TARGET TUBERCULOSIS
Financial Statements – 31st March 2014

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General Information

PATRONS	Sir Christopher France GCB Felicity Kendal CBE Patsy Wright-Warren CBE Andrew Russell FCA
TRUSTEES	Dick Bird OBE (Chairman) Dr Ian Harper MBBS PhD Marcus Hickman Neville Keenan ACIS AIMkt.M (UNISA) (Treasurer) Michael Marchment BDM, MCDH Dr Sarah Morgan MBChB DMMC Professor Melanie Newport MBBS PhD FRCP Ashim Paun MA MSC CAIA Christa Paxton Dr Maya Unnithan PhD
COMPANY SECRETARY	Janaki Jayasuriya, DChA
DIRECTOR/CHIEF EXECUTIVE	Wendy Darby, MBA, CIPD
REGISTERED OFFICE	Refuge House 49-50 North Street Brighton BN1 1RH
REGISTERED AUDITORS	Mazars LLP 37 Frederick Place Brighton BN1 4EA
BANKERS	Caf Bank Limited P O Box 289 West Malling Kent ME19 4TA
SOLICITORS	Griffith Smith Farrington Webb 47 Old Steyne Brighton BN1 1NW
CHARITY NUMBER	1098752
COMPANY NUMBER	4652230

Trustees' Report

The trustees present their report and the financial statements for the year ended 31 March 2014.

STATEMENT OF TRUSTEES' RESPONSIBILITIES

Law requires the trustees, who are also the directors for company law purposes, to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charitable company and of the net incoming or outgoing resources of the charitable company for that year. In preparing those 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;
- comply with applicable United Kingdom accounting standards 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 in operation.

The trustees are responsible for keeping proper accounting records which 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 Charities Act 2011 and the Companies Act 2006. They are also responsible for safeguarding the assets of the charitable company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustees have taken all steps that they ought to have taken in order to make themselves aware of any information relevant to the audit, and to establish that the auditors are aware of that information. As far as the trustees are aware there is no information relevant to the audit of which the company's auditors are unaware.

The charity's trustees have complied with the duty in the Charities Act 2011 to have due regard to the public benefit guidance published by the Charity Commission.

STRUCTURE, GOVERNANCE AND MANAGEMENT

Governing document

Target Tuberculosis (TTB) is a charitable company limited by guarantee governed by its Memorandum and Articles of Association dated 23 January 2003.

Recruitment, appointment, induction and training of trustees

The trustees are trustees for the purposes of the Charities Act 2011 and are directors under the Companies Act 2006. There must be at least three and not more than eleven trustees, all of whom must be members of the company.

The members of the company appoint the trustees at the Annual General Meeting. A vacancy in the number of trustees may be filled by the co-option of a person qualified to be a trustee; such a co-opted trustee holds office until the next Annual General Meeting. One third of the trustees must retire at each Annual General Meeting. No trustee may serve for more than nine consecutive years.

The trustees hold at least three meetings a year at which the quorum is three trustees. They have the responsibility for setting the strategic aims of the company and for approving its annual budget and accounts. The trustees regularly review their needs for skills to meet the requirements of their strategic aims and, where necessary, identify potential new members for the Board.

All new trustees are provided by the Chairman or the Chief Executive with an induction to the work of the

company. Training needs are kept under review by trustees at their meetings.

Organisational structure

The trustees delegate the day to day running of the company to the Chief Executive Wendy Darby. The Chief Executive reports to meetings of the trustees regarding progress towards achieving the company's strategic aims. Trustees are empowered to delegate their functions to committees, the membership of which must include at least two of their number.

Risk assessment

The trustees undertake annually a comprehensive review of the major risks to which the company is exposed and appropriate systems have been established to mitigate those risks. In the coming year 2014/15 we will establish a Finance, Audit and Risk Committee to assist in the oversight of these matters.

TRUSTEES

The trustees set out below have held office during the whole of the period from 1 April 2013 to date unless otherwise stated:

Dick Bird OBE (Chairman)
Helen Bray (retired 16th January 2014)
Dr Ian Harper MBBS PhD
Marcus Hickman
Neville Keenan ACIS AIKMkt (UNISA)(Treasurer) (Appointed 2nd November 2013)
Michael Marchment BDS, MCDH (Appointed 16th January 2014)
Dr Sarah Morgan MBChB DMMC
Professor Melanie Newport MBBS PhD FRCP
Dr Munirat Ogunlayi PhD (retired 2nd November 2013)
Ashim Paun MA MSC CAIA (Appointed 16th January 2014)
Christa Paxton
Andrew Russell FCA (Treasurer) (retired 2nd November 2013)
Dr Maya Unnithan PhD

OBJECTIVES AND ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE

Despite being largely preventable and curable, TB remains one of the world's biggest killer diseases. Nearly 1.3 million men, women and children die every year, over 95% of these being in low and middle income countries. Sadly TB overwhelmingly affects some of the world's poorest and most marginalised people who are often least able to deal with the impact of ill health on their already vulnerable lives. The World Health Organization declared TB a global emergency nearly 20 years ago and it was in the light of this that Target TB was launched in 2003 as a focussed response.

