SEVA CANADA SOCIETY

ANNUAL REPORT JULY 1 2007 – JUNE 30 2008

ABOUT SEVA CANADA

Since 1982, Seva Canada has helped communities in some of the poorest areas of the world develop their own capacity to deliver affordable eye care services. Seva Canada's partners in Nepal, Tibet, India and Tanzania provide eye care programs, centred on cataract surgery, but including all other eye diseases, as well as refraction services for glasses.

Seva (say-va) is Sanskrit for service. Seva has helped to create sustainable, economically viable, locally managed eye care programs that will continue to serve local populations long after Seva's involvement is complete.

MISSION STATEMENT
Through compassion in action, Seva Canada seeks to create a better world by volunteer and professional programs designed to alleviate human suffering – particularly through preventable blindness.

OUR FOCUS
Our focus is to establish and expand Seva's sustainable eye care programs with partners in developing countries. We strive to inform Canadians of our work and to inspire them to join us, thereby increasing our overall impact on global blindness.

CORE VALUES
We are guided by:

- Respect for cultural, ethnic, spiritual and other forms of diversity.
- Commitment to working with partners in a compassionate way to achieve appropriate goals.
- Belief that with adequate resources, all people can meet their own needs.

MESSAGE FROM THE CHAIR

During his five-year tenure our past Chair, Michel Maurer, clearly charted Seva's course into the future. Under the energetic hands-on leadership of Penny Lyons we continue to grow and fully support our partners overseas. In turn, Heather Wardle, our Development Director, is performing exemplary work in maximizing our fundraising activities with true enthusiasm and compassion.

I'm pleased to report that during our fiscal year 2007/2008 we exceeded our budgeted revenue by over $100,000 and contributed $451,000 to our sight programs, beating last year's contribution by $117,000. The major beneficiary was our partner in Tanzania.

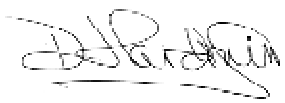
As Seva Canada celebrates its 27th Anniversary and I reflect on my own five years with the organization, I am extremely grateful to have had the opportunity to become involved with this truly life saving work and am overwhelmed at the generosity and loyalty of all our donors.

During a visit to Africa in 2006, I vividly recall being warmly welcomed inside a very simple home in a village in Tanzania, and hearing a mother explain that her semi-blind five-year-old daughter had a terrible fear that if she went into the eye hospital for surgery she would receive the eyes of a goat. Thanks to the intervention of the KCCO counsellor trained in community ophthalmology, this girl was convinced to undergo surgery and now enjoys a full and productive life.

We are a Member Organization of VISION 2020, a global initiative launched jointly by the World Health Organization (WHO) and the International Agency for the Prevention of Blindness (IAPB). Its goal is to eliminate the main causes of avoidable blindness by 2020 and prevent the projected doubling of vision impairment by that date.

In order to maximize our impact on what is truly a war against blindness and a race against time, we have added Guatemala, Egypt and Cambodia to the countries we serve, and have agreed to undertake a number of major donor campaigns to improve the ophthalmic infrastructures in Nepal, Africa and Tibet.

Yet we cannot ignore the current crises in the world's leading economies and anticipate that our partners overseas will require our unwavering support during these difficult times and so I appeal to you all, to once more join us in this act of compassion, which essentially underpins all we do.



David Hardouin
Chair of the Board

MESSAGE FROM THE EXECUTIVE DIRECTOR

Dear Donors, Supporters and Champions of Seva,

This past year has seen some significant changes at Seva Canada. For the first time since 2001, we have added new program partners: Visualiza in Guatemala, Battambang Ophthalmic Care Centre in Cambodia and the Al Noor Magrabi Foundation in Egypt. Each one of these organizations are leaders in community ophthalmology in their respective countries.

To ensure that we maintain our financial commitment to our partners in India, Tibet, Nepal and Tanzania, we are seeking alternate sources of funding for our three new partners from major gifts, grants and foundations. As Seva's annual revenues grow, we anticipate making annual financial commitments to all of our partners.

Seva has received some astonishingly generous gifts which you will see listed in this report. One of Seva's most committed donors is the Canadian International Development Agency (CIDA). For over 20 years, CIDA has supported our programs and believed in our mission. It is through their financial support that some of our most significant successes have been accomplished and we are truly grateful.

Because of the worldwide economic crises, Seva is being extra cautious with our expenses. This is simply prudent. Given that, we are approaching 2009 with a great sense of expectation and excitement.

Seva has been growing continuously, expanding our programs, reaching more people in need and educating more Canadians about how they can participate in eradicating preventable and treatable blindness. We see this growth continuing and are thrilled to be a part of it and delighted you will be a part of it as well.

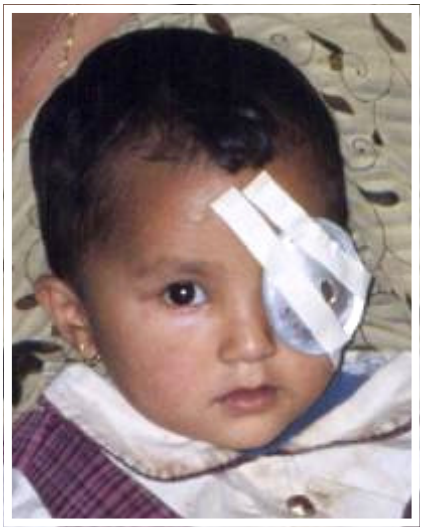
We will keep you up to date through our website, emails and newsletters. If you are not currently receiving either our emails or newsletter and would like to, just let us know.

