2015 ANNUAL REPORT



AU honours AHA with award

Africa Humanitarian Action

AFRICA HUMANITARIAN ACTION



CREDITS:
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This report provides a concise overview of the varied activities of Africa Humanitarian Action (AHA) in the countries it served during 2015.

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About AHA

Africa Humanitarian Action (AHA) is a pan-African international non-governmental organisation that provides effective humanitarian relief and recovery as well as development and advocacy services. Founded in 1994 in response to the atrocities in Rwanda, AHA has supported over 15 million people in 20 African countries to regain their health, dignity and wellbeing.

Affected populations are at the forefront of all AHA activities. AHA's vision is of an African continent whose own institutions can sustain its communities and individuals in human security, working peacefully together. The AHA mission is to respond to crises, conflicts and disasters in Africa; to enhance communities at risk, so they can solve their concerns themselves and to advise the international aid community and private sector on African Humanitarian issues.

AHA is guided by universal humanitarian principles and values. Upholding in independence, impartiality and integrity, AHA advocates and may speak out on humanitarian issues. AHA takes responsibility for its actions and is accountable for the resources it employs to those with whom it works and its program supporters.

The strength of AHA is in its African roots and reach. AHA is inclusive and makes use of the diversity and resources of the people with whom it works as it endeavours to deliver sound programs and outcomes. AHA embraces change and innovation at the same time as its seeks results that last.

Affected populations are at the forefront of all AHA activities, which ensures that its Field Offices respond appropriately to peoples needs in a timely and effective manner. Each Field Office is supported by a Country Office, which is backed by the Head Office team in Addis Abeba, Ethiopia.

AHA's Head Office is guided by a secretariat headed by the President, who works with an executive board that sets strategic priorities, and monitors and evaluates performance standard and results. The board is appointed by AHA's International Assembly of Trustees, whose members determine AHA's general policies and ensures quality and accountability to affected populations and to donors.



Foreword by the President

Africa Humanitarian Action (AHA), although a major player in Africa, is but one small actor in a myriad of the global spread laying claim to the humanitarian cause. With mounting demands stemming from more and more complex and enduring humanitarian crises, the system has continued to adapt, innovate and evolve to meet these diverse challenges. Over the past two decades of our existence, we at AHA have strived to play an active part in sector-wide debates, consistently advocating for a greater role and direct involvement of local and southern actors.

The year 2015 saw a number of consultations and meetings in preparation for the World Humanitarian Summit, which took place in Istanbul this year. In all the sessions AHA participated in; from Addis to New York, Johannesburg to Geneva we repeatedly aired this clarion call and it was gratifying for us to note that the points we have been promoting were finally gaining some traction.

This view has been amplified and highlighted in the UN Secretary General's Report to the Summit and in all documentations and resolutions which had come out. A new model of humanitarian action should thus follow.

On another front, as we started this year, we were honoured by the acknowledgment from the African Union (AU) of AHA's role in fighting the Ebola outbreak in 2014 and 2015. AHA provided a major share of the required human resources and technical support for the AU Ebola missions to West Africa. AHA has been presented with a Recognition Plaque at a ceremony held at the AU Summit of Heads of State and Government.

During 2015, AHA country programmes have extended their reach, strengthened and diversified their programmes in order to meet the needs of our populations of concern. AHA has expanded its operational footprint to the Republic of Djibouti, where our emergency intervention supported refugees from Somalia and Yemen. To meet increased needs of refugees from Burundi, we expanded our work in Rwanda, where we also launched cervical cancer screening, the first such in refugee camps in Rwanda. We have also strengthened and scaled up our SGBV prevention programmes in Uganda. 2015 also saw AHA handling a cholera outbreak in Burundi and strengthening our programmes for internally displaced persons in South Sudan to name a few.

The World Humanitarian Summit is a promising start, which should lead to improvements in humanitarian action. As needs continue to rise and remain unmatched by resources and responses, humanitarian tensions will continue to challenge us.