Vision and mission of Target Tuberculosis

Target Tuberculosis' (TTB) vision is a world free from TB. Its mission is to stop vulnerable people in Africa and Asia dying from TB by improving access to information, treatment, care and support.

TB on the world stage

Even in 2014, TB remains a major global health problem. Each year - 9 million people become ill with TB and more than 1.3 million die. TB is one of the main contributing factors to HIV deaths and is the third cause of death amongst women and children of childbearing age and the fourth cause of death among women of all

ages, equating to more than 500,000 female deaths each year. The impact on children sees more than half a million becoming ill with TB each year.
While major progress has been made towards the Millennium Development Goal 2015 targets there are still an unacceptably high number of new and existing sufferers of TB in the world. The emergence of drug resistant and multi-drug resistant TB is creating an ever increasing new challenge. There is still no effective vaccine against TB and the TB drugs have not significantly changed for decades.

It is estimated that around 3 million people, many of them in India and South Asia are lost or missed to treatment often because there is limited understanding of the causes and symptoms of TB; diagnostic services, drugs and follow up care are not easily accessible; treatment costs are beyond a patient's ability and conflict or disturbances interrupt care.

TTB's work is driven by the injustice that millions of people continue to suffer and die from TB, in an era where diagnosis and treatment are available to stop this. We target our approaches to the most vulnerable and difficult to access groups, working with the established health system to tailor responses to meet their unique needs, while ensuring service quality meets international guidelines. We also ensure that TB services are integrated with other service components such as HIV/AIDS; maternal and child health and nutrition.

Globally, financing for TB remains fragile with an estimated funding gap of US$ 22.5 million over the next 10 years.

How Target Tuberculosis (TTB) makes a difference?

Three distinctive approaches underpin TTB's work to achieve our mission:

1 Community-based TB control through civil society partnerships

Local communities need to play a significant role in supporting the health system as a whole to prevent and treat TB. Through building long term partnerships with indigenous civil society organisations we bring TB information and services to the heart of some of the most difficult to reach communities, building local ownership; engaging those communities most affected demand for and drive a more sustainable response from the health system.

2 Focusing on the most vulnerable communities

We work in Sub-Saharan Africa and South Asia, in countries with some of the highest global TB burdens. We focus our efforts on areas with the poorest performing TB control rates, taking into account TB's impact on other health issues such as HIV and Women's health, where government health infrastructure is weak.

As TB disproportionately affects the poorest in society, we concentrate our efforts on reaching the most vulnerable and marginalised people, for example tribal groups, people living with HIV, dalits, slum dwellers, women and children.

3 A holistic response to support communities affected by TB

TB is a disease which cannot be addressed through medical interventions alone. Through gaining a thorough understanding of both the medical and socio-economic determinants and consequences of TB, Target Tuberculosis ensure the delivery of more holistic programmes which bring about long-lasting improvements in TB control and the lives of people affected.

Treating TB and reducing people's vulnerability to TB are both vital to enabling people to return to productive lives, benefiting themselves, their families, and their communities long into the future.

What Target TB set out to do in 2013-2014

2013/14 was the second year of our Strategic Plan 2012-15 (see the plan in full on our website targettb.org.uk). We have developed six key objectives for this strategic period:

- To improve communities' health seeking behaviour and reduce stigma and discrimination
- To improve access to quality TB screening and diagnostic facilities
- To improve access to quality TB treatment and community based support to maximise cure and completion rates
- To increase knowledge and skills of volunteers and health workers in order to provide high quality services
- To promote and improve the integration of TB control into other health and development responses
- To influence policy and strengthen health systems to bring about long term sustainable improvements in TB control

What did we achieve in 2013/14?

The table below highlights people who have directly benefited from Target TB's work over the year:

TARGET TUBERCULOSIS BENEFICIARIES	2013/14 Asia	2013/14 Africa	2013/14 TOTAL	2012-14 STRATEGIC PERIOD TOTAL
People screened	70,558	56,846	**127,404**	**182,170**
People with TB symptoms referred	24,472	1,499	**25,971**	**47,710**
People accessing a diagnostic test	21,220	1,165	**22,385**	**37,610**
People diagnosed with TB	2,774	257	**3,031**	**7,517**
Patients who have started TB treatment	3,373	321	**3,694**	**7,526**
Patients who have been allocated a treatment supporter	3,144	353	**3,497**	**5,882**
Patients cured/completed treatment	1,960	100	**2,060**	**4,303**
Volunteers/community members trained	2,210	1,020	**3,230**	**6,786**
Government health workers trained	1,516	144	**1,660**	**4,506**
NGO members trained	343	26	**369**	**472**

Positive increases in numbers screened in African this year are due to our new 'active case finding' initiative in Malawi, where we aim to screen every single woman and child attending our project areas health centres.

