The Adara Group (formerly the ISIS Group) consists of a series of trusts, charitable entities and companies globally, as set out below.

Adara Development (Australia) (formerly The ISIS Foundation (Australia)) is incorporated as a company limited by guarantee in Australia (ACN 131 310 355) and has a licence to operate in Nepal as an international non-government organisation. It is registered as a charity in Australia, and Australian taxpayers can make Australian tax-deductible donations through Adara Development (Australia).

Adara Development (Bermuda) (formerly The ISIS Foundation (Bermuda)) is registered as a charitable trust in Bermuda (No. 508).

Adara Development (Uganda) (formerly The ISIS Foundation (Uganda)) is registered and incorporated as a foreign non-government organisation (Foreign NGO, No. S 5914/9780).

Adara Development (UK) (formerly The ISIS Foundation (UK)) is registered as a charitable trust in the United Kingdom (No. 1098152). UK taxpayers can make UK tax-deductible donations through Adara Development (UK).

Adara Development (USA) (formerly The ISIS Foundation (USA)) is registered as a charity in 37 states. It has 501(c)3 status, and US taxpayers can make US tax-deductible donations through Adara Development (USA).


Adara Advisors Pty. Limited (formerly ISIS (Asia Pacific) Pty. Limited) is registered in Victoria, Australia and operates under Australian Financial Services Licence 415611.

Entities in the Adara Group are not authorised to solicit funding from any jurisdictions other than those they are registered in. Please contact us if you require more information about which jurisdictions these are.

For more information, please see www.adaragroup.org.

The names and details of some people featured in this report have been changed to protect their privacy.

Photographs © Adara Group, 2013 and 2014, courtesy of our amazing staff, supporters and volunteers.
We have set our strategy for the next three years based on the outcomes and learnings set out in these pages, expanding our purpose and our model. Although we were horrified to find that our much-loved name had become synonymous with terror, we looked for a new name and tagline that would truly reflect what we do. And yet there is so much more that needs to be done. The Adara Foundation was made up of two parts. The first is a non-profit international development organisation, Adara Development. The second is an Australian-based corporate advisory business, Adara Advisors.

Two underlying philosophies drive us. First is the belief that every person on the planet deserves good quality health and education services, no matter where they live. Second is that the halls of business and power have incredible potential for driving change for communities in need.

The Adara Group is made up of two parts. The first is a non-profit international development organisation, Adara Development. The second is an Australian-based corporate advisory business, Adara Advisors.

Our two parts work together to improve the lives of women, children and their communities in remote and rural areas. Since we began in 1998, we estimate that we have touched the lives of hundreds of thousands of people. Adara Development implements Adara’s international development work, undertaking projects in our three main areas of expertise; maternal infant child health; remote and rural community development; and care, support, and reintegration of children at risk.

Adara Advisors is a business for purpose rather than profit – its sole objective is to fund our non-profit’s administration and emergency project costs. Up to the end of 2014, Adara Advisors has donated more than US$6.89 million (AUS$9.3 million) to Adara Development.

This innovative model allows 100% of all other donations received to go directly to Adara Development’s project-related costs for supporting women, children and their communities. Great administration and infrastructure are a hallmark of any well-run organisation, and we know many donors like to see their funds go straight to ‘the work on the ground’. With our model, anyone that supports Adara’s programmes can fund our work without having to spend a cent on overheads, while knowing they are fully covered, thanks to our business.

Like the work of Adara Development, Adara Advisors continues to grow, developing new business streams to ensure the Adara model’s long-term sustainability. Stay tuned for exciting news from the business in 2015.
We believe the most effective development interventions are evidence-based and take into account the social, cultural and economic contexts of the communities they are seeking to assist.

That is why research has been one of Adara’s pillars of excellence since 1998. We use research to gather feedback from the communities we support, to develop projects based on evidence, and to understand the impact of our work.

Our research also seeks to contribute to the field of international development. We share our findings by presenting them at international conferences, publishing them in academic journals and making them available on the Adara website.
**OUR RESEARCH STRATEGY**

**Baseline surveys and impact studies**

The research team has conducted baseline surveys and impact studies for more than 17 years to assess community needs and monitor the impact of their work. Surveys are conducted at the household level so that the needs and priorities of everyone in the community - even the most marginalised people - are heard. More than 1,500 people from the communities we support were interviewed in 2013 and 2014.

**Literature review**

The research team keeps current on the existing literature on international development and assesses and integrates relevant findings from across the field in internal reports and in their published work.

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**Monitoring and evaluation**

The team manages the monitoring and evaluation for Adara’s development work using a large set of indicators which are assessed quarterly. All indicators align with long-term outcomes associated with the Millennium Development Goals.

**RESEARCH IN 2013 & 2014**

**ANTHROPOLOGICAL RESEARCH IN 2013 & 2014**

Led by our Research, Monitoring and Evaluation Director, Dr Kimber Haddie MacKay, Adara has conducted significant research in the period, all of which has informed programme design and development.

**Maternal health attitudes**

During our 2013 fieldwork, the research team designed and carried out a survey to analyse safe motherhood knowledge, attitudes and practices in the Nakasoke District of Uganda.

The findings helped identify gaps in our outreach services and led to the expansion of the community based healthcare programme. The findings also allowed us to target our interventions towards particular groups of women that our data showed needed more support and education. They included women from minority tribes, those with less food under cultivation and those where the wife’s income was less robust than her husband’s.

**Menstrual hygiene management**

Once girls reach puberty, the lack of supplies and facilities for managing menstruation at school is a real disincentive for them to attend. Many drop out due to the stigma and shame they feel during menstruation. In 2012, Adara and our in-country partner in Uganda, Kiwoko Hospital, launched a Menstrual Hygiene Management (MHM) project in 15 primary schools to help address some of the issues girls faced.

