shortage of food requires intervention, this objective is targeted at improving access to and the quality in differential diagnosis and treatment at all levels of the health system.

In diagnosis, major steps continue to be taken in the widespread use of rapid diagnostic tests and acceptance that there should be parasitological diagnosis of malaria prior to diagnosis has been built into most countries' protocols. While this progress has been made, there is more to do to assure that protocol is followed, both in terms of quality supply and consistent clinician behaviour. There was a setback for in plans for expanding private sector use in Nigeria and Uganda when a funding extension was not forthcoming.

There has been significant progress on the field evaluation of different tools for diagnosis of pneumonia. Funded by the Bill & Melinda Gates Foundation, Malaria Consortium has led a piece of work evaluating multiple electronic devices across six countries, comparing to existing norms. There is certainly hope that cost-effective tools can be added to effectively diagnose, and therefore treat pneumonia.

Integrated community case management (iCCM) of malaria, pneumonia and diarrhoea remains a key approach to intervening in the common childhood diseases found in South East Asia and Sub-Saharan Africa. This is now being linked more regularly to community assessment of malnutrition and access to therapeutic feeding, directly or indirectly (iCCM+). We now have experience of this in Mozambique, Uganda, Nigeria, South Sudan and Myanmar. In each country the exact role played by the community workers differs and combination funding is required as a very supportive Global Fund can only provide commodities associated with malaria in this context.

We continue to push an agenda for engagement in case, morbidity and disability management for certain neglected tropical diseases (such as Lymphatic Filariasis (LF)) to complement programmes of mass drug administration. It continues to be a challenge in systems where chronic case management of any sort is not a common feature and where funding is constrained.

In this year we were also involved, in partnership with the Comic Relief 'Big Build', in the recreation of a health centre in Iyolwa, Uganda. This has been followed by further funding to ensure that referrals for complex case management operate effectively.

To improve health system effectiveness and efficiency, through enhanced surveillance, outbreak response, referral, reporting, and capacity and market development

Our last objective is focused on health system effectiveness and efficiency. Malaria Consortium has traditionally used malaria as our access point and leveraged off this to support wider aspects of service delivery such as community delivery, clinical capacity building, laboratory services, antenatal care, child and maternal health and data capture and analysis. This has been particularly effective in high malaria transmission areas as we help bring down the burden of both simple and complex cases of disease and allow the system to concentrate on improving differential diagnosis and targeted treatment in remaining cases. It also allows time for the clinical staff to build capacity and balance the supply chain.

As burden decreases and the thinking moves towards elimination, new tools and techniques have to be put in place. Surveillance and rapid response to outbreaks become key and surveillance becomes an intervention in its own right. Technology is increasingly playing a part in data capture and sharing and in the support and supervision of remote and community workers. Linkages are also being made to wider interventions in child and maternal health.
Malaria Consortium has invested through the reporting year to develop new sub-strategies and approaches for surveillance and interventions in the wider health system and have continued to build our portfolio of activities. In Myanmar and Ethiopia we have led the country-wide Malaria indicator surveys. We are working on key elimination strategies in Cambodia and Thailand. In Mozambique and Uganda, we finalised our work on the inSCALE programme, looking at the increased effectiveness of community health workers with the support of technology and, in Mozambique, this is now being expanded to widen the number of functions (e.g. pregnancy registration) and cover a significantly greater geography. In Sierra Leone we are exploring how best to rebuild the health system post-Ebola and instate a new, stronger surveillance approach. In Laos we completed a review of the dengue surveillance system and are looking to support implementation of recommendations. With our

communicable disease health system delivery research (COMDIS-HSD) activity in partnership with Leeds University, we are exploring: the barriers to uptake of intermittent preventive treatment of malaria in pregnancy in Uganda; the effectiveness of a community dialogues' approach in enhancing community participation and improving knowledge and practices for the prevention and control of NTDs; exploring factors which affect the rational use of antibiotics at community level in Zambia; and evaluating integrated community case management in rural and peri-urban settings in Uganda.

Financial Review

Income

Total income (excluding Gifts in Kind) received during the year amounted to £40.5 million, an increase of £3.2 million (9%) on the previous year. Total income (including Gifts in Kind) decreased by £17.4million (30%). Malaria Consortium, as in previous years, continues to receive the majority of its funding from institutional donors, including the British Government and the US Government. UNITAID directly and via sub-agreements with Population Services International and Medicine for Malaria Ventures contributed 38% of our total income. The UK Department for International Development (DFID) contributed 32% of our total income. The US government agency, USAID, via sub-agreements including FHI 360 contributed 9% of the total income with other donors contributing the balance. Please refer to Note 2c on page 21 for the full list of our donors.