TB rates for Asia are significantly higher than Africa due to the population size of India, where we work in more than three different states.

With a total annual spend of £926,136 for 2013/14 this crudely equates to the equivalent of £7.30 per person screened or just under £450 per patient cured of TB, following a 6 – 9 month treatment programme including regular psycho social support.

To improve communities' health seeking behaviour and reduce stigma and discrimination

All our project interventions are designed with a strong component involving education of the community and more particularly vulnerable groups within each project area. We first establish a baseline of knowledge

related to the causes; transfer and symptoms of TB and related conditions such as HIV; maternal and child health and nutrition; from these findings we develop and tailor approaches to increasing understanding including where to go for testing, what and how to access treatment and most importantly what support is available (financial and psychosocial) to help patients and families through the long and often arduous treatment.

Three baseline studies which were completed this year (India; Uganda and Zambia) demonstrated that while much of the population knew of TB, significantly less knew of the causes and that , with appropriate treatment , TB is a curable disease. This is due mainly to the prevalence of myths, misconceptions and stigma surrounding the disease. One Ugandan patient said ' when you tell people you were tested and found to have TB, immediately they think you have HIV; they start talking about you and you become a laughing stock in the community and people discriminate against you, they give you your own plate & cup and sometimes do not let you touch their things.'

We regularly monitor progress to attitudinal changes from our interventions, however long term social change takes time. Our recent end of project (a four year project in three states in India – Tamil Nadu, Orissa and Jharkhand) showed the following key achievements:

- 93% of people knew TB was curable;
- 88% said they no longer experienced discrimination and TB deaths in the project areas have reduced by half and cure rates increased to 95%.
- Marginalised /disaffected groups such as tribal minorities; transgender and PLHIV (people living with HIV)are more fully integrated and encouraged to use the available government health facilities
- The independent evaluation particularly commended our tailored 'tribal-centric' approach to programme delivery as an 'effective and innovative way of providing cost effective changes in health seeking behaviour and stigma reduction'

In Kampala, Uganda we have reached more than 30,000 slum dwellers and 3,000 secondary school children received basic health education in East Timor and Uganda.

To improve access to quality TB screening and diagnostic facilities

Key achievements in this area include:

In our new project in Malawi we have been actively screening each and every maternal and children client who visits the project centres. This has resulted in a significant increase this year in screened cases, however as yet this has not translated into a marked increased in cases referred for treatment.

In India we have increased opening hours of functioning health facilities, particularly in the remote areas and ensured that sufficient trained government staff are available. The majority of tribal groups in Odisha and Jharkhand indicated they now only needed to travel between 15-30 minutes to a treatment centre. Referral rates by the community have increased to 80% from virtually zero. The project also helped activate Village Health, Sanitation and Nutrition Committees (VHSC) to enable TB patients to access financial support to facilitate transportation costs.

In Tamil Nadu our local partners were instrumental in establishing a new clinic facility to meet the needs of local patients closer to their home base

Through support to a community clinic and providing volunteer led community outreach activities we have significantly improved access to TB and HIV screening and diagnosis among vulnerable slum populations in Kampala, Uganda this year. As a result 910 individuals have been screened and a total of 205 people have been diagnosed with TB, a significant proportion of who represent most at risk populations (out of school youth, commercial sex workers and boda boda drivers – the local ubiquitous motorbike taxi).

To improve access to quality TB treatment and community based support to maximise cure and completion rates

Community support is one of the core approaches used by TTB and our local civil society partners. We believe it is fundamental to ensuring that TB sufferers receive regular psycho social support during their 6 – 9 months of treatment – that can leave them feeling less well and very fatigued – to give them the stamina to see their treatment through to completion.

We are pleased to report that the independent end of project evaluation of our four year India project concluded significant progress had been made including:

- 98% of patients in Theni District, Tamil Nadu reported receiving home visits, half of these visits were being made by NGO staff and with the rest being made by an 'ASHA' (Village Health Nurse or equivalent or representative from the Revised National TB Control Programme (RNTCP).
- Before the project, sputum tests were not available for the poor, so infection went undetected and transfer of TB was rife. Since the project family member to family member TB infection has reduced significantly.
- ASHA's are now providing services for sputum collection, transportation for testing, providing medicine and monitoring of patients during treatment. For example, Brahmangaon Panchayat in Bangripasi block, which is remotely located, now has accessibility to TB services regularly through the ASHA.
- ASHA's maintained that for all the reported TB cases in all villages (except one) – they were able to maintain full treatment compliance, consistently between 2010 and 2013.