Preliminary evidence suggests the project has reduced the number of girls who miss or drop out of school once they reach puberty. In 2014, the research team conducted a review of the literature to ensure our programme is best practice, and collected data to measure the programme’s efficacy, focusing on data on attendance before and after the intervention.

**Mobile medical camps**

Each year, Adara conducts a mobile medical camp in Humla, Nepal – bringing doctors, nurses and medical specialists to this very remote region to improve access to health services for Humlis. In 2013, the research team embedded researchers for the first time into these camps to collect medical, social and economic information so we can assess patients’ healthcare needs and adjust our programmes. With this data we will develop a system for follow-up care for those patients needing further help once the clinicians have gone.

**Health-seeking behaviour**

The research team have used geographic information systems (GIS) to show the differences in health-seeking behaviour among different villages in Humla. Using this technology, we can connect behaviour to the region’s geography, to understand how it affects access to health services. For some communities we work with, the trek to health posts or the mobile medical camp is too arduous - they have to climb more than 8000 feet to reach services. This knowledge will help us address gaps in the communities’ access to healthcare.

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**CLINICAL RESEARCH IN 2013 & 2014**

In partnership with the University of Washington Department of Paediatrics, Division of Neonatology and Seattle Children’s Hospital, led by our Clinical Programmes Director, Debbie Lester, Adara has implemented several clinical research programmes in the Kiwoko Hospital neonatal intensive care unit (NICU).

**Electronic data collection**

Over several years, Adara’s clinical team has implemented and assisted the NICU to collect data on every infant admitted. The purpose is to track the demographics, clinical diagnoses, characteristics, treatment and neonatal outcomes for every patient, allowing the clinicians to target improvements in care. This data is extremely valuable and few such sets exist in the developing world. The team plans to implement a similar data collection system in the Kiwoko Hospital maternity ward in 2015.

**Peripheral intravenous monitoring**

The clinical team has been measuring the number of times peripheral intravenous (IV) catheters are inserted into neonates in the ward. These IVs are critical for administering fluids, medications and blood transfusions. Baby’s veins are smaller and more fragile than adults’. A premature or sick infant may require multiple cannulations (‘pokes’) during a prolonged stay in the NICU. The clinical team wants to reduce this.

The findings from this research will help the team develop an IV training programme on insertion, maintenance and safety checks.
In the villages of the Nakaseke district of Uganda where Adara has worked since 1998, many children and their families struggle with the impact of extreme poverty. Around 44% of the district’s population live below the poverty line. The country also has one of the highest birth rates in the world, so maternal and neonatal health is of great concern to the community.

Adara believes the best development projects are led by local people. Our priority in Nakaseke is to improve maternal, infant and child health through capacity building, training and programme design with our local partner, Kiwoko Hospital, serving a catchment area of 500,000 people. Our 17-year partnership with Kiwoko Hospital has been critical to our work since the very beginning.
Kiwoko Positive Airway Pressure (KPAP)

Continuous Positive Airway Pressure (CPAP) is a treatment that uses continuous mild air pressure to keep an infant’s airway open. It is used to treat preterm infants with immature lung development and babies who are in respiratory distress. In 2011 and 2012, in close collaboration with our partners at the University of Washington, Adara developed and initiated a CPAP programme at Kiwoko Hospital, built specifically for a low-resource setting. Designed by Dr Maneesh Batra from the University of Washington, the device was nicknamed Kiwoko Positive Airway Pressure (KPAP). Adara helped create the training manual and programme to roll it out in the Kiwoko NICU.

KPAP has had a big impact on improving infant mortality, helping many babies breathe. Our data suggests that 50% of babies who would have likely died from respiratory distress survived thanks to KPAP.

In 2013 and 2014, Adara focused on perfecting KPAP delivery with air and oxygen blending, as oxygen-only KPAP can leave babies with damage to their retinas. Blending is complicated in a resource-limited setting. We found a system that worked and tested it at Seattle Children’s Hospital. Once we were happy with the results, we rolled it out at Kiwoko in January 2014. We are working to further develop the blending technology, in partnership with the University of Washington Neonatology Team, Seattle Children’s Hospital and PATH.

Erica’s Quad Squad

Multiple births are extremely common in Uganda, and the NICU consistently cares for twins and triplets. However, even in Uganda it is rare to see quadruplets.

Almost all multiple births are premature, and the earlier the birth the greater the risk of complications for the babies. So when Erica came into the ward earlier this year with her four babies, who were born well before term, the NICU staff knew she would need a lot of support.

Erica had been abandoned by her in-laws, and her husband was in Somalia working as a peacekeeper. She was all alone. Kiwoko Hospital provided her with food to improve her nutrition and with accommodation so she could stay near her babies. The NICU staff provided excellent care to Erica’s babies to give them the best chance at life. As the babies were on the ward for a long time, the staff also gave Erica counselling to help prepare her for returning home. After several weeks, Erica and her beautiful babies were discharged, to begin life as a big, busy family.

*Pictures are only a representation of the story, and names have been changed to protect the individuals’ identities.

Kiwoko Hospital NICU Survival Data

<table>
<thead>
<tr>
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<tr>
<td>&lt;1 kg</td>
<td>11% 2/18 716</td>
<td>44% 7/16</td>
</tr>
<tr>
<td>1-1.4 kg</td>
<td>31% 19/19 81%</td>
<td>81/100</td>
</tr>
<tr>
<td>1.5-2.4 kg</td>
<td>73% 159/217 94%</td>
<td>270/287</td>
</tr>
<tr>
<td>2.5-4 kg</td>
<td>90% 327/363 91%</td>
<td>415/454</td>
</tr>
<tr>
<td>&gt;4 kg</td>
<td>100% 11/11 93%</td>
<td>25/27</td>
</tr>
</tbody>
</table>

In 2005, 13% of all low birth weight (≤2.5 kg) infants in the NICU survived. In 2014, 28% more likely to survive. 1,600 babies were admitted to the NICU for expert care in 2013 & 2014. 72 sets of twins, 3 sets of triplets and 1 set of quadruplets received care in the NICU in 2013 & 2014.
Uganda desperately needs maternal health services. Although the maternal mortality rate has declined by 36% since 1990, Uganda still has one of the highest rates in the world. The country is ranked 145 out of 180 countries globally for maternal health.