Expenditure

Charitable expenditure on programmes (excluding Gifts in Kind) increased by £5.6 million to £40.9 million. Charitable expenditure on programmes (including Gifts in Kind) decreased by £15.1 million to £41.1 million. Note 3 on page 22 shows this expenditure categorised according to our five strategic objectives. Preventive Treatment and Vector Control are our two biggest areas of work representing 31% and 25% respectively of the total programme expenditure for the year. 31% of programme expenditure occurred in Nigeria and a further 26% in Africa multi country. Support costs as a proportion of direct costs is 6% which is the same as the previous year. In carrying out its programmes Malaria Consortium works with a number of partners to which it sub-contracts its work. Total sub-contract expenditure during the year was £4.2 million.

Result for the year

The total net movement in funds for the year was a decrease of £0.3 million compared to an increase of £1.3 million in the prior year. At the end of the year restricted funds for on-going projects were nil and unrestricted funds were £6.1 million.

The main movements in the balance sheet were a reduction of cash on hand by £4.8 million and a corresponding decrease in creditors of £6.9 million offset by a decrease in debtors of £2.1 million. The decrease in creditors was due to the release of deferred income in the year whilst the decrease in debtors was due to the settlement of partner advances during the year.

Reserves Policy

The majority of the organisation's operational commitments are related to activities funded by restricted funds. The contractual agreements cover the completion of such tasks and related financial commitments. The Board of Trustees recognise the importance of building and maintaining unrestricted reserves at an appropriate level and entrust the Finance, Audit and Risk Committee to annually assess the charity's level of unrestricted funds. On their

recommendation, the Board of Trustees agree that the required range of the reserve is £3.0 million to £3.4 million, equivalent to approximately six months of operational costs, which would give the organisation flexibility to cover temporary timing differences for grant claims, adequate working capital for core costs and would allow the organisation to respond to emergencies quickly if required. At 31 March 2016, free reserves stood at £5.9 million, which is unrestricted funds of £6.1 million, of which £0.2 million is designated, less £0.6 million represented by fixed assets. The Board of Trustees will consider further designations of reserves in the forthcoming year.

Investment Policy and Performance

The nature of the activities of the charity is such that unforeseen calls can be made on its resources at short notice when new opportunities arise. Accordingly, the bulk of the charity's liquid reserves are held for the time being in interest bearing accounts that can be called on without notice. Monies will be held in the most likely currency of expenditure. The charity will not speculate on currency, but hedge against potential losses based on the cash flow requirements.

Disclosure of information to auditors

The Trustees who held office at the date of approval of the Trustees' Annual Report confirm that, so far as that are aware, there is no relevant audit information of which the company's auditors are unaware; and each Trustee has taken all the steps that he/she ought to have taken to make himself/herself aware of any relevant audit information and to establish that the company's auditors are aware of that information.

Auditors

KPMG were appointed as auditors by the Board of Trustees on 22 November 2012. Pursuant to section 487 of the Companies Act 2006, the auditors will be deemed to be reappointed and KPMG LLP will therefore continue in office.

Plans for Future Periods

Malaria Consortium will continue to have a primary focus on malaria whilst expanding our portfolio in our identified business areas, through selected related health areas, in particular, pneumonia, neglected tropical diseases, nutrition, child health, and where appropriate as part of integrated community case management (iCCM), maternal and neonatal health.

We will drive new activity in-country and through our business areas and develop both programmes and technical competence in these areas, looking to further enhance surveillance as an intervention in its own right. In addition, we will reinforce our capabilities in three communities of practice looking at Monitoring and Evaluation, Public Health Communication and Capacity Building, competences required across all of our programmatic activities. Specific research agenda, linked to our business areas and communities of practice, will be identified and funding sought. In particular, we will:

1. Expand our reach on seasonal malaria chemoprevention (SMC) across the Sahel, and deliver programmes to enhance take up of intermittent preventive treatment in pregnancy for malaria.
2. Push to widen uptake of preventive interventions for dengue and Zika, and continue to promote the distribution and use of LLINs in appropriate settings, both through campaigns and continuous distribution models.

3. Expand our portfolio in nutrition, both alone and linked to other interventions such as iCCM and SMC, and continue to drive access to high quality diagnostics and treatments, in particular, widening the assessment and use of new pneumonia diagnosis tools.
4. Explore new avenues for health system improvement through the use of surveillance models, data capture and use for decision-making, and greater economic impact analysis linked to the new Sustainable Development Goals.

Principal Risks and Uncertainties

The responsibility for overseeing the management of risk has been delegated by the Trustees to the Finance, Audit and Risk Committee that reports to the Board. The Risk Assessment and Risk Management processes are reviewed quarterly by the committee and updated. The major risks, to which the charity is exposed, as identified by the Trustees, are reviewed and processes have been established to manage those risks. The Finance, Audit and Risk Committee review quarterly the Risk Assessment Register (RAR) that shows the impact and probability of the major risks; this is updated and key risks are reported to the Board by the Committee.