Through our project in Zambia home based care and logistical support has been provided to 1,112 people (59 TB patients, 411 PLHIV and 642 Orphans and Vulnerable Children). This support focuses on ensuring clients are linked to a comprehensive package of care provided by the project and/or other government and non-government service provider schemes. The quality of care and support provided through our local partner, BISO, has contributed to the overall welfare and treatment adherence. Services provided by community volunteers include psycho-social support, health education and treatment adherence. Our Community volunteers also conduct health assessments on clients who are particularly poorly and referred them for further care.

In East Timor the National TB Programme, following advocacy from our project and other organisations, has adopted protocols for Isoniazid Preventative Therapy (IPT) for children under 5 years old; however implementation of the protocol is still limited. Our project partner in East Timor, Klibur Domin, has focussed on providing support to the community health centres (CHCs) in the three sub-districts to undertake IPT for children who live with patients with smear positive TB (TB that is known to be infectious). This year 87 children have been identified and initiated on preventative treatment.

To increase knowledge and skills of volunteers and health workers in order to provide high quality services

Volunteers and health workers can take different forms in different countries and with different partners. TTB does not aim to instil a 'one size fits all' approach to working with volunteers, rather we aim to work within the existing frameworks, equipping volunteers and health workers with the appropriate knowledge and skills relevant to the context in which they are utilised so that they can provide the best support to patients suffering from TB and related illnesses, such as HIV/AIDS.

Our project in Kampala, Uganda capitalises on the existing government structure of village health teams (VHTs) to improve community level provision and access to TB and HIV services. This year 250 VHT members among our target community have been recruited and trained in TB and HIV. These include 60 representatives from 'most at risk populations' (MARPs) - 20 boda boda drivers, 20 Commercial Sex Workers and 20 People Living with HIV/AIDS. By encouraging the inclusion of MARP's in the VHT's we ensure that

the views of these highly vulnerable target groups are represented and influence planning and delivery of appropriate project activities which address their specific needs.

125 volunteers were recruited to support project delivery in Zambia have received training built on the MoH Training Manuals for Community Volunteers/Caregivers and Peer Educators. Each Community Volunteer in Zambia is provided with bicycles, clothing and shoes to support activities. Support activities include treatment adherence including literacy education, advice in good nutrition, emotional support to client families and help with household chores. BISO has also developed a Volunteer Policy. 50 peer educators were recruited and trained to support information and education activities and 100 community monitors, who take responsibility for checking the quality and availability of services in the community are also reporting back to the project team.

In Malawi 165 government health workers delivering maternal and child health services at seven health facilities have benefitted from training in TB and TB/HIV in the maternal and child health context to enable them to carry out and support TB education, screening and referral among clients accessing maternal and child health services.

- **To promote and improve the integration of TB control into other health and development responses**

Tuberculosis is one of the leading causes of death amongst patients with HIV and other immune compromised groups. Globally organisations such as WHO, the Global Fund and The Stop TB Partnership are driving countries and project implementing partners to ensure better and more comprehensive integration of TB control activities with other initiatives.

In TTB's four year project in Kampala slums, Uganda we have taken a highly integrated approach, in response to the high level HIV prevalence and resultant TB/HIV co-infection. During community outreach activities and sports galas, health education messages are combined with active patient screening for HIV and TB. Those identified with one or both of the diseases are referred for treatment and follow-up.

The Ministry of Health has established Community Based Health Care (SISCa) in every village in Timor-Leste, aimed at providing basic health care as close to the patients as possible, however TB was not included in the service offering. This year, Target TB and our local partner Klibur Domin has aimed to fill this gap by providing TB awareness raising and screening during the Governments Maternal and Child health immunization programme at SISCa Posts. These sessions have reached more than 4,550 mothers and children.

In Malawi, after a positive review of our pilot project to provided integrated health interventions we have expanded from one to seven health facility sites. 13,231 pregnant women and 34,484 children aged under five who initially came for maternal and child health services have benefitted from enhanced and integrated health monitoring, including screening for TB. As a result of the TB screening referral, 118 pregnant women and 176 children aged under five have accessed TB diagnosis. Of those, seven women and 18 children (seven HIV+), have been diagnosed with TB and have started life saving treatment. Health worker and volunteers report improvements in knowledge of TB and links with HIV and MCH. An additional benefit has been that TB officers report significantly better cooperation and sharing between health workers, particularly with regard to maternal and child health issues.

- **To influence policy and strengthen health systems to bring about long term sustainable improvements in TB control**

TTB focuses our effort and attention towards the better integration and mobilisation of civil society within the wider health system and works to ensure that the lower levels of the government health care are equipped with the right knowledge and skills to provide services. We aim to influence the up-take of national policies at a local level and where appropriate equip local level officials to be able to input into national policies.