For the past 17 years, Adara has worked with Kiwoko Hospital with the goal of reducing maternal mortality in the Nakaseke district, and we are seeing great improvements.

Hospital-based birth

More women are choosing to give birth in the hospital. Since Adara supported the design, construction, equipping and staffing of a new maternity ward which opened in 2010, we have seen a 21% increase in annual admissions.

Skilled attendants

Midwives or skilled attendants can help avert two thirds of all maternal deaths, provided they are well trained, well equipped and well supported. Adara has worked with Kiwoko Hospital for many years to build capacity in the ward, with IMED teams providing training each year. In 2013–14, this included not only clinical training but training and mentoring on end-of-life care, ethics, leadership and delegation of authority, and the role of the hospital social worker.

Antenatal care (ANC)

ANC is critical for identifying complications in pregnancy. It is also an opportunity to promote the need for a skilled attendant at birth and healthy behaviours such as breastfeeding, postnatal care and family planning. More than 10,000 ANC appointments were conducted at the hospital in 2013 and 2014. Access to ANC has also improved through increased outreach services with the community based healthcare (CBHC) programme.

CLOSING THE MOTHER AND BABY CARE LOOP

In 2014, a new phase of the CBHC Safe Motherhood programme was introduced to bring the hospital’s maternal and child health expertise to the community and to improve local people’s basic health knowledge and skills. A total of 44 Village Health Trainers (VHTs) were selected from the community and trained to help women in their communities.

They learn to recognise early danger signs in pregnancy; encourage women to attend ANC and to seek a skilled attendant when giving birth; and also teach new mothers danger signs in the newborn. 34 clinicians from health centres in the district were also trained in basic maternal and neonatal health interventions. Pregnancy, delivery and newborn services are offered at many health centres, and they are often the first place women seek care. So it is critical the staff at these clinics have a good understanding of maternal and newborn health to help save lives and to refer women to the hospital if complex help is needed.

This programme is a way to ensure more women give birth with a skilled birth attendant to increase the chance both she and her baby will survive. It helps build a better understanding of safe motherhood practices in the community, strengthens the ties between communities, local health facilities, and the hospital, and helps more women give birth in a safe environment.

Uganda has extremely high birth rates - a woman has an average of 7.1 children in her lifetime. With such large families, it is often impossible for women to travel with all their children to the hospital or health clinic for services such as immunisations or antenatal care.

The clinics also address newborn health, weighing babies to measure their growth and providing mothers with health advice on infant follow-up. Babies are immunised, and if the team has any health concerns it can refer mothers and infants to the hospital.

Adara and Kiwoko Hospital address this through the CBHC Safe Motherhood clinics. These help ensure maternal health care before, during and after birth through an integrated community service, including family planning, antenatal care and postnatal care. Each month 22 one-day clinics are held, and each clinic services two villages at a time. More than 500 clinics were held in 2013 and 2014.

The clinics also address newborn health, weighing babies to measure their growth and providing mothers with health advice on infant follow-up. Babies are immunised, and if the team has any health concerns it can refer mothers and infants to the hospital.

Community antenatal care clinics were held in 2013 & 2014

500

Community antenatal care clinics were held in 2013 & 2014

Women were admitted to the maternity ward to give birth or for other complications associated with pregnancy in 2013 & 2014

14 15
Remote and Rural Community Development

Adara’s most remote programme of work is in the Humla district of northwest Nepal. High in the Himalayas, the remoteness of the region creates huge challenges for its people.

On any development measure, Humla fares poorly - they have the nation’s lowest literacy rates, maternal and infant mortality well above the Nepali average and food shortages each winter when families are sometimes snowed in for months. Life here is very, very challenging.

In these isolated hamlets, home to 50,000 people, Adara focuses interventions on two main streams: community health and education.
According to our latest research, this has changed as more Humli are having their basic needs met. Today, our research shows that Humli rate education as a much higher priority.

Adara has a holistic approach to education, working on school improvement, community empowerment, vocational training and non-formal education. By improving education in the district, Adara is eliminating the need for children to be sent away from their families in order to receive a quality education.

**School improvement**

Adara works closely with the District Education Office (DEO) in Humla to improve schools through the provision of teaching and learning materials, such as whiteboards, posters, science equipment, sports materials, musical instruments and books. We have refurbished seven classrooms in target villages to make them more child-friendly, to serve as a model for other schools to replicate. Since the programme began, there has been an overall improvement in school performance, student enthusiasm, discipline and attendance.

**Teacher support**

Due to Humli’s remoteness, it is difficult for the government to attract and maintain teachers. Plus it is not unusual for employed teachers to fail to turn up to class. Consequently, teacher to student ratios are extremely low - for students who make it to upper high school there is just one teacher for every 77 students. Adara is working to improve these ratios by funding the salaries of extra teachers in each of our target villages - training, mentoring and monitoring their attendance.

**Educational and vocational scholarships**

For many Humli families, the cost of basic school materials is an obstacle to their children attending school. During 2013 and 2014, Adara provided 1,434 school students with stationery, notebooks, warm track suits, school bags and other necessities. Adara also funded nine of Humli’s best and brightest to obtain post-school vocational training.

**Non-formal education (NFE)**

More than 180 children and 140 adults attended non-formal education classes in 2013 and 2014. The children’s classes were operated outside school hours for all primary level children in our target villages to help them with their studies, home assignments and the subjects that they find difficult. There is increasing demand for NFE in Humla, especially from women, who, despite their hectic work lives, are interested in improving their literacy.