On behalf of Seva Canada and our partners overseas, please accept my deepest gratitude for your continued support.

Yours very truly,

Penny Lyons
Executive Director

PROGRAM HIGHLIGHTS FROM THE EXECUTIVE DIRECTOR



Seva Canada is helping its partners create sustainable eye care programs in terms of revenue by charging fees for services and professionally by training of local health personnel. At the same time our program partners serve the unreached – particularly women and children, in some of the poorest regions of the world.

Seva's support to eye care programs follows a 'life-cycle' model that includes an initiation and exit strategy first established at Aravind Eye Care System in India and further refined with programs in Nepal. Seva begins by providing consultation and direct service funding, then supports development of manpower, establishment of infrastructure and sustainable systems. Later, when the programs are fully self-sustaining, they are transformed into regional anchors as training institutes.

Building Capacity
Cataract remains the leading cause of blindness worldwide, and providing cataract surgical services remains the main program focus, and source of cost-recovery income. By focusing on providing high-quality, high-volume and low-cost cataract services, Seva's partners achieve the greatest impact in reducing needless blindness.

Providing childhood blindness services has become a priority, but not because of cost recovery. In fact, providing these services requires considerable drain on other eye care program resources. However, when viewed in terms of the numbers of years of blindness, the various diseases that cause childhood blindness together contribute to the second leading cause of blindness globally. Seva therefore increasingly supports the development of these relatively expensive childhood services and the complex community and family outreach activities required for the prolonged follow-up periods, often several years.

Community Ophthalmology: Reaching the Unreached
Seva works with partners to develop and test strategies to increase utilization of available services. Correctable blindness is a condition of poverty and isolation, making its reduction a social and political challenge.

Connecting eye care services with the population in need requires active interventions, often termed 'bridging' strategies. Bridging strategies involve a significant investment in community liaison and our program partners must empower marginalized populations to facilitate the use of limited resources.

The challenge of breaking down the barriers to access at the community level demands innovation and experimentation. Seva's strong support for rigorous socio-epidemiological studies allows it to make significant contributions to the global knowledge about effective strategies to reach populations in need, particularly women.

PROGRAM HIGHLIGHTS continued

Human Resource Development
Seva helps to build the global human resource capacity necessary to meet the demand in eye care by strengthening the partner training programs: their faculty, teaching methods, curricula, and results. More recently, Seva's Indian partner has taken the next step of training – training institutes. It promotes and strengthens regional training institutes to prepare managers, clinicians and other human resources for delivery of high-volume, high-quality eye care services.

Cost Effectiveness
A large part of Seva's work is to teach its program partners to develop projects that serve as models to assess the cost-effectiveness of their work. Seva is also strengthening their efforts to document and publish their experiences, both successes and failures.

INDIA

Aravind Eye Care System, our program partner in India, has become a centre for training and research as well as service delivery. Funding to Aravind in 2007-2008 and into 2009 is designated to determine the most efficient and effective model of delivering eye care in rural communities. With participants from across India and Nepal, the best practices model of community eye care that is developed will be shared, and replicated, throughout the developing world.

TIBET

The Seva Tibet program is currently providing two-thirds of all eye care in the Tibet Autonomous Region and Tibetan regions of China.

In the latter part of this program year our partners faced significant challenges. The political uprising and subsequent restrictions on personal movement had an impact on the delivery of eye care – particularly in the field. Having said that, despite the significant barriers to providing services in Tibet during the first quarter of 2008, the average number of cataract surgeries at Menzikhang Hospital of Traditional Tibetan Medicine (Seva's oldest and principle institutional partner in Tibet) was 21% higher than the same quarters in 2007. In addition, the Menzikhang team conducted their first screening camp in Lhasa where 50 patients were examined and treated. However, Tibet's political situation since April 2008 drastically reduced the number of outreach services and patients treated in program hospitals.

Seva Tibet conducted 25 micro-surgical eye camps in 19 locations across central and far eastern Tibet throughout 2007/2008. Over 6,800 eye patients were treated and 2,204 sight-restoring surgeries were conducted. In addition, 20 patients in Chamdo in Central Tibet received eye duct surgery.

Seva-sponsored programs continue to take significant steps towards financial self-sustainability. Seva's surgical eye camps, which still constitute more than half of the surgery performed in the TAR, are held in existing facilities on loan from the local health authority. To compensate the