We are nonetheless the wiser and better prepared.
My most sincere gratitude for all your support!

Dawit Zawde



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UN Population Fund (UNFPA)
UN Women
UN World Food Programme (WFP)
UN World Health Organization (WHO)
United Support of Artists for Africa
US Agency for International Development (USAID)
World Bank

THE AFRICAN UNION HONORS AFRICA HUMANITARIAN ACTION

The African Union (AU) recognised Africa Humanitarian Action (AHA) for its "contribution and solidarity in the fight against Ebola".

A recognition plaque was presented by the current Chairperson of the AU, H.E. Mr. Idriss Deby Itno, President of the Republic of Chad and by Dr. Nkosazana Dlamini Zuma Chairperson AU Commission, to AHA's Founding President, Dr. Dawit Zawde, during the closing ceremony of the African Union's 26th Summit in the presence of African Heads of States on 31 January 2016.

During the ceremony, it was reiterated that AHA was the first to respond to the commission's call for medical staff. Throughout the African Union Support to the Ebola Outbreak in West Africa (ASEOWA) mission, AHA staff worked diligently at various capacities on the ground, in the affected countries and at Head Office level with the AU Team in Addis Ababa.

AHA was further acknowledged and Dr. Zawde commended for "establishing a truly African humanitarian organization". Following the ceremony, the chairperson of the AUC hosted a luncheon in honor of the efforts against Ebola attended by Heads of State, Government officials and partners that contributed to the ASEOWA.







AHA BURUNDI

AHA in Burundi has been providing services to refugees and asylum seekers since 2002. AHA assists refugee repatriation and provides essential health and nutritional and transportation services. AHA also works to mitigate the negative impact of HIV/AIDS and other communicable diseases.

POPULATION OF CONCERN

In 2015 AHA Burundi implemented health activities for refugees living in camps and in urban areas as well as asylum seekers. AHA managed health projects in four refugee camps: Gasorwe Kinama in Muyinga province, Musasa in Ngozi province, Bwagiriza in Ruyigi province and Kavumu in Cankuzo province. Asylum seekers were assisted at the Cishemere transit site in Cibitoke province.

DEMOGRAPHICS

The refugees are grouped in four camps and urban environment especially in Bujumbura.

The following tables show the numbers of refugees according to the 4 camps and in urban areas

Population Planning Group:	*Refugee and asylum seekers in Burundi*					
Sub-group (if applicable):	*N/A*					
Age Group	Male		Female		Total	
	in numbers	in %	in numbers	in %	in numbers	in %
0-4	709	8,55%	727	8,77%	1436	17,32%
5-11	971	11,71%	899	10,85%	1870	22,56%
12-17	589	7,11%	542	6,54%	1131	13,64%
18-59	1,723	0,02%	1,968	0,02%	3,691	0,04%
60 and >	64	0,77%	97	1,17%	161	1,94%
Total:	**4,056**	0,05%	**4,233**	0,05%	8,289	0,10%
Major Sites:	*Kinama*					

Population Planning Group:	*Refugee and asylum seekers in Burundi*					
Sub-group (if applicable):	*N/A*					
Age Group	Male		Female		Total	
	in numbers	in %	in numbers	in %	in numbers	in %
0-4	569	8,90%	536	8,38%	1105	17,28%
5-11	880	13,77%	597	9,34%	1477	23,10%
12-17	571	8,93%	519	8,12%	1090	17,05%
18-59	1031	16,13%	1291	20,19%	2322	36,32%
60 and >	37	0,58%	62	0,97%	99	1,55%
Total:	**3088**	48,30%	**3305**	51,70%	6393	100,00%
Major Sites:	*Musasa*					