Adara is tackling these issues through a holistic approach to healthcare by undertaking a number of interventions - health awareness and disease prevention; improving nutrition, hygiene, and sanitation; and providing access to health services.

**Nutrition**

Malnutrition is a serious problem in Nepal, and food shortages due to seasonality are common. It is estimated that more than 40% of Nepali children are stunted due to malnutrition. During the harsh Humla winter, green vegetables are traditionally unavailable. Adara improves nutrition by advising farmers on greenhouse construction and repair and supplying key materials, providing vegetable seeds and assisting with tree plantation and orchard development; and supplying solar driers to be used to dry food for the long cold winters. During the period, 129 greenhouses were built by Humli villagers.

**Hygiene and sanitation**

Waste management is a problem across Nepal, with 2,000 Nepali children dying each year from diarrhoea caused by unsafe water and poor sanitation. In Humla, Adara improves hygiene and sanitation through education, training and assistance in building, installing and managing pit latrines, smokeless metal stoves and drinking water systems. During the period, 71 pit latrines and five drinking water systems were completed. We also educate both women and men on reproductive health, disease prevention and hygiene and sanitation.

**Health post improvement**

Adara wants to improve long term regular access to medical services in Humla. We work local area health posts by supplying medicines and supporting the salaries of two health assistants. We also refurbished the health posts in our target villages to make them clean and functional. These interventions have helped to ensure Humlis have access to year-round care.

**Mobile medical camps**

In order to address gaps in health services, Adara runs annual mobile medical camps, which bring Nepali doctors, nurses and specialists into Humla for two months at a time to treat as many people as possible. The camps are stationed at local health posts and provide access to 28 surrounding villages. The clinicians train health post personnel during the camps and leave the medicines that they bring with them when they return to Kathmandu.

**Tibetan Medicine Practitioner**

Amchi Kelsang Tsering travels from village to village in upper Humla for eight months of the year, treating people and providing free Tibetan medicine to 25 villages. He fills gaps in access if the mobile medical camp is not occurring, the health posts are inadequately resourced, or the person is too sick to travel to the health post. In 2013 and 2014, a total of 2,587 people received care from the Amchi.
The couple live in Chala, the most remote village in Humla, and possibly in the world. There are no medical facilities and people mostly depend on health support from traditional healers. Thankfully, the Adara mobile medical camp doctor was in the area, and together with our health coordinator, they traveled to Sajita’s home to check on her.

When they arrived, Sajita was extremely weak and tired. She had not had much to eat or drink. They examined her and could hear the baby’s heartbeat! The baby was alive. They counseled Pratosh to wait and remain calm. After several anxious hours, the couple welcomed a beautiful baby boy into the world without any complications for either mother or child.

*Pictures are only a representation of the story, and names have been changed to protect the individuals’ identities.

**RURAL HEALTHCARE IN NAKASEKE UGANDA**

WITH 44% OF NAKASEKE PEOPLE LIVING BELOW THE POVERTY LINE, ADARA BELIEVES OUTREACH HEALTHCARE SERVICES ARE CRITICAL TO IMPROVING THE COMMUNITY’S HEALTH.

Community based healthcare
Adara helps Kiwoko Hospital reach some of the most vulnerable people in the community. This includes people living with disabilities, epilepsy, mental illness and tuberculosis. The community based healthcare programme also focuses on health promotion, hygiene education and sanitation practices.

| Test for Tuberculosis (TB) were conducted, to help identify and treat those living with TB in 2013 & 2014 |
| 284 PEOPLE LIVING WITH EPILEPSY ARE ON THE EPILEPSY REGISTER AND ARE PROVIDED WITH LIFESAVING TREATMENT EACH YEAR |
| People living with HIV/AIDS were provided with free medical treatment through the work of the Himalayan Medical Foundation in 2013 & 2014 |
| Malnourished people living with HIV received fortnightly food packages each year |
| Adults & 828 children living with HIV received medicines to treat opportunistic infections in 2013/14 |
| Orphans and vulnerable children received support for their education each year |

**CREATING OPPORTUNITIES FOR HUMLA’S MOST VULNERABLE**

One of the most marginalised and vulnerable groups in Nepal is children born to unmarried mothers. They experience significant stigma and discrimination in their community.

They are unable to obtain birth certificates without the name of their father, and cannot get citizenship certificates when they turn 16. Many of these children do not attend school and they are often relegated to a life of domestic work or sent to be a monk in the monasteries. Adara works with The Himalayan Innovative Society (THIS), to ensure that these children are not left behind and can enjoy the same rights as any other child. We support 53 of these children to attend school in Humla.

53 CHILDREN FROM SINGLE PARENT FAMILIES WERE PROVIDED WITH COUNSELLING AND EDUCATIONAL SUPPORT THROUGH THE WORK OF THE HIMALAYAN INNOVATIVE SOCIETY EACH YEAR

ACCESS TO HEALTH SERVICES FOR KATHMANDU’S POOREST

Over 30% of Nepalis live on less than US$1 per month, meaning many cannot afford to access healthcare.

From a friendship and connection that we struck up during the most difficult years of the Nepal conflict, Adara has partnered with the Himalayan Medical Foundation (HMF) since 2001 to provide free basic healthcare services to severely disadvantaged people in and around Kathmandu through their health clinics. The clinics provide free health check-ups, laboratory services, prescriptions and dental check-ups. More than 11,000 people receive these services every year.

23,362 PEOPLE IN KATHMANDU RECEIVED FREE MEDICAL TREATMENT THROUGH THE WORK OF THE HIMALAYAN MEDICAL FOUNDATION IN 2013 & 2014

**HOPE TO HUMLA**

Like all expectant parents, 36 year old Sajita was excited and nervous to be having her first baby with her husband Pratosh.