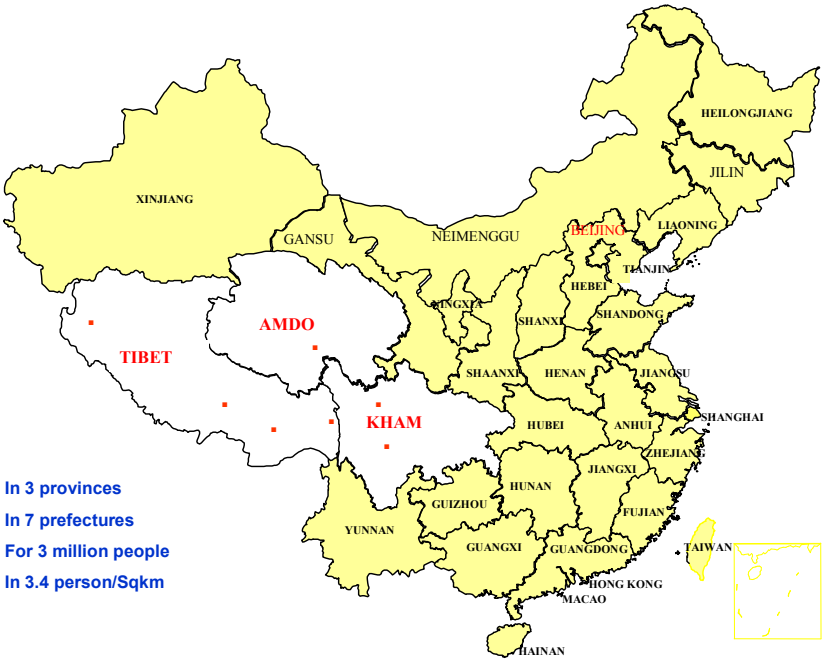
facility, all cataract surgical patients that are able pay approximately $30 to the partner hospital which is then matched by the health authority. Very poor patients receive surgery free of charge as well as a subsidy for transportation.

The eye department of Menzikhang Hospital in Lhasa has started charging patients for care according to the patient's capacity to pay. For the first time, the eye department is contributing its revenue toward purchasing new equipment. The department anticipates creating the first economically sustainable eye care system in central Tibet.

In the past program year, 40 teachers from 20 primary schools in Lhasa were trained in primary eye care skills and educational materials were distributed to each trainee. In addition, 40 rural health care workers from four counties were trained in the prevention of childhood blindness. Training materials and antibiotic ointment was distributed to each of the trainees.

Basic oculoplastic surgical training was conducted in Seva supported Menzikhang Hospital in Lhasa. Dr. Basant Sharma and Mr. Amod Mishra from Lumbini Eye Institute conducted the training of doctors from Menzikhang, Chamdo and Nyitri – all Seva supported institutions. The training was specifically in oculoplastic surgery and, as a result of the training, the volume of oculoplastic surgery in Menzikhang has increased from 46 to 177 cases. In Nytri and Chamdo, where previously no surgeries of this type had been performed, in last half of the program year 40 were conducted.

Seva Tibet Sight Program



PROGRAM HIGHLIGHTS continued

TANZANIA

Seva Canada's partner in Tanzania is the Kilimanjaro Center for Community Ophthalmology (KCCO). KCCO is the pre-eminent community ophthalmology program in Tanzania, and a leader in eastern Africa. It also acts as a training institute for eye care program planners, administrators and evaluators from throughout Africa.

As a training institute, KCCO has faculty dedicated to teaching program development and management, population health assessment, information systems and resource centres.

KCCO's capacity to provide training greatly increased because of a new building funded in part by Seva Canada donors.

One of the most significant courses this year was a two-week program on how to conduct a Rapid Assessment of Avoidable Blindness (RAAB). The RAAB is a relatively new survey method used to efficiently survey large populations for the purposes of program planning and monitoring the effects of services. The data allows programs to track and determine pre-operative characteristics which impact surgical success and post-surgical care.

KCCO ran a course for leading ophthalmologists who are expected to help their countries develop District VISION 2020 plans. Ophthalmologists from Sudan, Zambia and Malawi participated. In June, KCCO conducted a similar training for eye care providers in South Africa, Zambia, Malawi, Kenya, Uganda and Tanzania.

A one-week course on bridging strategies for community ophthalmology drew participants from Tanzania, Kenya Madagascar and Uganda. The course used real-life examples to learn about the variety of steps needed to "bridge" communities with eye care providers which has proven to be a meaningful way to help students understand their communities and how to reach them.

KCCO is continually expanding and strengthening existing community ophthalmology services, focusing special attention on childhood blindness strategies and gender – particularly related to cataract and trachoma.

KCCO significantly increased the number of people reached through an outreach strategy known as the Direct Referral Site (DRS) program. This increase was due to a number of factors including increased publicity, purchasing a bus to transport patients, and increasing immediate counseling at the DRS site. KCCO continues to train community and religious leaders in eye

diseases and eye care. They are asked to help identify community members in need of care and people too poor to pay for surgery so they can receive free services.

The cataract surgical rate for Kilimanjaro Region for 07/08 was 15% higher than 06/07. In Kilimanjaro Region and Arumeru District for the last quarter of 2007, 13,111 people were examined and 619 people were provided with transportation to hospital for cataract surgery in 2007. KCCO continues to work with the Ministry of Health (MoH) Regional Eye Coordinator and with the district health authorities to improve local government support for eye care services in the districts.

Childhood program

The DRS program served as the major strategy to identify children in need of cataract surgery from throughout Kilimanjaro Region as well as among the half-million people who live in Arumeru District of neighbouring Arusha region. During the one year period starting April 1, there were 73 children from this area that had cataract surgery (92 surgeries).

KCCO staff is expanding their research and program evaluations to better define the current status of childhood cataract surgery (and childhood cataract surgical rate) in Tanzania. They also study the impact of their expanded follow-up program at KCMC Hospital.

KCCO studies found that most of the “backlog” of cases have now been identified and have had surgery. The patient population has shifted to be more incident congenital cataract and preliminary analysis shows that these children are now coming in earlier (which translates into a better outcome). In addition gender inequity is decreasing. Changing behaviors at the community level is extremely difficult.