Population Planning Group:	*Refugee and asylum seekers in Burundi*					
Sub-group (if applicable):	*N/A*					
Age Group	Male		Female		Total	
	in numbers	in %	in numbers	in %	in numbers	in %
0-4	795	8,92%	747	8,38%	1542	17,29%
5-11	1263	14,16%	1176	13,19%	2439	27,35%
12-17	686	7,69%	702	7,87%	1388	15,57%
18-59	1505	16,88%	1863	20,89%	3358	37,66%
60 and >	89	1,00%	101	1,13%	190	2,13%
Total:	4338	48,65%	**4579**	51,35%	**8917**	100,00%
Major Sites:	*Bwagiriza*					

Population Planning Group:	*Refugee and asylum seekers in Burundi*					
Sub-group (if applicable):	*N/A*					
Age Group	Male		Female		Total	
	in numbers	in %	in numbers	in %	in numbers	in %
0-4	968	10,40%	970	10,42%	1938	20,82%
5-11	1346	14,46%	1274	13,69%	2620	28,15%
12-17	711	7,64%	725	7,79%	1436	15,43%
18-59	1359	14,60%	1837	19,74%	3196	34,34%
60 and >	57	0,61%	61	0,66%	118	1,27%
Total:	**4441**	47,71%	**4867**	52,29%	9308	100,00%
Major Sites:	*Kavumu*					

Population Planning Group:	*Refugee and asylum seekers in Burundi*					
Sub-group (if applicable):	*N/A*					
Age Group	Male		Female		Total	
	in numbers	in %	in numbers	in %	in numbers	in %
0-4	1311	5,62%	1282	5,49%	2593	11,11%
5-11	2278	9,76%	2326	9,96%	4604	19,72%
12-17	1976	8,46%	1948	8,34%	3924	16,81%
18-59	5655	24,22%	5959	25,52%	11614	49,75%
60 and >	269	1,15%	342	1,46%	611	2,62%
Total:	**11489**	49,21%	**11857**	50,79%	23346	100,00%
Major Sites:	*Urbains*					







HEALTH CARE AND NUTRITION

In all the camps the refugees were provided with access to basic health care to improve their health and nutritional well-being. Main activities focused on the treatment of acute diseases and ensuring that complicated cases were refered to hospitals in Bujumbura. Prevention activities focused on the fight against epidemic diseases, malaria, improving maternal and child health through proper immunization coverage and improved access to reproductive health issues. AHA also supported national structures including the management of cholera in the province of Makamba in partnership with UNICEF.

HIV/AIDS

In the HIV health sector, activities focused in providing support for people living with HIV, voluntary testing and community mobilization for behavior change.

AHA in the year 2015, continued activities in the sense of improving physical health, nutritional and psychosocial of PVVS, prevention of the spread of HIV in the population and PTME. Listening and counseling rooms located in camps have also facilitated access to HIV services in private.

In addition, Particular attention was given to pregnant women attending the PTME programme-the results were also encouraging, as PCR results showed all newborns were HIV negative.

AHA CAMEROON

Since 2010, AHA in Cameroon has been UNHCR's main implementing partner in health nutrition and infrastructure development sectors in Kadey (Eastern Cameroon), Lolo and Mbile Refugee Camps–(following the crisis in neighboring Central African Republic (CAR) which resulted in the migration of refugees crossing the border and seeking stability in Cameroon). AHA also operates in Batouri, Kette, Ndelele, Yokaduma and Kentzou health districts; providing primarily refugees with health care and nutrition services.

POPULATION OF CONCERN

Due to the conflict suffered within its neighboring countries, Cameroon has been forced to absorb their fleeing citizens. According to the latest refugee registration performed by UNHCR, around 250,569 refugees have been recorded. The majority of refugees are settled in the East region (177,613) and the remaining 121,744 are integrated in the Adamoua and Northern regions.