Sajita is Pratosh’s second wife – he had lost his first wife during childbirth several years earlier, and was very concerned about history repeating, especially after Sajita had been in labour for more than 24 hours. Because of this long labour, and because Sajita was experiencing terrible pain, Pratosh wanted to make sure Sajita survived the labour. He would remove it with a sharp iron clip. He was very afraid the baby had died inside Sajita and she too would die during labour.

Together, Sajita and Pratosh decided that if the baby did not come out soon, Pratosh would remove it with a sharp iron clip. He wanted to make sure Sajita survived the labour, but this intervention would have meant that the child would not live.
CARE, SUPPORT AND REINTEGRATION OF CHILDREN AT RISK
Since 2006, Adara has been caring for 136 trafficked children who had been taken from their homes, mainly in Humla, and brought to Kathmandu during a period of enormous political unrest in Nepal. We affectionately call these children the Adara Kids.

When we first found the children, we set up 10 homes and hired a big Nepali team. Each home was assigned “home parents” to provide around-the-clock care for the children. Each child was also enrolled in school and given educational support and encouragement by their home parents and tutors.

As the children got older, their needs changed and our programme evolved. Our focus first shifted from emergency care and rehabilitation, to reconnecting the children with their communities and families of origin, and then to preparing them for independent adulthood. The programme continues to evolve, and today we are sharing our knowledge and experience with other child-focused organisations to positively impact more children around the world.

Over the years we have witnessed significant and positive changes in these fantastic kids, and we are very proud of them.

Academic success
22 students sat their school leaving certificates (SLC) in 2013 and 2014, passing with flying colours. Another 30 students sat their SLC in March 2015.

Reintegration
In 2013 and 2014, 33 children were reintegrated with their families in Humla, with continuing Adara support. Their transition back home will improve their family connection and enhance their educational future. Youth who undertake their SLC exams in disadvantaged districts such as Humla can gain access to state subsidies and positive discrimination in education, training and employment. This will be highly beneficial considering Nepal’s long-term youth unemployment problem. In addition, they are building a strong bond with their family, culture and environment, which they have missed for so long.

Youth independent living
After the children complete their SLC, they move into independent living. This teaches them about the practicalities of the real world – managing their own finances and living arrangements with the support of an Adara social worker. During this time they either finish the last two years of high school or undertake vocational training courses. At the end of 2014, 29 youth were in the independent living programme.

Graduation
After they finish their courses, the youth graduate from Adara’s care with skills to start their adult lives. Already 37 youth have graduated, embarking on a journey to independence. The graduates are doing well – most are either in higher education or working. Some even have families of their own! We are very proud of our graduates, all of whom have assimilated well into their communities and are working hard.

*Pictures are only a representation of the story and names have been changed to protect the individuals’ identities.

<table>
<thead>
<tr>
<th>WHAT ARE THEY DOING NOW? (AT DECEMBER 2014)</th>
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<tbody>
<tr>
<td>Number of children in boarding school in Kathmandu</td>
<td>24</td>
</tr>
<tr>
<td>Number of children in youth independent living</td>
<td>29</td>
</tr>
<tr>
<td>Number of children reintegrated back with their family</td>
<td>46</td>
</tr>
<tr>
<td>Number of children graduated</td>
<td>37</td>
</tr>
<tr>
<td>Total children</td>
<td>136</td>
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</tbody>
</table>

Young people graduated from Adara’s case management to begin their lives as independent adults in 2013 & 2014

23

Children were reintegrated with their families, with continuing Adara support in 2013 & 2014

33

Going Home to Humla

Despite feeling loved and settled with Adara, Roshan felt a deep longing to return to his village and his family. He was only five when he was separated from them, but he still had loving memories of growing up in Humla.

After locating his parents with nothing but a photo, Adara began the process of sensitive reintegration, including extensive counselling for Roshan and his family. Roshan visited his home village several times with Adara, to maintain family connections. He enjoyed his visits and loved his village and the freedom he found at home.

Today, Roshan is a lively boy of 15 and loves to have fun. He is outgoing, can talk for hours and is always entertaining people. We were thrilled that Roshan was reintegrated with his family in 2014. He loves being home. Adara will continue to support his education and his living expenses to give him the best opportunities for his future. He has dreams of growing up and travelling abroad for work like his older brother. He wants to support his family and continue his studies.

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In memory of Bashir

In 2014, the Adara family was devastated to farewell one of the Ebenezer Boys – Bashir – after he passed away due to AIDS-related causes.

When we first met Bashir, he had been sleeping on the verandas in the hospital compound for many months, eating what food he could find. He lost his mother to AIDS, and after her death his family unit collapsed.

The Kidoko Hospital team asked us to consider taking Bashir into the Ebenezer Boys programme. Bashir was about 15 at that time. He was very small and ivory, and painfully shy.

When we asked the other boys if Bashir should join them, they were immediately enthusiastic. He quickly became their brother – a quiet and loved addition to this lively, very happy group. In sharing their happiness, Bashir slowly came out of his shell.

On 28 December 2014, Bashir passed away after a battle with tuberculosis, various infections, and lung problems.

Bashir was a loved member of the Ebenezer Boys and Adara family. His death has left a mark on us all. Rest in peace.

We will not forget you, Bashir.
How we share our knowledge

- Building best practice models that can be replicated elsewhere
- Sharing our findings in published literature or from the stage
- Collaborating with government and other non-profits
- Conducting training programmes
- Creating manuals for medical and other interventions

Knowledge sharing in action 2013-2014

In 2013 and 2014, there are four key areas where we were able to share what we know and add value to others' work.