KCCO tested a new method to find children with visual disabilities. “Key informants”, a few respected members in selected villages, were trained by the MoH District Eye Coordinators to keep a list of children in their villages with visual difficulties. This strategy was designed to increase the efficiency and effectiveness of the KCCO teams visiting the villages. As a result more affected children were identified and referred to the hospital for further examination and treatment.

In addition to general support for the program activities listed above, Seva supported a childhood blindness outreach camp from November 11th to 20th. Over 155 children were screened, 40% of them necessitating surgical intervention. Medical services, food and transport were provided free of charge to the patients. Many children were screened on the first and second day. Theatre work started in the afternoon of the second day and continued to 20 November. In this period 50 surgeries were done on 33 children.

In additional to the surgical services, many children who had surgery during a previous outreach in June came back for follow up. Of the 65 children having surgery in June, 47 (72.3%) returned for follow up. A few of the parents who came for follow up contributed to their transport costs, an indication that parents recognize the value of this program to their child.

PROGRAM HIGHLIGHTS continued

Program limits

KCCO continues to interview patients who choose not to accept surgery. In a few instances, they are too poor to pay and have accepted surgery once this barrier is removed. However, the costs of surgery (or indirect costs such as transport and food) do not constitute the primary reason for not accepting surgery. Most non-accepters are simply unwilling to have surgery, particularly the most elderly. While disappointing, the program has gradually become more accepting of this limitation.

Future directions

Many of the younger people are requesting and paying for surgery before they become blind. Preventing blindness is far more cost-effective and desirable than “curing” blindness. It is anticipated that this trend will lead to a generational shift in terms of use of eye care services. Earlier surgery does create specific demands, however, including the need to provide high-quality surgery (to provide clear benefit when the degree of baseline impairment is less) and to ensure that examiners do not turn away people because “the cataract is not mature”.

Expansion to east Africa

KCCO undertook a number of initiatives in other parts of Africa in this program year including: development of outreach services in the Masaka Region of Uganda; facilitation of district planning in Rwanda; assessment of current eye care activities in Beira province, Mozambique; and improving hospital management and bridging strategies to met the eye care needs of a population of 20 million in Madagascar.

KCCO started new work with the Kwale District Eye Project in Kenya. The aim of the project is to better understand why people who are visually impaired or blind continue to refuse surgery, even when it is provided free of charge. The project, with support from Seva and CIDA, will be exploring new strategies to address this challenge.

At the request of the MoH Rwanda, Dr Courtright (supported by Seva Canada) helped facilitate the development of the second Rwandan five-year VISION 2020 plan. The commitment to VISION 2020 by the government is strong, exemplified by the active engagement of high-level government personnel as well as all of the participating NGOs.

NEPAL

Community Ophthalmology Programs in Lumbini Zone and Chitwan District

Seva Canada supports program activities designed and conducted by Seva Nepal staff. The Seva Nepal staff, in turn, integrates Seva supported activities with Nepal eye care facilities, primarily the Lumbini Eye Institute (LEI) and specific training programs such as the Sherman School of Primary Eye Care Management and the Nepal Hospital Orthoptic Training Program.

Seva Canada’s primary goal is to reduce avoidable blindness in remote and rural regions by improving community ophthalmology programs. The past year’s objectives focused on expanding service delivery and improving financial and program accountability and sustainability. Seva Canada’s secondary goal was to support clinical training for staff at the Lumbini Eye Institute.

PROGRAM HIGHLIGHTS continued

The primary challenge in the community programs is retention of staff in the more remote areas. Additional training opportunities and improvement of living conditions has significantly improved retention rates.

LEI is Seva's main partner institution in Nepal. This tertiary care hospital and training institute has acted as the focal point for several initiatives to improve community access to services both in the lowland and hill regions.

LEI is linked with secondary eye care facilities, staffed by ophthalmologists that provide full cataract surgical services, in Tansen, Palpa, a hill district north of Lumbini, and in Bharatpur, Chitwan District.

In the past program year, over 100,000 patients were examined and just under 15,000 surgeries were performed in all of the Seva-supported hospitals and primary eye care clinics. In addition, the following outreach activities occurred:

- Village screening camps: regular visiting satellite clinics conducted at Rampur, Jhadewa and Pokhara Thok.
- Diagnostic screening and treatment camps in Syanja, Gulmi and Palpa Districts in partnership with local organizations.

Seva's programs in Tansen, in particular, were very successful because of a full-time ophthalmologist who joined the hospital in May of 2007.

The school screening program was very successful, with just over 59,000 children screened for eye conditions and refractive error.

Community ophthalmology and outreach have been further improved with the training of 104 additional female community heath volunteers and 20 traditional healers.