DEMOGRAPHICS

Population Planning Group:		***Central Africa Refugees in Kadey Department ,East Region***					
Sub-group		*population* **in-site Refugees**					
Age Group	**Male**		**Female**		**Total**		
	in numbers	**in %**	**in numbers**	**in %**	**in numbers**	**in %**	
0-4	5558	50.65%	5415	49.35%	**10973**	**19.65%**	
5-17	10334	48.46%	10990	51.54%	**21324**	**38.19%**	
18-59	9883	45.18%	11993	54.82%	**21876**	**39.18%**	
60 and >	975	58.52%	691	41.48%	**1666**	**2.98%**	
Total:	**26750**	**47.9%**	**29089**	**52.1%**	**55839**	**100%**	
Major Sites:	***Lolo, Mbile, Timangolo, Gadol, Gado II***						

Population Planning Group:		***Central Africa Refugees in Kadey Department ,East Region***					
Sub-group:		*Population* **off-site Refugees**					
Age Group	**Male**		**Female**		**Total**		
	in numbers	**in %**	**in numbers**	**in %**	**in numbers**	**in %**	
0-4	8601	50.05%	8584	49.95%	17.185	14.11%	
5-17	27095	48.71%	28528	51.29%	55.623	**45.68**	
18-59	18957	40.0%	26236	20.0%	45.193	37.11%	
60 and >	2183	57.86%	1590	42.14%	3.773	3.10%	
Total:	**56836**	**46.67%**	**64938**	**53.33%**	121.774	**100%**	
Major Sites:	*Kentzou, Ndokayo, Garoua Boulai*						

The difference between the number used during planification and the reporting period is due to the fact that there have been some new sporadic entries throughout the year.

PROGRAMME SUMMARY

The massive influx of refugees has created a significant impact on the countries existing assets including health care. Following the crisis that followed the resignation of the Central African Republic President in early 2014, AHA implemented emergency strategic interventions in villages and on borders by expanding its operational catchment areas.

AHA's scope of activities mainly targets refugees but also includes the host community, providing primary health, RH& HIV/AIDS and nutrition services as well as the development of public infrastructures. Since May 2015, AHA's interventional zones have expanded to 7 health districts with 51 health facilities.



HEALTH CARE AND NUTRITION

The programmes of community management of acute malnutrition and the supplementary feeding programmes intensified throughout 2015 and ambulances were used to transport malnourished children. Emphasis was placed on organising and maintaining the supply chain, which has resulted in a great improvement.

The prevalence of malnutrition in Cameroon is extremely high in the East Region. AHA has implemented infant and young child feeding programmes using the strategy of model mothers as well as implementing culinary demonstration sessions using locally available food.

Though the main cause of malnutrition is food insecurity, lack of knowledge on how to prepare and utilise available food appropriately still contributes to the severity of the conditions. Additional problems are inadequate clean water supply, poor hygiene and sanitation, which lead to many intestinal parasites, diarrhoea diseases and other chronic illness like tuberculosis. Epidemic diseases like poliomyelitis, measles and tetanus have also surpassed the refugee crisis and have become a greater concern for Cameroon.

The fight against anaemia and the Blanket Supplementary Feeding (BSF) program was introduced (rations are administered each month to under-5 children and pregnant and lactating mothers) in the sites of Lolo, Mbile and Timangolo to prevent malnutrition. Moreover, AHA strengthened the community sensitisation and mobilisation program on disease prevention. Much emphasis was also placed on administering public health education about malaria, TB and other communicable diseases.

HIV/AIDS

AHA facilitated the opening of two new HIV/AIDS management units at Betare Oya and Kette District hospitals to facilitate medicinal provision from a shorter distance. Around 15 exposed children benefited from PCR analysis and fortunately all of them tested negative.

The national prevalence of HIV/AIDS is still high (5.5%) especially in the East (6.3%, according to 2011 National Health Demographic Survey). Though the prevalence rate among refugees is considered low, those refugees being integrated with the local community with high rates of HIV/AIDS makes them vulnerable.

AHA has facilitated community awareness and sensitisation programmes as well as discussion forums and strengthened health education programmes in health facilities–these included the promotion of positive sexual behavior among high risk groups creating awareness and organising periodic free HIV/AID and STI screening and condom distribution.