The Adara Group model
One of the purposes of the Adara Group is to change the way people think about the role of business in the world and the power of business/non-profit partnerships. We do this by sharing globally our business-for-purpose model. Over the past two years, the founder of the Adara Group, Audette Exel, and the CEO of Adara Development, Susan Biggs have presented to more than 75 businesses, MBA classes, young leaders, philanthropists and corporations on the Adara model and our successes and mistakes. We try hard to give time to social entrepreneurs and start-ups looking to implement business models with purpose at their core.

Neonatal health
Adara's work in maternal, infant and child health at Kiwoko Hospital is widely respected, and the NICU is now considered a centre of excellence of neonatal health in a low-resource setting.

The magnitude of the challenge of poverty is too big for any one organisation to face alone. To even scratch the surface, the development sector needs to band together and learn from each other by sharing knowledge and expertise.

We know we don't have all the answers. We hope what we share can help prevent other organisations from making the same mistakes we have made and add value to others' work. What we can touch more people's lives is by sharing our expertise and experiences with others. We are taking our very best ideas and our biggest mistakes, distilled from 17 years of working in the field, and sharing them locally, nationally and globally to reach as many people as possible.

The Yalbang School

The Yalbang School is a model school in Humla. Adara works in partnership with the Himalayan Children Society to share their model of school management, education and learning to feeder schools in Humla, aiming to improve education across the district.

In 2014, Debbie was asked to join the steering committee for the Every Newborn Action Plan which is a UNICEF and WHO initiative aimed at reducing newborn deaths worldwide in order to meet Millennium Development Goal number 4. Debbie was asked to join the group because the neonatal programmes we have implemented are considered to be a model for what is possible.

Non-violent care and reintegration of children at risk

For many years, Adara has had the wonderful experience of working with children at risk in both Uganda and Nepal. Over this time, we have developed extensive knowledge in the care and reintegration of these children through all the ups and downs of their journeys to adulthood.

Over the past two years, our Nepal team has partnered with government and non-government organisations to provide training on best practice support of children in residential care. Training programmes have included alternative care systems, non-violent child discipline and case management of children at risk. Pradhod Dhakal has addressed the child welfare officers from all 75 districts in Nepal about children at risk.

Every year a two day workshop is held for surrounding schools. The Yalbang School Management Committee, teachers, the Parent Committee, and the Child Club are all present to talk with participants. In 2014, 40 people attended from eight schools in the district. The main objectives of these workshops is to analyse the current situation of the schools and formulate plans and goals for the future; and to raise awareness about the role and responsibility of school management committees and parents in preparing school improvement plans.

Know more about the Adara Group model and the work they do at www.adara.group.
Adara has a big vision for the future, set out in our new three-year strategic plan. Over the next three years, we want to take what we have done and make it deeper and better with more of an impact.

We will continue to devote our energy to serving the communities in Humla and Nakaseke which we have been committed to for the past 17 years by deepening our health and education services. Our research team will continue to work closely with our local teams, integrating more closely into the planning process to ensure our projects are always evidence-based and best practice. And we will share our knowledge as widely as possible so we can reach more people.

**Maternal, Infant and Child Health**

Adara will continue to build our maternal, infant and child health programme at Kiwoko Hospital, improving training and interventions in the hospital and growing the community-based healthcare work. Some of the projects in the pipeline are:

- Development of orientation systems to ensure all nurses in the maternity ward and NICU are comprehensively trained when they begin working in the wards.
- Scenario-based training from PRONTO International in the maternity ward, to upskill staff in how to deal with different obstetric emergencies that often end a woman’s life.
- Development of the CBHC Safe motherhood programme, with deeper education of village health trainers, local clinicians and an NICU follow up programme.
- A follow-up survey from the baseline to measure how knowledge, attitudes and practice around maternal and neonatal health have changed since the CBHC safe motherhood programme was launched.

Beyond the programmes at Kiwoko, Adara is also focused on sharing our maternal, infant and child health expertise as widely possible. We will continue to partner with peak bodies such as the Every Newborn Action Plan to make sure we are sharing our expertise with the groups working toward reducing maternal and neonatal mortality globally.

We will also host a two-day summit at Kiwoko Hospital, in conjunction with the University of Washington and PATH, inviting clinicians from across Africa who are utilizing CPAP to try and improve this technology.

**Remote and Rural Community Development**

We will continue our work in remote Nepal with a new three-year Humla work plan. The 2015–2017 plan will focus on nine villages in upper Humla, which includes one new village to our target group.

The new Humla plan streamlines our work to emphasise community health (especially for mothers, infants and children) and education. Our community health projects will focus on providing health services, health education and awareness, nutrition, hygiene and sanitation. Our education projects will focus on school improvement; community empowerment; outside-school engagement; and vocational education.

**Care, Support and Reintegration of Children at Risk**

The Ebenezer Boys in Uganda and the Adara Kids in Nepal are growing up fast – all are now teens. Like teens everywhere, they grapple with issues of independence and self-identity, and this is made more complicated by their difficult pasts. Over the next three years we will help steer them through these difficult years and set them on the path to independent adulthood.

By the end of 2018, almost all the children in our care will have graduated from the programmes, having reached adulthood and completed their education or vocational studies. They will always be a part of the Adara family, but these programmes will not continue beyond this point. Instead we will focus on capturing the children’s history and sharing with other organisations our knowledge of the care, support and reintegration of children at risk.
Our Partners and Supporters

In 2013 & 2014:

- 146 individuals, foundations and companies donated to Adara
- $5.2M was donated to Adara, both by Adara Advisors and our other donors
- 17 people volunteered or provided pro bono support in our Sydney Global Support Office
- 6 people assisted with clinical research in the Seattle office, and hundreds of other volunteers worked with our clinical team to sort, pack and transport desperately needed medical equipment
- $306,298 was raised by staff of our incredible corporate partner, Aspen, helping fund life-saving work at Kiwoko Hospital
- 7 students and volunteers assisted our Montana based research team
- 11 international medical volunteers undertook capacity-building at Kiwoko Hospital

Spotlight on the Minter Ellison Ambassador Programme

Minter Ellison is one of the largest Australian-based corporate law firms. It is an organisation with a genuine commitment to creating social change through its many pro bono programmes. In 2014, Minter Ellison partnered with Adara to create the Minter Ellison Ambassador programme, which provides the Adara Group with a top-tier lawyer on secondment for six to nine months of each year. The Minter Ellison Ambassador works in our Sydney office alongside Susan Burns, our pro bono General Counsel. They work on both the non-profit and the business sides of Adara, and have the opportunity to travel to project site in either Nepal or Uganda. Michelle Drury and Nick Slack have been our first two Minter Ellison Ambassadors, and they have given our work a huge boost.