Primary Eye Care Centres

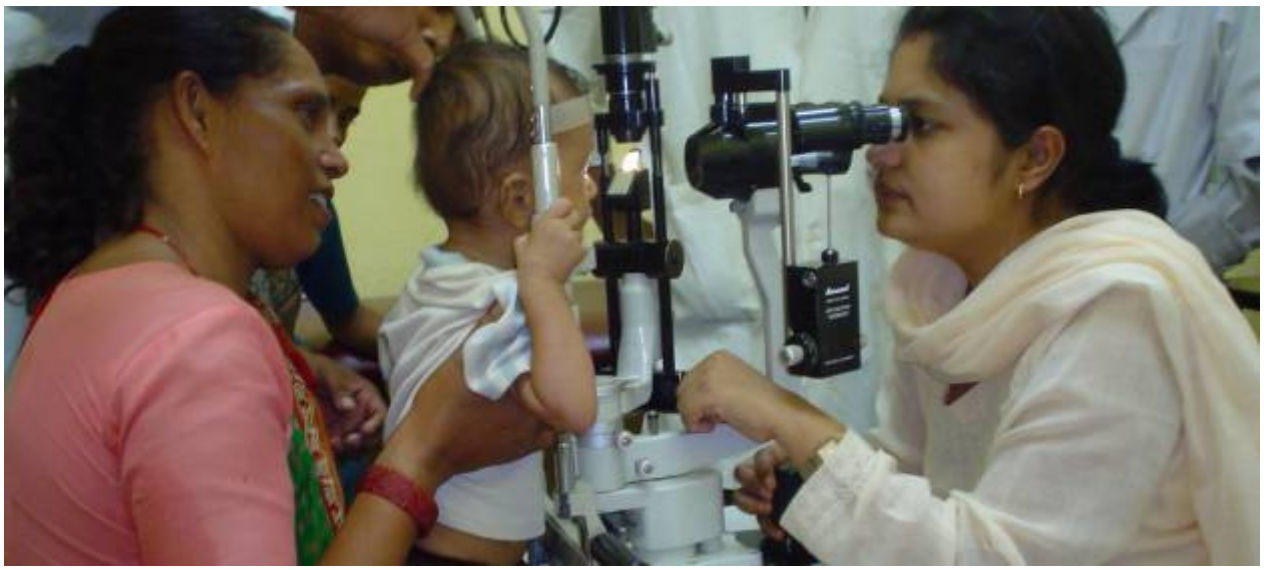
Seva-sponsored primary eye care centres (PECCs) provide eye services and training in some of Nepal's most remote areas. Each primary eye care centre operates in a model designed to recover full operational costs through revenue generation, primarily through the sale of spectacles and minor eye treatment registration fees. Many of the original PECCs are

financially self sustainable.

A case study was conducted to determine a process and protocols for determining the costs of both the PECCs and the screening/surgical camps. This information will become critically important with the planned development of 11 new PECCs in Nepal's remote western region. The intention is to create two PECCs per year over the next five years. In order to ensure the continued success and operation of these facilities, the most cost-effective plan that still ensures services to the most vulnerable populations must be created. Funding for the first PECC has been secured and development has begun.

Training and Teaching

Seva-supported training of local health care workers to screen patients for, and arrange their travel to, the surgical eye camps. This training was performed in conjunction with the Sherman's School of Primary Eye Care Management in the hill district of Tansen. In addition, Mr. Gokarna Bhatta finished his three-year ophthalmic assistant training at the Lumbini Eye Institute. He has been posted to a PECC in Doti in far western Nepal. Two ophthalmic assistants from the hill district were awarded scholarships for training at LEI beginning in September.



Seva-sponsored candidates, Dr. Arjun Malla Bhari and Dr. Amrit Singh Khadka successfully completed MD Ophthalmology programs from LEI and Tilganga respectively. Dr. Bhari joined LEI and Dr. Khadka has joined the hospital in Bharatpur. Dr. Nanda Gurung from LEI went to Aravind Eye Hospital in Madurai, India on a six-month glaucoma fellowship. She has finished the fellowship and is now in the process of establishing a glaucoma unit at LEI. Three new orthoptic students were enrolled at Nepal Eye Hospital, two are Seva sponsored: Ms. Aktara Begum from Bangladesh Eye Hospital and Mr. Padam Ghale from LEI.

Mr. Amod Singh and Mr. Parajuli from LEI are undertaking 6 months of hospital management training at the Aravind Eye Care System, another of Seva's partners located in India.

Gender and Blindness programs

Seva's Gender and Blindness Initiative continued to support the development of a community ophthalmology program in the Chitwan District of central Nepal. The goal is to increase utilization of services, particularly by women and children, by integrating eye care into primary health care. Primary health care in each "Village Development Committee", the basic administrative zone (10,000 people) is focused around a Health Post with three staff (a Community Medical Assistant, and village and maternal-child health workers). The Health Posts provide vaccinations and vitamin A distribution, as well as programs in reproductive health and health education.

In addition to paid staff, the Health Posts work with a number of female community health volunteers. Interested volunteers were trained by the Gender and Blindness Initiative to recognize basic eye problems and to refer people, particularly older women, to diagnostic screening and treatment camps organized in each area. During these camps, ophthalmic assistants conducted clinical examinations and refraction free of charge, while eyeglasses and medications were provided at affordable rates. For children below 15 years of age, glasses and medication were provided free of charge.

This year, approximately 16,000 people were examined and provided treatment in the diagnostic screening and treatment camps and approximately 1,600 people with cataract blindness were transported to the King Mahendra Memorial Eye Hospital in Bharatpur for surgery.

The training of female community health volunteers which is ongoing, the distribution of health information and materials and coordination of all eye care work with the district health posts facilitates gender equity in uptake of services.