CAPACITY DEVELOPMENT

AHA intensified its interventions in infrastructure development as a key component to be able to deliver suitable services. These include the rehabilitation, extension and equipment of Kette and Garoua Boulai hospitals, the rehabilitation of care giver compounds at Bertoua Regional Hospital, incinerator construction at Kantzou and Mbilé health centers, the rehabilitation of schools at Mbile, Kentzou, Yokadouma, Gbiti, Ndokayo, Gado and Woumbou. In addition AHA strengthened the capacity of health facilities by providing human resources, medicine and consumables and coordination activities in order to provide the highest quality of services.

AHA has done much to reduce the mortality and morbidity of the population and eight ambulances were dispatched within the entire operational zone. The provision of drugs and laboratory reagents continued in sites.

AHA also recruited and trained community health workers and health & nutrition promoters to run the community mobilisation and sensitisation programmes especially in refugee sites.

REPRODUCTIVE HEALTH SERVICE

AHA has worked with great emphasis to ensure refugee women have better accessibility and can benefit from reproductive health services by making services client friendly. Assisted deliveries ante and post natal services, family planning, prevention of malaria and immunization for pregnant woman have become the main objectives of AHA teams throughout 2015.

55,839 refugees are installed in refugee sites, whereas the remaining 121,774 are integrated in different villages within the host community.

PUBLIC ADVOCACY:

AHA continued to deliver health, RH&HIV/AIDS, and nutrition education services according to the newly adopted health and nutrition strategy.

To promote social cohesiveness, AHA uses public health infrastructures where both refugees and host communities receive health and other related services to facilitate the improvement of the technical capacity; human resources, material, equipment drug provision and infrastructures.

AHA recruited around 500-community health workers from villages to provide information, sensitise the community and promote services.

AHA DJIBOUTI

AHA expanded its operational footprint in the Republic of Djibouti in 2015. AHA's intervention in the country focuses on the physical, mental, and reproductive health of refugees as well as their nutritional well-being and HIV/AIDS prevention and care.

POPULATION OF CONCERN

With support from the UNHCR, AHA Djibouti delivered comprehensive health care support to refugees and asylum seekers; during the year 2015, 49, 087 adult and pediatric medical consultations took place from the refugee and host communities.

HEALTH CARE AND NUTRITION:

Health care services were provided through three health centers with inpatient, laboratory, pharmacy and maternity units operating 24/7 and through an urban clinic with outpatient facilities.

Acute malnutrition rate of 10.6% is down from the previous year of 17.7%. 7, 546 educational and assessment home visits were conducted during the year; 1,002 children were identified as malnourished and referred to the health centers, 847 vulnerable individuals, 356 chronically ill individuals, 679 pregnant women and 418 lactating women were supported with supplementary foods.

Addressing the needs and detection of chronic and acute malnutrition in the camps among children under five, pregnant and lactating women, AHA emphasised efforts on reducing malnutrition and anaemia which included awareness education and communication to enable a change in behaviour in nutrition and hygiene (supported by WFP, UNICEF and UNHCR);

- 19,728 community based health education visits were carried out.
- 51,128 home visits were conducted by AHA community health workers in the three camps;
- 1,016 children were vaccinated;
- 232 births were attended by AHA health staff;
- 232 pre-and postnatal consultations were carried out

AHA Djibouti engaged in an emergency medical response to an influx of refugees arriving from Yemen. In collaboration with UN and other entities operational in Djibouti, AHA was engaged in establishing a response plan for this emergency taking charge of health and nutrition interventions.

HIV/AIDS:

The overall physical health, nutritional and psychosocial wellbeing of persons living with HIV/AIDS was monitored; 100% of known HIV positive individuals had access to ARV and other preventive health care services, received supplementary food and periodic biological monitoring. AHA worked closely with government partners and the UNHCR on prevention of the spread of HIV within the population; testing and counseling rooms located in camps facilitated access to HIV services in private (particular attention was provided to pregnant women attending the maternity programme). 87,908 condoms were distributed and 970 individuals were voluntarily tested for HIV/AIDS.