Minter Ellison has also provided us with generous pro bono legal advice from a range of specialists at the firm. With so many different entities, our legal and compliance issues are complex. Working with a top-tier firm such as Minter Ellison has made a big difference to our operations, and it has provided firsthand specialised experience in a business for purpose and not-for-profit for their lawyers. We cannot thank Minter Ellison enough for its support. It truly is an organisation prepared to put substantial resources into doing the right thing for its staff, and for people in need.

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In 2013 & 2014: FAREWELL TO THE PACKATHON, AND HELLO EQUIPMENT SUSTAINABILITY!

Eleven years ago, Debbie Lester, Adara’s Clinical Programmes Director, had an idea that would spark more than a decade of volunteering, bringing together hundreds of people from access Washington state to help Adara deliver life-saving medical supplies and equipment to Kiwoko Hospital to assist in caring for women and babies.

At that time, babies were dying at Kiwoko Hospital from preventable causes. With simple interventions and the necessary supplies, Debbie knew a huge difference could be made. A part of Adara’s development philosophy is that we always purchase supplies and equipment locally, to stimulate the local economy. However, at that time critical pediatric supplies were unavailable in Uganda, and the hospital had no means of sourcing them.

Debbie knew that whenever a baby was delivered in the US, any supplies that might be needed, such as a bulb syringe, ambu bag and oxygen cannula, were sent for each medical procedure. Even if they were unused and unopened, the protocol was to throw these supplies away.

With the support of a dedicated voluntary team of medical staff from 10 Washington state hospitals, Debbie began to diligently collect these needed supplies to ship to Uganda.

Once a year, enthusiastic volunteers came together for the Packathon, to get busy counting and sorting thousands of syringes, packing hundreds of rubber gloves and sorting suction tubes from oxygen tubes. By the end of the two days, Adara would have a 20x40 foot shipping container jam-packed full of supplies and equipment to send to Kiwoko Hospital.

The Packathon helped equip the local staff at Kiwoko Hospital with the tools they needed to save maternal and infant lives for more than a decade.

Our dream has always been to help Kiwoko Hospital be more sustainable and access supplies and equipment locally. After 11 years, we are thrilled to have reached this stage, and to now be able to access this critical equipment from more local sources.

So in 2014, Adara held its last Packathon, knowing that we can now source all that is needed at Kiwoko Hospital, in Uganda, or in the region. This is truly a dream come true.

To all the dedicated volunteers and supporters who helped us with this project for more than a decade, we cannot thank you enough. It is because of your generosity and dedication that so much has been achieved. On behalf of Adara and Kiwoko Hospital, we are deeply grateful.

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THE ADARA FAMILY
OUR BOARD

ANDREW DELLA CASA
TRUSTEE OF ADAHA DEVELOPMENT (UK)

AUDETTE EXEL
CHAIR OF ALL ADAHA DEVELOPMENT ENTITIES, TRUSTEE OF ADAHA DEVELOPMENT (BERMUDA) AND ADAHA DEVELOPMENT (UK), DIRECTOR OF ADAHA DEVELOPMENT (AUSTRALIA), ADAHA DEVELOPMENT (UGANDA) AND ADAHA DEVELOPMENT (USA)

DEREK STAPLEY
DIRECTOR OF ADAHA DEVELOPMENT (USA)

EDITH G. CONVERS
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DIRECTOR OF ADAHA DEVELOPMENT (AUSTRALIA) AND ADAHA DEVELOPMENT (UGANDA)

THOMAS R. DICKSON
DIRECTOR OF ADAHA DEVELOPMENT (USA)

TOM GLYNN
DIRECTOR OF ADAHA DEVELOPMENT (USA)

VICTOR KHOSLA
DIRECTOR OF ADAHA DEVELOPMENT (USA) (RETIRED JAN 2015)

ALISTAIR STRUTHERS
TRUSTEE OF ADAHA DEVELOPMENT (UK) (RETIRED NOVEMBER 2013)

JOHN ATKINSON
DIRECTOR OF ADAHA DEVELOPMENT (AUSTRALIA) (RETIRED AUGUST 2013)
Adara has received an incredible total of US$22.4 million (A$26.1 million) in donations since we began in 1998. Of this, more than US$6.9 million (A$8.3 million) has been contributed from the Adara business towards Adara Development’s administration and infrastructure costs and emergency project costs.