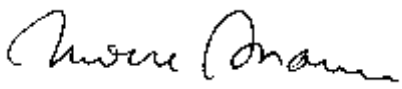
SEVA CANADA SOCIETY

STATEMENT OF FINANCIAL POSITION
AS AT JUNE 30, 2008

	2008	2007
ASSETS		
CURRENT ASSETS		
Cash and term deposits	$ 289,064	$ 255,597
Internally restricted term deposit (note 3)	55,544	57,739
Accounts receivable	904	184
Goods and services tax receivable	2,389	1,666
Inventory (note 2 c)	11,214	9,447
Prepaid expenses	16,595	15,587
	375,710	340,220
CAPITAL ASSETS (note 4)	8,221	7,524
	$ 383,931	**$ 347,744**
LIABILITIES		
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	$ 18,751	$ 23,182
Due to government agencies	82	-
	18,833	23,182
NET ASSETS		
Internally restricted	55,544	57,739
Invested in capital assets	8,221	7,524
Unrestricted	301,333	259,299
	365,098	324,562
	$ 383,931	**$ 347,744**

APPROVED ON BEHALF OF THE SOCIETY:

Director



Director

The accompanying notes are an integral part of these financial statements.

SEVA CANADA SOCIETY

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2008

	2008	2007
REVENUE		
CIDA program grants	$ 187,350	$ 168,837
Project grants and contracts	46,625	20,643
Donations	409,514	642,680
Donations – in kind	47,940	7,923
Special events, presentations and net merchandise sales	68,840	39,866
Investment and other income	13,038	2,526
	773,307	882,475
EXPENDITURES		
Program payments (Schedule 1)	451,243	334,371
Program administration (Schedule 1)	124,328	116,563
Fundraising (Schedule 2)	91,472	95,812
General administration (Schedule 2)	65,728	60,956
	732,771	607,702
EXCESS OF REVENUE OVER EXPENDITURES	40,536	274,773
FUND BALANCES, BEGINNING OF YEAR	324,562	49,789
FUND BALANCES, END OF YEAR	**$ 365,098**	**$ 324,562**

The accompanying notes are an integral part of these financial statements.

SEVA CANADA SOCIETY

STATEMENT OF CASH FLOW
FOR THE YEAR ENDED JUNE 30, 2008

	2008	2007
OPERATING ACTIVITIES		
Excess of revenue over expenditures	$ 40,536	$ 274,773
Add items not requiring cash outlay:		
Amortization	2,342	2,833
Changes in non-cash working capital:		
Accounts receivables	(1,443)	2,782
Inventory and prepaid expenses	(2,775)	22,814
Accounts payable and accrued liabilities	(4,349)	(28,759)
Deferred revenue	-	(1,500)
NET CASH PROVIDED BY OPERATING ACTIVITIES	34,311	272,943
INVESTING ACTIVITIES		
Acquisition of capital assets	(3,039)	-
NET INCREASE IN CASH	31,272	272,943
CASH, BEGINNING OF YEAR	313,336	40,393
CASH, END OF YEAR	**$ 344,608**	**$ 313,336**
CASH CONSISTS OF THE FOLLOWING:		
Cash and term deposit	$ 289,064	$ 255,597
Internally restricted term deposit	55,544	57,739
	$ 344,608	**$ 313,336**

The accompanying notes are an integral part of these financial statements

NOTES TO THE FINANCIAL STATEMENTS
JUNE 30, 2008

1. PURPOSE OF THE SOCIETY

Seva Canada Society's (the Society) mission is to prevent and relieve suffering and generate meaningful change through compassionate action. The Society's commitment is to serve through partnerships and projects around the world that promote health, nutrition, education, economic sustainability, environmental protection, cultural survival, human dignity, and social and economic justice.

The Society is a registered charitable organization and is, therefore, tax exempt.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Revenue Recognition

The Society follows the deferral method of accounting for contributions. Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

(b) Restriction on Net Assets

Since 1998, donations received in memory of Trish Turner, a long time supporter of the Society and the spouse of a Board Member, have been segregated, invested and used only for certain activities designated by the Board. Until the year ended June 30, 2006, the activity consisted of support for overseas travel to program sites for volunteers who could not otherwise afford to go. In 2007, the application of the income from the investments has been expanded to include two additional alternatives.

To support education, training, and development of individuals with partner organizations who have potential to take on important medical or administrative roles or administrative roles within their organizations, and

To fund existing people within partner organizations to spend time in less developed partner organizations and help them move along the path to self sufficiency.

This group of donations has been characterized as *internally restricted net assets*. These internally restricted amounts are not available for other purposes without the approval of the Board of Directors. Income from the investments not used for the above purposes is added to the internally restricted net assets.

(c) Inventory

Inventory is recorded at lower of cost or current replacement cost in the case of donations in kind.

NOTES TO THE FINANCIAL STATEMENTS: JUNE 30, 2008

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES continued

(d) Amortization

Capital assets are recorded at their original cost and amortized as follows:

Furniture	-20% declining balance method
Equipment	-20% declining balance method
Computers	-30% declining balance method

In the year of acquisition, assets are amortized at one-half the normal rate.

(e) Allocation of General Support Expenses

The Society's policy is to allocate 33% of administrative expenses to programs and project expenditures unless the expenses are directly attributable to an expense category and then the allocation reflects the direct attribution.

(f) Financial Instruments

The carrying value of cash, term deposit, accounts receivable, and accounts payable and accrued liabilities approximate fair value because of the short maturity of these financial instruments. The Society is not exposed to significant interest rate risk due to short-term maturity of its monetary current assets and current liabilities. The Society is not exposed to significant credit risk with respect to its receivables as they were substantially received by the audit report date.

(g) Volunteers and Donated Goods

In addition to the donations-in-kind recorded in the financial statements, the Society benefits from goods and services which are not recorded in the financial records of the Society.