CAPACITY DEVELOPMENT

Periodic expertise training for national staff (doctors, nurses, midwives, medical assistants, laboratory technicians, pharmacists and community health worker or health promoters) and refugee volunteers were conducted with the objective of enhancing staff capacity to adapt and manage goals and become familiar with the resources deployed (namely priority pathologies, national protocols, goods and drugs). AHA personnel participated in various capacity building programmes organised by the Ministry of Health and other operational partners in the camps: WFP, UNICEF, ONARS, UNHCR.

Refugee and national associations were supported in the camps and Djibouti Ville through learning and collaboration opportunities throughout the year that included youth clubs and associations supporting women and chronically ill people; the Djibouti Handicap Association was one of the main organizations, which collaborated with AHA in 2015.







MENTAL HEALTH

In 2015 AHA introduced a mental health response programme for refugees and asylum seekers in Djibouti. Children exposed to harmful traditional practices, people suffering from depression and other mental illnesses were provided with access to full-time psychiatric support.

AHA ETHIOPIA

AHA has been involved in two major programmes since 1997; Community Based Health and Refugee Based Humanitarian Services. The Community Based Health Programme includes access to better reproductive health intervention (family planning and reproductive health) supported by international NGO engender in 28 woredas in 6 zones.

POPULATION OF CONCERN

AHA in collaboration with United Nations Higher Commissioner for Refugee (UNHCR) and Administration for Refugee and returnee Affairs (ARRA), has been providing various humanitarian services to the refugees residing at different refugee camps since 2008. During the last eight years, AHA implemented various programs/projects that include Water, Sanitation and Hygiene (WASH), community services (HIV/AIDS prevention and control; non-formal education (NFE-preschool); Gender Based Violence (GBV) prevention and response) and construction and provision of emergency and transitional shelters to the Eritrean Afar refugees residing in Aysaita and Barahle refugee camps both located in Afar regional state.

CAPACITY BUILDING

AHA has developed an independent water supply system through drilling a deep borehole and installing water supply structures. The discharge from the borehole provides enough water to supply all of the refugees in the camp and can be shared by the surrounding communities, whenever there is demand. About 8,979 Eritrean refugees were hosted in Aysaita refugee camp and benefited from the programme.

The Water Supply project for 2015 was to strengthen the water supply system through:

- Construction of additional tap stands
- Provision of generator and submersible pump, water testing kits,
- Operation, monitoring and maintenance of water supply structures
- Upgrading or replacement of main pressure line
- Expansion of existing supply system

AHA has also secured a total of 20,000 Euro (about half a million ETB) from an international organization called “Sign of Hope” for the purpose of strengthening WASH services in Aysaita refugee camp.

Short-term contraceptive methods such as pills condoms and injectable were provided to clients and referrals for safe and comprehensive abortion care to the nearest health facility. Community awareness and information dissemination were conducted through community dialogue sessions and house-to-house visits.

Refugee children (and adolescent children from the host community) in Aysaita and Barahle camps attended education sessions covering various topics such as personal hygiene, traditional practices, healthy environmental conditions, language, basic science – with the aim of strengthening the education system and enhancing education facilities through construction of additional infrastructures, provision of furnishings, teaching aids and the capacitating of teachers and caregivers in early child hood teaching and functional adult literacy.

The child protection programme was also undertaken with the objective of providing protection for refugee children through provision of appropriate psychosocial support; providing child friendly space, training and sensitising of the refugees and host communities.

HIV AIDS

Programmes providing prevention, care and support services were designed to benefit the refugees and the surrounding host communities in Aysaita and Barahle towns. Major activities included: prevention and control of transmission, sensitisation programme offering behavioral change and information education training as well as distribution of condoms and referral of refugees to the nearest health facility.







PUBLIC ADVOCACY:
Community awareness and information dissemination was conducted through community dialogue sessions and house-to-house visits.

Training was provided covering the topics of performance enhancement; permanent methods of family planning mobilisation and comprehensive maternal care referral; community dialogue; home visits; referral registration and reporting system management.