Risk Assessment

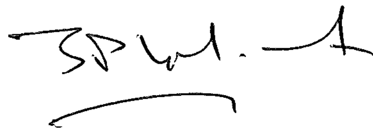
The achievement of our objectives depends on many factors, both inside and outside the control of the organisation. The identified risks, and our approach to their management, include:

1. *Strategic:* There continues to be increased competition for resources driven by: increased pressure on international aid budgets; individual calls for proposal for funding becoming less linked to specific diseases or conditions, more linked to wider health system support and increasingly competitively bid; the subsequent increase in interest from organisations with a less focused portfolio of activities; and the appropriate demand to ensure that solutions are sustainable for the communities that we serve and transferred to them. To mitigate these challenges to sustainability, Malaria Consortium is working with a wider combination of international partners, testing the effectiveness of working across multiple disease conditions in the communities at risk of Malaria, increasing the number and scale of implementation programmes undertaken to combine with our operational research activities, building on our business development capacity and transitioning to operate more often as the primary recipient of funding, as opposed to being generally 'sub-recipient' under the auspices of other organisations.
2. *Governance*: Any organisation governed by a Board of Trustees is put at greater risk if it does not have the right combination of skills among the Trustees that reflect the diversity of the organisation, its work and its clients, to effectively guide and monitor the strategic development of the organisation. The Board includes 12 trustees from a more diverse background than previously bringing expertise in many different fields. At the Board Retreat, in November the Board sets and agreed the priorities for the forthcoming year, based on feedback from the trustees and the senior management team.
3. *Performance:* The programmatic achievements of the organisation remain impressive with repeated, and increased, funding from donors. In addition, the organisation has increased its accountability, transparency and assurance to enable the organisation to demonstrate good value for money to donors. The project performance assessment system was refined and is used to monitor the implementation, technical quality and financial spend on all projects. Operational calls between Senior Management in the

Head Office and in the Regional Offices were implemented last year and continue to review performance and expenditure on a monthly basis.

4. *Operational*: We continue to operate in some areas with a high, and changing, security risk but these are also where those who suffer from the highest burden of malaria and communicable diseases are found. Security of personnel and property is paramount for management teams at all levels. We ensure we keep up-to-date information about the security situations where we work, and have suitable insurance to cover our work and staff. We regularly review the locations where we work and where necessary, if security risks are persistent, relocate, and/or suspend operations. We continue to monitor closely on-going developments in Nigeria, Myanmar in addition to South Sudan.

5. *Financial*: Continued growth, and any requirement for post, rather than pre, financing of projects can lead to challenges of maintaining the quality of delivery programmes and the adequacy of cash flow to finance operations. Maintaining an appropriate level of unrestricted funding for strategic investments is a continuing risk for the organisation. Current policies, the portfolio of donors and improved financial reporting systems allow the monitoring of our cash flow and we work closely with the bank to minimise any currency fluctuations. With careful control of overhead costs we are able to maintain our reserves in line with our current reserve policy and are in a position that we are able to make substantial investments for our future.



Julian Lob-Levyt
Chairman
28 July 2016

Statement of Trustees' responsibilities in respect of the trustees' annual report and the financial statements

The trustees are responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations.

Company law requires the trustees to prepare financial statements for each financial year. Under that law they have are required to prepare the financial statements in accordance with UK Accounting Standards and applicable law (UK Generally Accepted Accounting Practice), including FRS102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

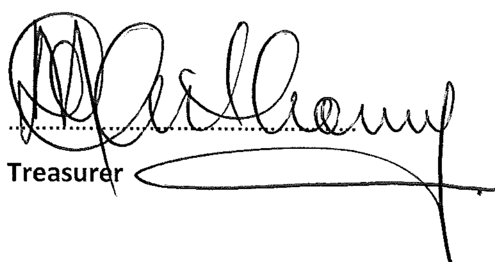
Under company law the trustees must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the charitable company and of the excess of income over expenditure for that period. In preparing these financial statements, the trustees are required to:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charitable company will continue its activities.

The trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the charitable company's transactions and disclose with reasonable accuracy at any time the financial position of the charitable company and enable them to ensure that the financial statements comply with the Companies Act 2006. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charitable company and to prevent and detect fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the corporate and financial information included on the charitable company's website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Approved by the trustees on 28 July, 2016 and signed on their behalf by:



Treasurer

Independent Auditor's report to the Members of Malaria Consortium

We have audited the financial statements of Malaria Consortium for the year ended 31 March 2016 set out on pages 16 to 25. The financial reporting framework that has been applied in their preparation is applicable law and UK Accounting Standards (UK Generally Accepted Accounting Practice), including FRS102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

This report is made solely to the charitable company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the charitable company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to any party other than the charitable company and its members as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditor

As explained more fully in the Trustees' Responsibilities Statement set out on page 13 the trustees (who are also the directors of the charitable company for the purposes of company law) are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at www.frc.org.uk/auditscopeukprivate.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charitable company's affairs as at 31 March 2016 and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with UK Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Opinion on other matter prescribed by the Companies Act 2006

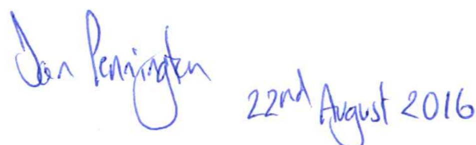
In our opinion the information given in the Trustees' Annual Report, which constitutes the Strategic Report, for the financial year for which the financial statements are prepared is consistent with the financial statements.