(h) Use of Estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying disclosures. Although these estimates are based on management's knowledge of current events and actions the Society may undertake in the future, actual results may differ from the estimates

3. INTERNALLY RESTRICTED TERM DEPOSIT

Distribution of the revenue earned from this investment is determined each year by the Board of Directors of the Society.

NOTES TO THE FINANCIAL STATEMENTS: JUNE 30, 2008

4. CAPITAL ASSETS

	Original Cost	Accumulated Amortization	Net Book Value 2008	Net Book Value 2007
Office furniture	$ 4,573	$ 3,753	$ 820	$ 1,025
Computer	34,875	31,143	3,732	5,331
Office equipment	7,260	3,591	3,669	1,168
	$ 46,708	**$ 38,487**	**$ 8,221**	**$ 7,524**

5. CIDA PROGRAM GRANTS

The Society had a three year funding agreement with the Canadian International Development Agency (CIDA) and has committed to providing up to $562,050 for the Society's programs over the three-year term of the contract expiring April 30, 2010. The Society has committed over this period to match CIDA contributions to a total of $204,975. These funds are to be used exclusively for the programs implemented under the agreement.

6. RELATED PARTY TRANSACTIONS

Transactions with Board Members and the Executive Director, their businesses and shareholders, their immediate families or businesses related to them are summarized below:

	2008	2007
Donations and other funds received from Board Members	**$ 54,520**	**$ 102,933**

Payments for goods provided, expenditures incurred and/or services performed on activities of the Society:

Fundraising	$ 2,062	$ 1,468
Administrative	-	7,906
Programs	2,062	53,164

Some Board Members provide program services at international sites. They are reimbursed for their expenditures in performing these services. This has been included under Programs above. Members of the Board are also permitted to purchase calendars at wholesale prices.

7. LEASE

The office premises lease was renewed for an additional three year term expiring January 31, 2010. Future annual lease payments are 2009 - $16,800 and 2010 - $9,800. The lease has been indemnified by a member of the Board of Directors.

NOTES TO THE FINANCIAL STATEMENTS: JUNE 30, 2008

8. ALBERTA REVENUE

Composition of revenue from Alberta is as follows:

	2008	2007
Wild Rose Foundation	$ 23,000	$ 1,500
Donations	29,322	23,747
Ticket and merchandise sales	-	245
	$ 52,322	**$ 25,492**

The grant from the Wild Rose Foundation requires that the Society contribute an amount equal to the grant to the project.

9. VOLUNTEERS

Professional and non-professional volunteers provide services for the international and local programs of the Society, as well as administrative services.

10 LINE OF CREDIT

.

The Society has a $35,000 line of credit with VanCity Savings which is secured by a claim against the assets of the organization. The loan bears interest at prime plus 1.5%.

11 FINANCIAL INSTRUMENTS

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In January 2005, the CICA issued Handbook Section 3855, “Financial Instruments – Recognition and Measurement”. The section prescribes when a financial instrument is to be recognized on the statement of financial position and at what amount. It also specifies how financial instrument gains and losses are to be presented. This new standard is effective for years commencing on or after October 1, 2006. The Society is in compliance with the recommendations.

12 FUND BALANCES

.

Due to the nature of “Not for Profit” organizations, it is often difficult to match revenue raised by donations with ongoing operating expenditures. However, although the Society has operated at times with a deficit from current operations, their accumulated net assets have remained in a surplus balance.

13 COMPARATIVE FIGURES

.

Certain prior year financial statement figures have been reclassified to conform to the current year’s presentation. The comparative figures were audited by another auditor.

SCHEDULE 1 – PROGRAM EXPENDITURES
FOR THE YEAR ENDED JUNE 30, 2008

	2008	2007
PROGRAM PAYMENTS		
INTERNATIONAL		
CIDA India	$ 23,021	$ 42,885
CIDA Tanzania	96,221	60,445
CIDA Nepal	70,702	54,504
CIDA Tibet	66,690	56,376
Sight projects	152,798	100,662
	409,432	314,872
DOMESTIC		
Public engagement	41,811	19,499
Total program payments	**$ 451,243**	**$ 334,371**
PROGRAM ADMINISTRATION		
Events	$ 7,076	$ -
Office and miscellaneous	42,030	30,381
Professional fees	5,052	2,415
Rent	6,238	4,993
Telecommunications	2,000	2,729
Travel	7,925	14,083
Wages, benefits and subcontracts	54,007	61,962
Total program administration	**$ 124,328**	**$ 116,563**

The accompanying notes are an integral part of these financial statements.

SCHEDULE 2 – OTHER EXPENDITURES
FOR THE YEAR ENDED JUNE 30, 2008

FUNDRAISING	2008	2007
Events	$ 7,017	$ -
Other fundraising expense	15,442	15,790
Publication postage and production	3,998	2,839
Rent	7,292	5,067
Telecommunications	607	1,365
Travel	2,199	5,842
Wages, benefits and subcontracts	54,917	64,909
Total Fundraising	**$91,472**	**$ 95,812**
GENERAL ADMINISTRATION		
Amortization	$ 2,342	$ 2,833
Equipment leases and maintenance	1,181	2,427
Insurance, licenses and fees	2,464	1,816
Office and miscellaneous	7,864	5,773
Professional fees	5,610	3,551
Rent	6,238	6,236
Telecommunications	607	1,151
Travel	334	-
Wages, benefits and subcontracts	39,088	37,169
Total General Administration	**$65,728**	**$ 60,956**

The accompanying notes are an integral part of these financial statements.