AHA LIBERIA

AHA began its operations in Liberia in 2004, starting with refugee repatriation to health systems management, supporting over 1.5 million people including humanitarian assistance to refugees, displaced people and host communities.

POPULATION OF CONCERN:

Mantserrado, Nimba, Grand Gedeh and Maryland continue to host Ivorian refugees in the host communities and in three refugee camps namely Bahn, PTP and LW camps. AHA is implementing a project aimed at providing essential health and nutrition services for refugees residing in three camps.

DEMOGRAPHICS:

Population Planning Group:			***Refugees and Asylum Seekers in Liberia***			
Sub-group (if applicable):			***Ivorian Refugees in Liberia***			
	Male		**Female**		**Total**	
Age Group	**numbers**	**%**	**numbers**	**%**	**numbers**	**%**
0-4	2567	9.20%	2,679	9.60%	5,246	18.80%
5-17	5162	18.50%	4,884	17.50%	10,046	36.00%
18-59	4855	17.40%	6,726	24.10%	11,581	41.50%
60 and >	362	1.30%	670	2.40%	1032.485	3.70%
Total:	12948	46.40%	14,957	53.60%	27,905	100%
Major Sites:		Bah, PTP and LW Camps				

HEALTHCARE

The health system of Liberia has been extremely affected by the outbreak of the Ebola Virus Disease (EBD), which hit all counties in the country and claimed thousands of lives. The EVD outbreak in West Africa was considered the longest and most complex of the EVD out breaks documented elsewhere. Among the three West African Countries under EVD outbreak, Liberia observed the highest case reporting and deaths during the height of the transmission.

Full maternal health services including Ante-natal visits and deliveries were restored; these included 1,050 deliveries conducted by skilled personnel, 229 children being fully immunized and 805 children screened for malnutrition and admitted to the feeding programme.

Children under five, pregnant and lactating women all receive daily nutritional screening (through anthropometric and clinical anaemia identification) from community health workers either in the clinic or the community; community engagement and early identification of the sick and timely referral to the clinic is conducted including traditional birth attendants (TBAs). 500 Children under five years were actively identified and assessed for nutritional deficiencies as well as their vaccination status; malnourished children were then placed on nutritional and clinical treatment plans.

All the three Refugee Camp clinics (Bahn, PTP and LW) are operating fully providing the Essential Package of Health Services (EPHS) 24 hrs a day, 7 days pw; 54,803 patients were treated.

The 2015 AHA projects also covered restoration of health services in 14 health facilities in Mantserrado county, provision of comprehensive essential health and nutrition services to refugees in Bahn, PTP and LW camps (covering curative services, EPI, reproductive health, nutrition, mental health, STI/HIV/GBV- clinical care, malaria control, referral/ambulance services, drug and medical supplies).

In addition, AHA provided the following support to refugees: supplementary feeding; accommodation; support for blood transfusion patients; new born baby support; administering medicine and medical supplies; burial arrangement; financial support to bereaved families; transportation of discharged patients (plus caretaker); referral services; support for translators and home service for patients awaiting secondary and tertiary care.





HIV/AIDS

Comprehensive reproductive health as well as HIV/AIDS services is available in all clinics with selected staff trained on comprehensive HIV/AIDS prevention, care, treatment and support. A total of 254 eligible patients were put on ART and condoms were distributed.

Beneficiary perspective: Mr. Yaune Konde is thirty years old with a bright mind and full of energy. His enthusiasm for life, and smile on his face started to fade and ended up changing the course of his life. A small wound on his leg appeared; he sought medical care but it did not relieve his pain and instead the wound continued to grow in size and pain. The years passed and he learned to live with it as best he could along with the pain and discrimination. He lost his friends because of his bad smelling foot; he spent his days sitting outside under the hot sun and dust so as not to afflict his own family members with the bad smell. He was dependent on others for basic needs support and he felt depressed and worthless and that his future was bleak.