Huge thanks to all Adara financial partners for their belief in the work of Adara and their on-going commitment and support.
MATERNAL INFANT CHILD HEALTH

Clinical Support at Kiwoko Hospital Uganda

- 59 local NICU, ANC and maternity nurses, 1 doctor and 13 ward support staff each year
- Medical equipment, drugs and supplies for the NICU and maternity ward
- Nutrition support for mothers caring for babies in the NICU
- Training and development for NICU and maternity staff
- CBHI-PC programme support for safe motherhood services for women and children, including antenatal care, postnatal care, family planning and immunisation services
- 7 other local hospital support staff including a finance manager, finance officer, senior finance officer, HR officer, lab technician, electrician and a Maternity NICU head manager each year

Clinical Advisory USA and Uganda

- Clinical Programme Directors Office
- Activities to collaborate with the clinical team at Kiwoko Hospital to plan and implement strategies to improve maternal, infant and child health outcomes
- Regular and sustained capacity building for Kiwoko Hospital NICU and maternity ward clinicians
- Introduction of new technologies and treatments for patients
- Development and management of international medical volunteers programme, where experts visit the hospital for short periods of time to train and advise local clinicians
- Analysis of NICU data from Kiwoko Hospital
- Telephone and email medical advisory service
- Collection of medical supplies and equipment from 10 US hospitals, the organisation and hosting of the final two years of the Packathon and the shipment of the container to Kiwoko Hospital
- Activities to share globally Adara’s knowledge on maternal infant child health

CHILDREN AT RISK

Adara Kids Nepal

- Care and support of children who were previously trafficked (24 children in boarding school in Kathmandu, 29 children in the youth development programme, 46 children reintegrated with family and 37 children graduated)
- 16 local staff and related office costs each year
- Education, nutrition, health, post-school options, life skills and independent living training
- Reconnection and reintegration with families of origin
- Activities to share knowledge on Adara’s experience of non-violent care and reintegration of children at risk

Ebenezier Boys Uganda

- 21 boys in vocational education
- 1 local social worker and related office costs
- Education, nutrition, health and post-school options for the boys
- School holiday workshops on life skills and independent living
- Reconnection with families of origin
- Volunteer programme for the boys to learn how to contribute to their community

Women’s Foundation Nepal

- 1 local lawyer who leads a team of lawyers
- 679 cases of abuse supported by legal team

Hands in Outreach Nepal

- 2 local staff and related office costs
- Healthcare assistance for 113 girls so they are healthy enough to attend school and learn
- Living supplies to support families in need

RURAL AND REMOTE COMMUNITY DEVELOPMENT

Local Programme Staff Nepal

- 11 local staff members, including Humla programme manager, agriculture assistant, community health coordinator, community education coordinator and a technical consultant

Hygiene and Sanitation - Humla Nepal

- Build and repair of communal micro hydro power systems, gristmills and drinking water systems
- Construction and repair of pit latrines, initiated by villagers

Nutrition - Humla Nepal

- Household level solar driers, greenhouses and smokeless metal stoves
- Food security projects, such as nursery development

Health Post Improvement - Humla Nepal

- Local health post infrastructure, medicines and staff to ensure Humlis have access to year round healthcare

Mobile Healthcare - Humla Nepal

- Plan and implementation of mobile medical camp held annually. 6,230 people were treated in 2013 and 2014.
- Tibetan health practitioner, or Amchi, to travel through Humla for eight months at a time providing medicines and healthcare to 2,587 people in Humla villages in 2013 and 2014.

Education Projects - Humla Nepal

- 9 scholarships for Humla’s best and brightest to obtain vocational training
- Non-formal education classes for more than 180 children and 140 adults

Himalayan Children Society - Humla Nepal

- 7 local staff and related office costs
- School supplies, uniforms, textbooks and music class materials for children
- Food and hostel support for children from families living in poverty
- Teacher workshops to improve the quality of education provided in the school
- District workshops to share information about the Yalbang School model

The Himalayan Innovative Society - Humla Nepal

- 4 local staff and related office costs
- FM radio programme to raise awareness about child trafficking and child abuse in Humla
- 53 educational scholarships for children of single parents
Himalayan Medical Foundation - Kathmandu Nepal

- 6 local staff and related office costs
- 3 free health clinics in the outskirts of Kathmandu for people unable to afford care
- Medicine and laboratory materials for 3 clinics - Benchin, Nagi and Pharping

HIV and Diabetes Clinics at Kiwoko Hospital Uganda

- Nutrition, treatment and counselling support for adults and children living with HIV/AIDS
- Education support for orphans and vulnerable children affected by HIV/AIDS
- Weekly diabetes clinic operating at Kiwoko Hospital

Community Outreach Services at Kiwoko Hospital Uganda

- CBHC programme servicing 44 villages and providing support to people living with chronic conditions such as epilepsy, TB and people living with disabilities

RESEARCH, MONITORING AND EVALUATION

- 2 Montana based PhD Anthropologists
- Research support to Nepal and Uganda
- Mobile medical camps – embedded researchers
- Household re-surveys in Humla
- Maternal health baseline study in Nakaseke Uganda to understand community health needs
- Menstruation programme research and review
- Monitoring and evaluation of all projects

GENERAL MANAGEMENT IN-COUNTRY

US$315,483

Nepal

- 3 local staff including the Country Director and related office costs in Kathmandu
- Management of project planning, implementation, capacity building and coordination with partner organisations ensuring they exercise good governance and maximum impact

Uganda

- 4 local staff including the Programme Manager and related office costs
- Management of project planning, implementation, capacity building and coordination with the partner organisation ensuring good governance and maximum impact

CORE SUPPORT

US$2,083,153

Core support expenditure during 2013 and 2014 ensured all areas of our project-related work have the necessary resources and help they need to operate effectively. These costs were all paid for directly by Adara Advisors (both by prepayment in 2012 and donations during the period) and a small number of core support partners, ensuring that 100 cents in every dollar of all other financial partners’ support went directly to project and project related costs.

- 10 global support staff (plus 3 pro bono staff) and related office costs
- Leadership and development of short and long-term strategy and direction
- Global coordination of activities and policies to ensure project staff have the resources and assistance to be effective as they partner
- Managing global governance, compliance, legal, human resources, information technology and administration
- Financial compliance including global budgeting, ensuring every dollar is followed, keeping accounts, systems and controls and regular audits in each jurisdiction
- Global communications internally and externally
- Fundraising and regular reporting and liaising with existing financial partners worldwide
- Office support for research and clinical programmes, finance, fundraising and communications
- Office of the Chief Executive Officer