VOLUNTEERS

Volunteers have always played a crucial role in Seva's work. From ophthalmologists helping train local physicians, to the epidemiologists conducting blindness surveys, to nurses, management consultants, graphic designers, envelope stuffers, special events helpers, information technologists, writers and editors – volunteers sustain Seva programs. Volunteer opportunities abound at Seva. For current volunteer openings, please visit our website at www.seva.ca or contact admin@seva.ca.

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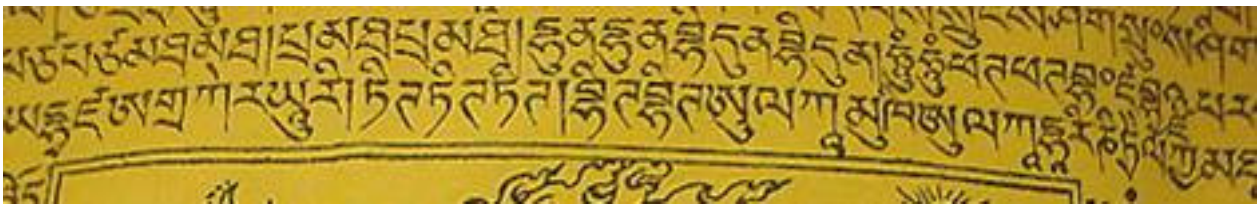

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A number of our supporters have made Seva Canada part of their long-term charitable giving plan and named Seva Canada in their Wills. We thank these people for believing in the continuation of our work. Planned giving can take many forms and create opportunities for both Seva Canada and our donors. If you are interested in making a planned gift, please contact Penny Lyons at 604-713-6622 or 1-877-460-6622 or email director@seva.ca.

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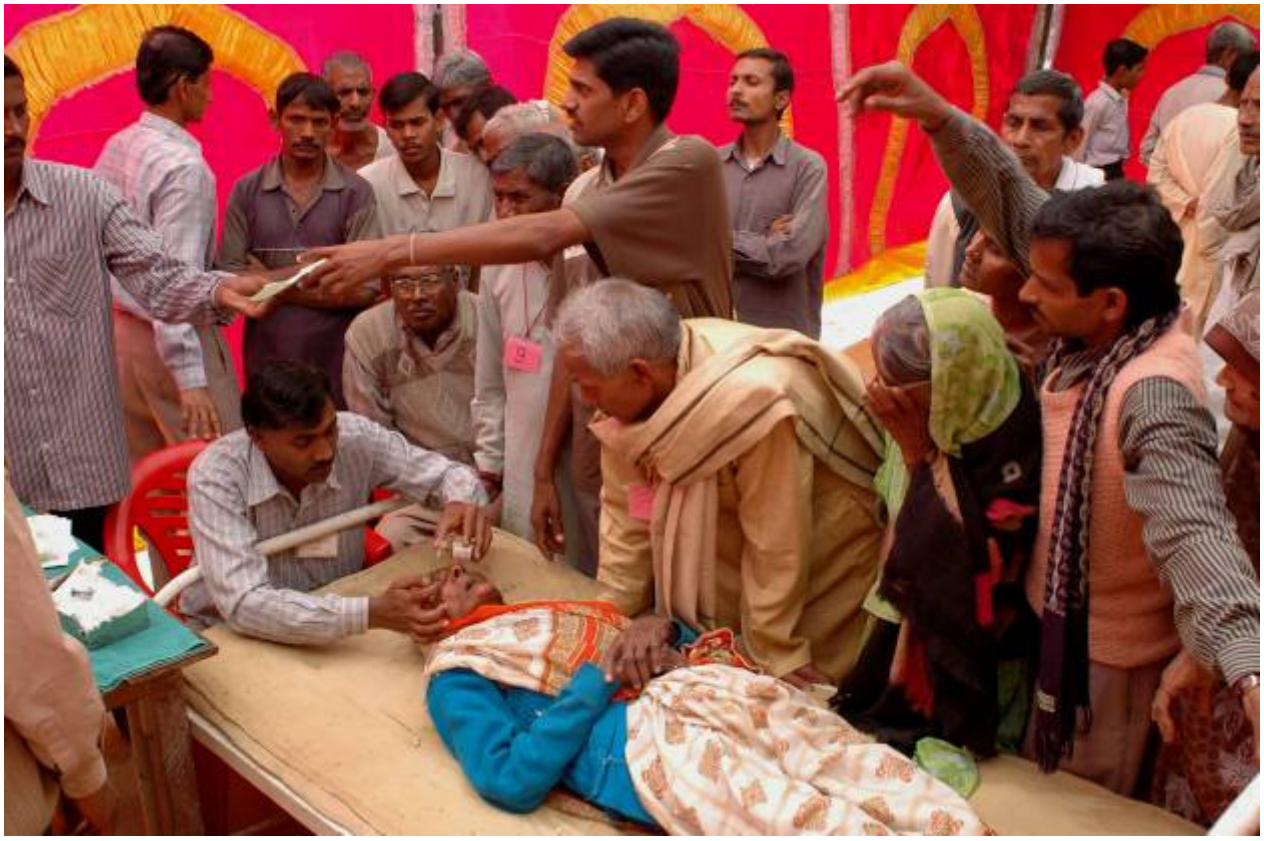

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