Based solely on the work required to be undertaken in the course of the audit of the Financial Statements and from reading the Strategic Report:

- we have not identified material misstatements in that report; and
- in our opinion that report has been prepared in accordance with the Companies Act 2006.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- the charitable company has not kept adequate accounting records or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of trustees' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit.



Ian Pennington (Senior Statutory Auditor)
For and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL

Malaria Consortium
Statement of Financial Activities (incorporating an Income and Expenditure Account) for the year ending 31 March 2016

	Note	2016 Unrestricted Funds £000s	2016 Restricted Funds £000s	2016 Total Funds £000s	2015 Total Funds £000s
Income from:					
Donations	2a	2	-	2	2
Donated Goods	2b	124	231	355	20,991
Charitable activities					
Grants, contracts & consultancy income	2c	5,283	34,767	40,050	37,139
Investments - Interest received		8	-	8	7
Other		438	-	438	159
Total Income		**5,855**	**34,998**	**40,853**	**58,298**
Expenditure on:					
Raising funds		94	-	94	652
Charitable activities	3	5,792	35,303	41,095	56,157
Total Expenditure	7	**5,886**	**35,303**	**41,189**	**56,809**
Net (expenditure) / income		**(31)**	**(305)**	**(336)**	**1,489**
Transfer between funds		(305)	305	-	-
Net movement in funds		**(336)**	**-**	**(336)**	**1,489**
Reconciliation of funds					
Total fund brought forward		6,482	-	6,482	4,993
Total fund balances at end of year	8	**6,146**	**-**	**6,146**	**6,482**

All income and expenditure derive from continuing activities.

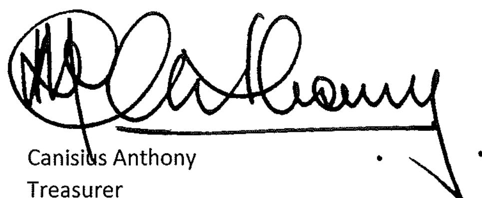
The notes on pages 19 to 25 form an integral part of these financial statements.

Malaria Consortium

Balance Sheet as at 31 March 2016

	Note	2016		2015	
		£000s	£000s	£000s	£000s
Fixed Assets					
Intangible Assets	9		19		21
Tangible Assets	9		580		600
Total Fixed Assets			**599**		**621**
Current Assets					
Debtors	10	5,927		8,048	
Cash at bank and in hand		7,996		12,766	
Total Current Assets		**13,923**		**20,814**	
Current Liabilities					
Creditors falling due within one year	11	(7,654)		(14,526)	
Net Current Assets			**6,269**		**6,288**
Total assets less current liabilities			**6,868**		**6,909**
Provisions					
Provisions for liabilities	12		(722)		(427)
Net Assets			**6,146**		**6,482**
Represented by:					
Unrestricted income funds	8		6,146		6,482
Restricted income funds	8		-		-
Total Funds			**6,146**		**6,482**

The financial statements on pages 16 to 25 were approved by the Board and authorised for issue on 28 July 2016 and signed on its behalf:



Canisius Anthony
Treasurer

Company registration number: 4785712

The attached notes on pages 19 to 25 form an integral part of these financial statements.

Malaria Consortium
Cash Flow Statement for the year ending 31 March 2016

	Notes	2016 £000s	2015 £000s
Cash flows from Operating Activities			
Cash (outflow) / inflow from operating activities	A	(4,662)	1,421
Cash flows from Investing Activities			
Interest income		8	7
Purchase of fixed assets		(116)	(86)
Net cash (used in) / provided by investing activities		(108)	(79)
(Decrease) / Increase in cash in the year		**(4,770)**	**1,342**
Cash at the beginning of the year	B	12,766	11,424
Cash at the end of the year	B	**7,996**	**12,766**

Notes to the Cash Flow Statement for the year ending 31 March 2016

A Reconciliation of Net Income / (Expenditure) to Net Cash Flow from Operating Activities

	2016 £000s	2015 £000s
Net (expenditure) / income for the year	(336)	1,489
Depreciation charge	121	64
Decrease / (increase) in debtors	2,121	(4,623)
(Decrease) / increase in creditors	(6,872)	4,171
Increase in provisions	295	291
Investment income	(8)	(7)
Loss on disposal	17	36
Cash (outflow) / inflow from operating activities	**(4,662)**	**1,421**

B Analysis of cash

	At 1 April 2016 £000s	At 31 March 2015 £000s
Cash at bank and in hand	7,996	12,766
Total cash	**7,996**	**12,766**

1 Accounting Policies

a Basis of Financial Statements

The financial statements have been prepared under the historic cost convention and in accordance with applicable Financial Reporting Standard (FRS102) and the Statement of Recommended Practice (SORP) 2015 "Accounting and Reporting by Charities". The format of the Income and Expenditure Account has been adapted from that prescribed by the Companies Act 2006 to better reflect the special nature of the charity's operations. The accounts comply with the Companies Act 2006.