The independent evaluation of our four year India project, funded under the UK Governments Civil Society Partnership Fund concluded that significant progress had been made, specifically:

- For the first time in the history of the Revised National TB Control Programme (RNTCP) India, more than 100 TB patients from tribal groups benefitted from the health assistance scheme of the Welfare Department of the district administration in West Singhbum, Jharkhand. Each TB patient received their entitlement of Rs.1000 (approximately £10). This is a fundamental contribution made towards greater equality for all populations and patient groups in India and only came about through regular and consistent advocacy with the government by our implementing partner Alternatives for India Development (AID).
- One Tamil Nadu Village Health Service Committee advocated, through the media using a local TV channel, to highlight the need for a village health nurse
- The role of the ASHA and *Anganwadi* workers (similar to health volunteers) in the TB programme was found to provide significant support to service delivery and monitoring. The project facilitated the regularising of ASHA's honorarium from local government, where previously the backlog in payment was 2 to 3 years, honoraria are now received within 2-3 months.
- Prior to our project interventions the Tribal Action Plan of RNTCP had become a dead document in Jharkhand and Odisha. The project sensitised the State TB Officer and State RNTCP Officer about the need for tribal friendly intervention and realities for of specific problems of tribes. This spurred the State RNTCP to launch a state-specific RNTCP Tribal Action plan for the first time, which is now under implementation in 12 'Scheduled Districts' of Jharkhand. The Director of AID, our implementing partner in Jharkhand, is the thematic lead for the TB Advocacy Group at the national level and has played a national role in shaping up the advocacy agenda of civil society. Several times tribal based experiences have been shared at the national and international platforms on TB, drawing this to the attention of the wider Indian civil society.
- In Tamil Nadu the project formed zonal and a state level TB networks, the latter comprising of 40 state NGO/CBOs. The state TB Network was registered under the society registration act.

In our new, four year project in Zambia we seek to build on progress made in a previous five year project, funded by Comic Relief, by enhancing and improving relationships with district and provincial authorities and advocating for improved TB and HIV service delivered at local, district and provincial level. This year significant ground work has been undertaken including:

- Completion of an advocacy context analysis and the development of an advocacy strategy including rights & responsibility for community empowerment; utilisation of the rights based approach; strengthening networks and coalitions and utilisation of standard tools for community monitoring
- Training of Trainers in Advocacy skills was completed for 19 project implementers. Training has been cascaded to lower levels within the community structure including Neighbourhood Health Committees, particularly focusing on how to apply the Community Score Card tool to highlight advocacy issues. 100 people (65 males & 35 females), were trained as community monitors (CM). The role of the CM is to advance the advocacy agenda by monitoring gaps and issues in service delivery
- Coalition Building Training was provided for our in country partner BISO and 12 other organisations.

Thanks and recognition

With incoming resources increasing by 10% in the year, the impact of Target TB's work continues to grow. The Trustees are grateful to all who make this happen, especially our partner agencies overseas, and our donors, volunteers and staff here in the UK. This year marked Target TB's 10th anniversary. For all that time the Honorary Treasurer has been Andrew Russell, and an anniversary event at the Ritz Hotel in March, generously sponsored by Cepheid, provided an opportunity for us to thank Andrew on his retirement, for his outstanding, assiduous stewardship.

FINANCIAL REVIEW

The results for the year ended 31 March 2014 are set out on pages 13-21 of these financial statements.

	2014	2013
	£	£
Incoming resources for the year	**972,140**	**881,618**
Costs of generating funds	116,939	88,920
Direct charitable expenditure for the year	843,278	575,896
Governance costs for the year	23,546	15,455
Total resources expended	**983,763**	**680,271**
Investment gains/(losses)	-	4,780
Net incoming resources for the year		
Restricted funds	(51,422)	173,133
Unrestricted funds	39,799	32,994
Total funds	**(11,623)**	**206,127**

Principal funding sources in the year were grants from Big Lottery Fund, Comic Relief, UKAid/Department for International Development and various other UK grant making trusts and foundations. TTB was the beneficiary of investments from the Ryder-Cheshire Foundation which were donated to TTB on dissolution. These investments generated realised gains during the year which are included within the Statement of Financial Activities.

TTB maintained a low ratio of fundraising costs in comparison to income (2014 12%, 2013 10%, 2012 12%). As a small charity operating with limited resources, TTB maintains strict controls over its costs, ensuring our operations remain cost effective and maximising resources available to support charitable activities.

There was an overall deficit this financial year, primarily due to a multi-year restricted grant being completed. TTB's unrestricted reserves increased in the year by £39,799.