Malaria Consortium meets the definition of a public benefit entity under FRS 102.

Key judgements and assumptions that apply to these accounting policies are listed where applicable.

The going concern basis has been adopted in preparing the financial statements as there is reasonable expectation that the charity has adequate resources to continue its activities for the foreseeable future.

The financial review in the Trustees Report reviews the finances of the charity for the year ended 31 March 2016 in comparison to the prior year. The charity has a healthy cash balance and a large proportion of grant funding required for 2016/17 and 2017/18 is contracted with donors. The Trustees report explains how the charity is structured and managed and how major risks are dealt with. The Board has a reasonable expectation that the charity has adequate resources to continue for the foreseeable future. Thus the Board of Trustees continue to adopt the going concern basis of accounting in preparing the financial statements.

b Reconciliation with previous Generally Accepted Accounting Practice

When applying the accounting polices required by the Charities SORP and FRS 102 (2015) the Trustees considered whether any restatement of comparative items were required and concluded there were none.

c Funds Accounting

Unrestricted funds are general funds that are available at the trustees' discretion for use in furtherance of the objectives of the charity.

Designated funds represent unrestricted funds that have been set aside by the trustees for particular purposes.

Restricted funds are those provided by donors for use in a particular area or for specific purposes, the use of which is restricted to that area or purpose.

d Income

Income for a specific purpose is credited to a restricted fund.

All income becoming available to the charity is recognised in the Statement of Financial Activities on the basis of entitlement. In respect of income not tied to time-limited grants, income is recognised as soon as it is prudent and practicable to do so. In the case of performance related grants or long term contract income, income entitlement is considered to be conditional upon delivery of the specified level of service, in accordance with FRS102 and the Charities SORP 2015 . Income is therefore recognised to the extent the charity has delivered the service or activity, with the grants less the management fee being credited to restricted income in the SOFA. The expenditure incurred to date is used as a reasonable estimate or approximation of the charity's performance and so income entitlement. Any such income not recognised in the year will be carried forward as deferred income and is included in liabilities in the balance sheet.

e Expenditure

Expenditure is recognised in the period in which it is incurred and includes attributable VAT which cannot be recovered. Expenditure is allocated to a particular activity where the cost relates directly to that activity.

Support costs of technical, managerial financial and administration oversight and direction are apportioned on a project by project basis, in line with the requirements of the various funding agencies.

The costs of raising funds are those incurred in seeking voluntary contributions and institutional income.

1 Accounting Policies continued

f Donated goods and services

Donated goods and services are valued and brought in as income and expenditure, when the items/services are recieved. Where the gift is a fixed asset, the asset is capitalised and depreciated. Where this intangible income relates to project activities it is included as an activity in furtherance of the charity's objects. The values attributable to donated goods are an estimate of the gross value to the organisation, usually the market value.

g Foreign Currencies

Transactions in foreign currencies are recorded using the rate of exchange ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies are translated using the rate of exchange ruling at the balance sheet date. Non-monetary assets and liabilities denominated in foreign currencies are not retranslated. Gains or losses on transactions are included in the statement of financial activities.

h Intangible Fixed Assets

Intangible fixed assets purchased from restricted funds for a particular project are charged to that project and are not capitalised. Intangible fixed assets purchased from unrestricted funds and costing more than £1,500 are capitalised and included at cost. Depreciation is provided on all intangible fixed assets at rates calculated to write off cost on a straight line basis over four years.

i Tangible Fixed Assets and Depreciation

Tangible fixed assets purchased from restricted funds for a particular project are charged to that project and are not capitalised. Tangible fixed assets purchased from unrestricted funds and costing more than £1,500 are capitalised and included at cost. Depreciation is provided on all tangible fixed assets at rates calculated to write off cost on a straight line basis over four years, except for buildings which are depreciated on a straight line basis over 25 years.

Malaria Consortium did consider revaluing the buildings in Uganda and commisioned a report. However the change in value was not significant enough to warrant a revaluation.

j Debtors

Amounts due from donors and other debtors are recognised at the settlement amount. Prepayments are valued at the amount prepaid.

k Cash at bank and in hand

Cash at bank and in hand includes petty cash and bank accounts including short term deposit accounts.

l Creditors and Provisions

Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount sue to settle the obligation can be measured or reliably estimated. They are normally recognised at their settlement amount.

m Financial Instruments

Malaria Consortium only has financial assets and liabilities of a kind that qualify as basic. These basic financial instruments are shown in the balance sheet and intially recognised at transaction value and subsequently measured at their settlement value.

n Pension Costs

The company makes agreed contributions to individual "Defined Contribution" pension schemes for certain employees. The assets of the scheme are held separately from those of Malaria Consortium in independently administered funds. The cost represents amounts payable in the year.