RESERVES POLICY

Target TB intends to build up reserves sufficient to cover six months' running costs. Funds in excess of this requirement will be invested in the expansion of services provided by the charity. Despite another challenging financial year, TTB's unrestricted reserves increased to £143,708 at the end of the year. The value of Target TB's unrestricted reserves remains slightly short of the level the Trustees would like to retain.

This report has been prepared in accordance with the small companies regime of the Companies Act 2006.

Approved by the trustees on 19th July 2014
and signed on their behalf by

DICK BIRD OBE
Chairman

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF TARGET TUBERCULOSIS (TTB)

We have audited the financial statements of Target Tuberculosis for the year ended 31 March 2014 which comprise the Statement of Financial Activities, the Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

Respective responsibilities of trustees and auditors

As explained more fully in the Statement of Trustees' Responsibilities set out on page 2, the trustees (who are also the directors of the charity 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 (APB's) Ethical Standards for Auditors. This report is made solely to the charity'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 charity'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 anyone other than the charity and the charity's members as a body for our audit work, for this report, or for the opinions we have formed.

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 web-site at www.frc.org.uk/auditscopeukprivate.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2014and 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 United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Opinion on the other matter prescribed by the Companies Act 2006

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

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 2006requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, 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; or
- the trustees were not entitled to prepare the financial statements in accordance with the small companies regime and take advantage of the small companies exemption in preparing the Trustees' Report**.**

Alistair Fraser (Senior Statutory Auditor)
for and on behalf of Mazars LLP
Chartered Accountants and Statutory Auditors
37 Frederick Place, Brighton, BN1 4EA

TARGET TUBERCULOSIS (TTB)

Statement of Financial Activities
For the Year Ended 31 March 2014

	Notes	Unrestricted funds £	Restricted funds £	Total funds 2014 £	Total funds 2013 £
INCOMING RESOURCES					
Voluntary income					
Grants received		50,344	696,562	746,906	789,382
Other donations		178,540	-	178,540	85,849
Legacies		-	40,989	40,989	500
Investment income		4,532	-	4,532	5,887
Insurance claim		1,173	-	1,173	-
Total incoming resources	11	234,589	737,551	972,140	881,618
RESOURCES EXPENDED					
Costs of generating funds	2	107,727	9,212	116,939	88,920
Charitable activities	3	81,571	761,707	843,278	575,896
Governance costs	4	23,546	-	23,546	15,455
Total resources expended	11	212,844	770,919	983,763	680,271
Net incoming resources before other recognised gains and losses		21,745	(33,368)	(11,623)	201,347
Realised gains/losses on investments		-	-	-	4,780
Transfers between funds		18,054	(18,054)	-	-
Net movement in funds		39,799	(51,422)	(11,623)	206,127
Fund balances brought forward at 1 April 2013		103,909	392,114	496,023	289,896
Fund balances carried forward at 31 March 2014	11	£143,708	£340,692	£484,400	£496,023

There were no recognised gains or losses other than the net movement in funds for the year.

The incoming resources and net movement in funds for both years arose from continuing operations.

TARGET TUBERCULOSIS (TTB)

Balance Sheet at 31 March 2014

	Notes	£	2014 £	£	2013 £
FIXED ASSETS					
Tangible assets	7	3,946			4,432
Investments	8	-	-		-
			3,946		4,432
CURRENT ASSETS					
Debtors	9	129,305		298,745	
Cash at bank		422,323		276,328	
		551,628		575,073	
CREDITORS - AMOUNTS FALLING DUE WITHIN ONE YEAR	10	(71,174)		(83,482)	
NET CURRENT ASSETS			480,454		491,591
TOTAL ASSETS LESS CURRENT LIABILITIES			484,400		496,023
CREDITORS - AMOUNTS FALLING DUE AFTER ONE YEAR	10		-		-
NET ASSETS			£484,400		£496,023
FUNDS					
Unrestricted general funds	11		143,708		103,909
Restricted funds	11		340,692		392,114
			£484,400		£496,023

The financial statements have been prepared in accordance with the special provisions relating to companies subject to the small companies regime within Part 15 of the Companies Act 2006.

Approved by the trustees on 19th July 2014 , and signed on their behalf by:

Dick Bird OBE
Chairman

TARGET TUBERCULOSIS (TTB)

Notes to the Financial Statements
For the Year Ended 31 March 2014

1 ACCOUNTING POLICIES

The financial statements have been prepared in accordance with applicable accounting standards and in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities', issued in March 2005.

(a) Accounting convention
The financial statements are prepared under the historical cost convention.

(b) Incoming resources
Grants received are treated in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities'. Grants are credited to the Statement of Financial Activities when received, unless they relate to a specified future period, in which case they are deferred.

Donations are recognised on a receivable basis.

(c) Resources expended
Costs of generating funds include costs directly attributable to raising income.