1 Accounting Policies continued

o Operating Leases

Rentals payable under operating leases, where substantially all the risks and rewards of ownership remain with the lessor, are charged to the statement of financial activities in the year in which they fall due.

p Group accounts

The financial statements present information about the Company as an individual undertaking and not about its Group. The operation of the subsidiary company Malaria Enterprise Limited in the year is not material to the Company for the purpose of giving a true and fair view. The Company has therefore taken advantage of the exemptions provided by Section 405 of the Companies Act 2006 not to consolidate.

2a Income from donations

	2016 £000s	2015 £000s
Unrestricted Funds		
Other donations	2	2
Total	**2**	**2**

2b Donated Goods

Donated goods, received this year relate to commodities from UNICEF in Ethiopia and South Sudan with a market value of £125k (2015: £363k) including artemismin-based combination therapies. In addition in South Sudan we received and distributed other donated goods valued at £106k (2015: £91k) to support our work within the community from Population Services International and the World Food Programme. In the UK, Linklaters LLP provided pro-bono legal services valued at £124k (2015: £65k). Last year we distributed long lasted insecticide nets (LLINs) donated by DFID and PMI for Universal Net Coverage in Uganda (2015: £20,472k).

2c Income from charitable activities

	2016 £000s	2015 £000s
UNITAID	12,196	1,078
Department for International Development UK	6,099	10,219
Department for International Development UK Contribution - Programme Partnership Arrangement (PPA)	5,283	2,143
FHI360 / USAID	3,228	4,874
Population Services International / UNITAID	2,434	2,485
Bill & Melinda Gates Foundation	2,052	1,983
Population Services International / DFID	1,631	1,856
Comic Relief	1,204	1,406
Global Fund / World Vision International Mozambique	1,110	1,698
WHO	743	597
Medicine for Malaria Ventures / UNITAID	731	682
Global Fund / Population Services International	587	760
Centers for Disease Control and Prevention	526	652
Three Millennium Development Goal Fund	299	-
Addis Continental Institute of Public Health /USAID	401	-
Save the Children Canada / WHO	391	377
United Nations Children's Fund (UNICEF)	252	402
University Research Co / USAID	219	-
Global Fund / UN Ops	166	-
Global Fund / Ministry of Health (Thailand)	182	254
John Hopkins University / USAID	-	3,796
Global Fund / Ministry of Health (Uganda)	-	1,551
Global Fund / National Center for Parasitology, Entomology and Malaria Control, Cambodia	-	77
Grants and Contracts for projects of less than £100,000 each	316	249
Total income from charitable activities	**40,050**	**37,139**

3 Details of charitable activities

The amount spent on charitable activities, including support costs analysed by programme area is as follows:

	Operational programmes £000s	Grants to Partners £000s	Support costs £000s	2016 Total £000s	2015 Total £000s
Guide Policies	5,394	72	370	5,836	2,363
Preventive Treatment	8,173	3,672	802	12,647	1,295
Vector Control	9,605	127	658	10,390	41,137
Case Management	9,144	24	620	9,788	9,581
Health Systems	2,002	278	154	2,434	1,781
Total spent - charitable activities	**34,318**	**4,173**	**2,604**	**41,095**	**56,157**

	Operational programmes £000s	Grants to Partners £000s	Support costs £000s	2016 Total £000s	2015 Total £000s
Burkina Faso	1,232	-	83	1,315	-
Chad	11	-	1	12	-
Ethiopia	1,147	-	78	1,225	113
Ghana	1	-	-	1	25
Mozambique	1,976	-	133	2,109	2,143
Nigeria	11,761	65	800	12,626	13,816
South Sudan	2,981	-	202	3,183	2,931
Uganda	3,489	24	237	3,750	27,766
Africa multi country	6,241	3,671	671	10,583	6,046
Cambodia	978	63	70	1,111	136
Myanmar	1,092	266	92	1,450	58
Thailand	192	-	14	206	250
Asia multi country	167	72	16	255	292
United Kingdom	3,050	12	207	3,269	2,581
	34,318	4,173	2,604	41,095	56,157

4 Support costs

These costs have been apportioned across the work of the charity in note 3 on the basis disclosed in note 1.