Charitable expenditure comprises those costs incurred by the charity in the delivery of its activities. It includes both costs that can be allocated directly to such activities and those costs of an indirect nature necessary to support them. Grants payable are recognised when the grant has been awarded, and any conditions attached have been satisfied or fall outside the charity's control.

Governance costs include those costs associated with meeting the constitutional and statutory requirements of the charity and include the audit fees and costs linked to the strategic management of the charity.

All costs are allocated between the expenditure categories of the Statement of Financial Activities on a basis designed to reflect the use of the resource. Costs relating to a particular activity are allocated directly; others are apportioned based either on staff time or on estimated usage as a proportion of directly attributable expenditure.

(d) Pensions
The charity operates a defined contribution pension scheme. Contributions are charged to the statement of financial activities as they become payable in accordance with the rules of the scheme. The assets of the scheme are held separately from those of the charity in an independently administered fund. The pension charge represents contributions payable by the charity to the scheme.

(e) Fund accounting
Funds held by the charity are either unrestricted general funds or restricted funds.

Unrestricted general funds are funds which can be used in accordance with the charitable objects at the discretion of the trustees.

Restricted funds are funds that can only be used for particular restricted purposes within the objects of the charity. Restrictions arise when specified by the donor or when funds are raised for particular restricted purposes. The transfer of funds from restricted to unrestricted funds occurs when all conditions attached to the restricted funds have been fully discharged.

Notes to the Financial Statements
For the Year Ended 31 March 2014 (cont)

1 ACCOUNTING POLICIES

(f) Capitalisation and depreciation of fixed assets

Tangible fixed assets are recorded at cost. Depreciation is calculated on a straight line basis at rates appropriate to write off the costs of the assets over their expected useful economic lives as follows:

Office equipment	-	33% straight line
Fixtures and fittings	-	20% straight line

(g) Investments

Investments are stated at market value at the balance sheet date. All investments are in quoted securities. Dividend income is included within investment income. Realised and unrealised gains and losses on investments are recognised in the statement of financial activities in the period in which they arise. The movement in the market value of investments is reflected in the balance sheet.

(h) Foreign currencies

Income and expenditure expressed in foreign currencies is translated into sterling at the rate of exchange ruling on the date of the transaction. Monetary assets and liabilities are translated at the rate ruling at the balance sheet date. Differences arising on the translation of such items are dealt with in the Statement of Financial Activities.

(i) Donated services and facilities

Donated services or facilities are included in incoming resources when the benefit to the charity is reasonably quantifiable and measurable. They are valued by the trustees at the amount the charity would have been willing to pay for the services or facilities on the open market.

2 COSTS OF GENERATING FUNDS

	Unrestricted funds £	Restricted funds £	Total 2014 £	Total 2013 £
Staff costs	73,683	-	73,683	67,364
Training	1,528	-	1,528	2,184
Advertising and promotion	26,898	-	26,898	2,398
Subscriptions and fees	2,818	-	2,818	8,691
Allocated support costs	2,800	9,212	12,012	8,283
	£107,727	£9,212	£116,939	£88,920

Notes to the Financial Statements
For the Year Ended 31 March 2014 (cont)

3 CHARITABLE ACTIVITIES

	Unrestricted funds £	Restricted funds £	Total 2014 £	Total 2013 £
Project grants	-	633,735	633,735	388,975
Staff costs	28,448	54,903	83,351	77,029
Training	814	-	814	542
Other direct costs	2,264	17,223	19,487	51,430
Advocacy and awareness raising	13,488	5,784	19,272	2,159
Allocated support costs	36,557	50,062	86,619	55,761
	£81,571	£761,707	£843,278	£575,896

4 GOVERNANCE COSTS

	Unrestricted funds £	Restricted funds £	Total 2014 £	Total 2013 £
Staff costs	11,611	-	11,611	4,589
Training	320	-	320	74
Audit fee	3,988	-	3,988	4,112
Trustees' travel and meetings	2,061	-	2,061	2,187
Subscriptions and fees	670	-	670	473
Legal and professional fees	2,479	-	2,479	2,580
Allocated support costs	2,417	-	2,417	1,440
	£23,546	-	£23,546	£15,455

5 SUPPORT COSTS

	2014 £	2013 £
Staff costs	33,460	31,813
Travel	767	836
Training	41,858	286
Insurance	372	306
Rent and rates	14,165	21,645
Computer support	2,824	514
Printing, postage and stationery	1,700	878
Telephone, fax and email	1,738	1,547
Bank charges	157	109
Recruitment	1,236	3,576
Foreign exchange differences	-	-
Repairs and maintenance	256	342
Depreciation	2,515	2,624
Investment management fee	-	1,008
	£101,048	£65,484

Notes to the Financial Statements
For the Year Ended 31 March 2014

6 STAFF COSTS

	2014 £	2013 £
Salaries	215,724	159,524
Social security costs	17,663	15,470
Pension costs	6,472	5,801
	239,859	£180,795

The average number of persons employed by the charity was:

2014	2013
6	6

No employee received more than £60,000 remuneration.