	2016 Total £000s	2015 Total £000s
Communications	159	134
Finance	574	712
Human Resources	184	191
Information Technology	114	116
Management	451	651
Programme Support	958	1,001
Governance	164	377
	2,604	3,182

5 Personnel and staff costs

	2016 UK	2016 Overseas	2016 Total	2015 Total
Average number				
Project and technical staff	20	219	239	184
Operations and logistics staff	0	73	73	84
Management, finance and administration staff	30	56	86	82
	50	348	398	350

Aggregate costs	2016 Total £000s	2015 Total £000s
Fees, salaries and agency staff costs	8,773	7,311
Social security costs	283	225
Pension costs	170	276
Overseas staff allowances	696	602
	9,922	8,414

Higher Paid Employees

The number of employees whose emoluments amounted to more than £60,000 during the year was as follows:

	2016 Number	2015 Number
£60,000 - £69,999	3	7
£70,000 - £79,999	4	6
£80,000 - £89,999	4	4
£90,000 - £99,999	4	3
£100,000 - £109,999	1	1
£110,000 - £119,999	2	-
£150,000 - £159,999	-	1
£170,000 - £170,999	1	-

During the year, pension costs on behalf of these employees amounted to £17,105 *(2015: £17,414)*

6 Taxation

The charity is considered to pass the test set out in paragraph 1 schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable company for UK tax purposes. As such, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by chapter 3 part II Corporation Tax Act 2010 or Section 256 of the Taxation and Chargeable Gains Act 1992, to the extend that such income or gains are applied exclusively to charitable purposes. Country Offices are subject to local tax regulations.

7 Expenditure

The expenditure figures are stated after charging:

	2016 £000s	2015 £000s
Operating lease rentals	537	538
Depreciation	121	64
Auditors' remuneration:		
Audit of these financial statements	75	56
Amounts receivable by the company's auditor in respect of audit-related assurance services	70	59
Taxation compliance services	9	3
Trustees' reimbursed expenses	7	7

Trustees' reimbursed expenses represents the travel and subsistence costs relating to attendance at meetings of the trustees and overseas field trips for 2 trustees (2015: 4). Trustees are not remunerated.

8 Statement of Funds

		As at 1 April 2015 £000s	Total Income £000s	Total Expenditure £000s	Inter-fund Transfers £000s	As at 31 March 2016 £000s
	Restricted Funds					
1	Guide Policies	-	41	(41)	-	-
2	Preventive Treatment	-	11,845	(11,845)	-	-
3	Vector Control	-	9,732	(9,732)	-	-
4	Case Management	-	9,168	(9,168)	-	-
5	Health Systems	-	2,279	(2,280)	-	(0)
		-	33,065	(33,065)	-	-
	Unrestricted funds - Free reserves	5,532	7,788	(8,091)	684	5,913
	Unrestricted funds - Designated funds	950	-	(33)	(684)	233
	Total funds	6,482	40,853	(41,189)	-	6,146

The transfer of £684k (2015: Nil) to free reserves from designated funds is for exchange losses which reverses the transfer made in 2015.

Purpose of Restricted Funds

1 To guide international and national policies and strategies to enhance control and accelerat elimination of targeted diseases and malnutrition.

2 To reach at least 10 million people with preventive treatment by supporting the appropriate uptake of emerging vaccines and drug-based prevention approaches.

3 To engage in at-scale delivery of effective vector control interventions and develop, investigate, promote and implement novel, vector-focused approaches that reduce disease transmission.

4 To improve access to, and the quality of, services for the diagnosis and treatment of diseases and/or those that enhance child and maternal health.

5 To improve health system effectiveness and efficiency, through enhanced surveillance, respose, referral, reporting, and capacity and market development.

Each restricted fund represents several separate projects funded by different donors who are listed in note 2 on page 21 and further details of these project funds is given below.

Purpose of Designated Funds

The designated funds are for strategic investments to achieve funding for work in neglected tropical diseases and to provide against future exchange losses.

8 Statement of Funds (continued)

Further analysis of restricted funds by project is shown below:

Restricted Funds	As at 1 April 2015 £000s	Total Income £000s	Total Expenditure £000s	Inter-fund Transfers £000s	As at 31 March 2016 £000s
Scale up SMC	-	193	(193)	-	-
ACCESS SMC	-	11,652	(11,652)	-	-
SuNMaP	-	5,305	(5,305)	-	-
MAPS	-	2,690	(2,690)	-	-
Malaria Prevention and Control GF	-	1,121	(1,121)	-	-
DDT/GEF	-	19	(19)	-	-
Tororo	-	421	(421)	-	-
e-Coupon Enhanced Social Marketing	-	1	(1)	-	-
Regional Artemisinin Initiative	-	91	(91)	-	-
Evaluation of Spatial Repellents	-	1	(1)	-	-
RAI-ICC2	-	75	(75)	-	-
Residual Malaria Transmission	-	8	(8)	-	-
Uganda PCA	-	66	(66)	-	-
Investment for the future - malaria control	-	137	(137)	-	-
HMM ACTs Under 5s	-	1	(1)	-	-
Private Sector Market for RDTs	-	2,566	(2,566)	-	-
Rapid Access Evaluation	-	376	(376)	-	-
ICCM+NBEG	-	1,670	(1,670)	-	-
Severe Malaria	-	833	(833)	-	-
Grand Challenges	-	1	(1)	-	-
Pneumonia Diagnostics	-	1,064	(1,064)	-	-
RACE Nigeria	-	678	(678)	-	-
Verboice	-	6	(6)	-	-
Integrated Community based Interventions	-	85	(85)	-	-
Iyolwa Health Centre Phase 1 & 2	-	184	(184)	-	-
ICCM + MNC	-	439	(439)	-	-
Scaling Up for Universal Coverage	-	586	(586)	-	-
Strengthening Healthcare in Iyolwa	-	182	(182)	-	-
Nutrition Programme in NBeG	-	212	(212)	-	-
Sustained Scale-up Malaria Elimination	-	82	(82)	-	-
InScale	-	504	(504)	-	-
Containment and malaria pre-elimination	-	41	(41)	-	-
COMDIS HSD	-	220	(220)	-	-
Containment & Elimination of Plasmodium	-	178	(178)	-	-
Immerse	-	158	(158)	-	-
Myanmar Malaria Indicator Survey	-	624	(624)	-	-
IVM for Control of Dengue Transmission	-	29	(29)	-	-
TRAction	-	179	(179)	-	-
SMMES of Ethiopia Program	-	342	(342)	-	-
mHealth Systems Strenthening	-	4	(4)	-	-
Other Projects	-	41	(41)	-	-
Total restricted funds	-	33,065	(33,065)	-	-
Unrestricted funds - Free reserves	5,532	7,788	(8,091)	684	5,913
Unrestricted funds - Designated funds	950	-	(33)	(684)	233
Total funds	6,482	40,853	(41,189)	-	6,146

9 Fixed assets

	Intangible Assets	Tangible Assets				
	Software Applications £000s	Land and Buildings £000s	Office Equipment £000s	Furniture & Fixtures £000s	Motor Vehicles £000s	Total £000s
Cost						
At 1 April 2015	158	542	200	101	642	1,485
Asset reclassifications	-	-	(37)	-	26	(11)
Additions	9	-	3	2	103	108
Disposals	-	-	(6)	(3)	(10)	(19)
At 31 March 2016	167	542	160	100	761	1,563
Depreciation						
At 1 April 2015	(137)	(92)	(178)	(68)	(547)	(885)
Asset reclassifications	-	-	37	-	(42)	(5)
Charge for the period	(11)	(24)	(7)	(22)	(58)	(110)
Disposals	-	-	6	2	10	18
At 31 March 2016	(148)	(116)	(142)	(88)	(637)	(983)
At 31 March 2016	19	426	18	12	124	580
At 31 March 2015	21	450	22	33	95	600

10 Debtors

	2016	2015
	£000s	£000s
Amounts due from donors	3,287	3,663
Other debtors	2,440	4,204
Prepayments	200	181
	5,927	8,048

11 Creditors

Creditors: amounts falling due within one year	2016	2015
	£000s	£000s
Trade creditors	779	837
Other creditors	190	48
Taxation and social security	137	69
Accruals	1,773	1,415
Deferred Income (note 13)	4,775	12,157
	7,654	14,526

Pension contributions were made during the year to defined contribution schemes in Ethiopia and the UK. As at 31 March 2016, there were £11k (2015: £6k) of outstanding contributions to such schemes, that are included in Other creditors above.

12 Provisions for Liabilities

	Overseas tax	Staff costs	Grants	2016 Total	2015 Total
	£000s	£000s	£000s	£000s	£000s
At the beginning of the year	362	-	65	427	136
Utilised during the year	(42)	-	(65)	(107)	(16)
Charge to the SoFA for the year	64	110	228	402	307
As at 31 March 2016	384	110	228	722	427

The provision for overseas tax relates to obligations in countries where Malaria Consortium is operating or has operated in the past. The staff provision includes amounts for severance payments on contract completion. The remainder are potential liabilties through grants not yet realised but may become payable. It is expected that Malaria Consortium will settle these obligations within the next five years.

13 Deferred Income

The deferred income relates to funding received for activities in a future period and is analysed as follows:

	2016	2015
	£000s	£000s
Deferred income at 1 April	12,157	8,878
Amounts released from previous and current year	(36,531)	(17,345)
Incoming resources deferred in the year	29,149	20,624
	4,775	12,157

14 Operating lease commitments - land and buildings

	2016	2015
	£000s	£000s
The amount payable on leases expiring:		
Within 1 year	376	430
Between 2 -5 years	46	458
	422	888

15 Analysis of net assets between funds

	Unrestricted funds	Restricted funds	Total 2016	Total 2015
	£000s	£000s	£000s	£000s
Fixed Assets	599	-	599	621
Net Current assets less provisions	5,547	-	5,547	5,861
	6,146	-	6,146	6,482

16 Related Parties

The Board of Trustees as key management personnel are considered related parties. During the year transactions with the Board of Trustees were limited to the reimbursement of expenses as disclosed in note 7.