No remuneration was paid to any trustee during the year. Travel costs and other out of pocket expenses totalling £915 (2013 - £1,125) were paid to 6 (2013 – 6) trustees during the year.

7 FIXED ASSETS

	Office equipment £	Fixtures and fittings £	Total £
COST			
At 1 April 2013	9,303	6,816	16,119
Additions	2,029	-	2,029
At 31 March 2014	£11,332	£6,816	£18,148
DEPRECIATION			
At 1 April 2013	4,871	6,816	11,687
Charge for the year	2,515	-	2,515
At 31 March 2014	£7,386	£6,816	£14,202
Net book value at 31 March 2014	£3,946	-	£3,946
Net book value at 31 March 2013	£4,432	-	£4,432

Notes to the Financial Statements
For the Year Ended 31 March 2014 (cont)

8 INVESTMENTS

FIXED ASSET INVESTMENTS	2014 £
Listed investments	
At 1 April 2013	-
Additions	-
Disposals	-
At 31 March 2014	-
Historic cost	-

9 DEBTORS

DUE WITHIN ONE YEAR	2014 £	2013 £
Other debtors	125,139	218,191
Other prepayments	4,166	80,554
	£129,305	£298,745

10 CREDITORS

DUE WITHIN ONE YEAR	2014 £	2013 £
PAYE and NIC	4,511	5,203
Trade creditors and accruals	32,777	40,068
Other creditors	1,039	667
Deferred income	32,847	37,544
	£71,174	£83,482
DUE AFTER ONE YEAR		
Deferred income	-	-

Notes to the Financial Statements
For the Year Ended 31 March 2014 (cont)

11 ANALYSIS OF FUNDS

	At 1 April 2013	Incoming	Outgoing	Transfers	At 31 March 2014
	£	£	£	£	£
Unrestricted general funds	103,909	234,589	212,844	18,054	143,708
Restricted funds					
1. Zambia - Bwafwano	126,916	113,302	161,364		78,854
2. Malawi – SRFIM	121,517	91,812	107,688		105,641
3. Uganda – IMF	31,449	114,036	137,908		7,577
4. India – AID and MAAS	14,617	111,573	101,855		24,335
5. India - Blossom Trust	4,558	65,924	60,930	(598)	8,954
6. India - AID and DACT/AA	3,833	129,691	125,806		7,718
7. Ryder Cheshire Foundation	55,661	-	-	(17,456)	38,205
8. Other Restricted Funds	33,563	70,224	70,368		33,419
9. Legacy	-	40,989	5,000		35,989
	392,114	737,551	770,919	(18,054)	340,692
Total funds	£496,023	£972,140	£983,763	-	£484,400

Restricted fund descriptions

1. Zambia, Bwafwano–Umweo: Home based care and support programme funded by Comic Relief.
2. Malawi, SRFIM – Kutukula Umoyo: integrating TB into maternal and child health services funded by Comic Relief.
3. Uganda, IMF – Touch Namowongo Urban Slums TB HIV control project funded by DFID GPAF grant number IMP 066. There were no DFID monies held at the year end. The restricted fund balance of £7,577 relates to funds raised from match funding.
4. India, AID& MAAS - The Jharkhand tribal health project funded by Big Lottery Fund - ICB/2/010424145.
5. India, Blossom Trust –Development grant for Campaign for education, prevention and treatment of TB funded by Big Lottery Fund -ICA/2/010450900.
6. India, AID &DACT/AA - Promotion of equal access to TB health services in India funded by DFID CSCF grant number 502. At the year-end Target TB was holding £7,718 of DFID monies.
7. This fund represents the balance of a grant received in earlier years specified to be applied to the support of core costs.
8. Other restricted funds related to restricted grants provided to Target TB to support TB control programmes in Southern Africa and South Asia.
9. Legacy income restricted to Target TB's work in India

Notes to the Financial Statements
For the Year Ended 31 March 2014 (cont)

12 ANALYSIS OF NET ASSETS BETWEEN FUNDS

	Tangible fixed assets	Net current assets	Total
	£	£	£
General funds	3,946	139,762	143,708
Restricted funds	-	340,692	340,692
	3,946	£480,455	£484,400

13 GRANT COMMITMENTS

At 31 March 2014 the charity had entered into a number of agreements to provide funding to partner organisations in periods commencing after 1 April 2014. Payments made under these agreements are contingent upon ongoing satisfactory monitoring and evaluation. Target Tuberculosis is not liable to make any payments until it has received the funds from the relevant project funder. The value of these commitments was £151,208 (2013 - £193,364).