In February 2015, he showed up to an AHA clinic supported by family members; the physician there conducted a thorough physical examination and communicated to the patient that he was suffering from Histiocytoma/Madura Foot, with extensive damage and deformity of the supporting soft tissue and that only surgical intervention could alleviate his pain. A medical referral was arranged following a consultation with a surgeon in the area and a pathology result confirmed the clinical diagnosis with an extensive preparation for below the knee amputation planned. A four-hour surgery was successfully conducted and he was supported during the hospital for a stay of three weeks before he was transported back to the refugee camp. His long lost smile has returned, he gained some weight and after a through clinical examination of the wound, additional medical support was provided to him for an additional three weeks, while a wheel chair was being facilitated for him.

He said that "AHA saved my life"; even though he is using a wheel chair, he claims "I feel that I am different person" and added "People will now consider me as someone with "a normal" disability and not someone to flee away from because of my former foul smelling leg".

CAPACITY DEVELOPMENT

AHA supported health workers were trained on Infection Prevention Control (IPC) and actively mentored and supervised. Triage and isolation rooms in all AHA supported health facilities were constructed. In addition, incinerators, hand pumps and fencing were constructed while 14 health facilities were reconstructed.

Moreover, training was conducted on the following topics: comprehensive HIV/AIDS patient treatment and care; comprehensive outreach health services; nutritional screening; family planning; neonatal resuscitation and IPC trainings including the Standard and Quality Service (SQS) training.

AHA NAMBIA

AHA has been working in Nambia since 2001 providing a wide range of programmes in the Osire refugee settlement, which include accommodation, water, sanitation, food security, community mobilisation and voluntary repatriation. AHA continues to maintain systems of operation that guarantee the continued smooth running of programmes in Osire settlement.

POPULATION OF CONCERN:

On the 30th of September 2015, the total population of concern in Namibia according to UNHCR was 2778; 1117 of them are asylum seekers and 1661 of them are refugees.

Due to the repatriation and resettlement of former Angolan asylum seekers the settlement population has decreased. However, the on-going influx of refugees from the DRC and other African countries stretches the already fragile environment and scarce resources in this area. In addition, the lack of an alternative source of energy to firewood leads to the depletion and degradation of the environment surrounding the settlement.

To circumvent this, AHA provided kerosene to the refugees monthly for the whole year and educational programmes were put in place to ensure peaceful co-existence between refugees and host communities living on the nearby surrounding farms. Planting of trees was followed up to combat effects of desertification.

Osire refugee settlement in Namibia is surrounded by commercial farms and has been hosting refugees from various African countries since 1992. The refugee situation is therefore termed protracted given that some refugees have been living in Osire since its establishment. The planning figure for the year 2015 was (2599) as there still remain a number of asylum seekers coming in every month mainly from the great lakes region.

Local integration is on its way and many individuals have naturally integrated into Namibian society through employment or by virtue of being married to Namibians.

DEMOGRAPHICS

Population Planning Group			**(All nationalities)**			
Age Group	**Male**		**Female**		**Total**	
	numbers	**%**	**numbers**	**%**	**numbers**	**%**
0-4	171	12.1	156	13.1	327	**12.58**
5-11	235	16.6	249	9.3	484	**18.22**
12-17	169	11.9	223	8.3	392	**15.08**
18-59	823	58.2	544	20.4	1367	**52.59**
60 and >	14	0.99	15	0.5	29	**1.11**
Total:	**1412**	**53.1**	**1187**	**44.67**	**2599**	**100**
Major Sites:						

HEALTH CARE

AHA provided and strengthened psycho-social support to all persons of concern in the settlement. These included teenage mothers, children, and unaccompanied minors as well as people living with disabilities. In addition, counselling and referral services were provided for survivors of SGBV victims. AHA also ensured that the number of refugee women in decision making bodies is maintained at fifty percent (50%).





CAPACITY DEVELOPMENT

WASH services was provided towards the supply of sufficient quantity of safe drinking water (20 Liters /person/day) and maintenance of the water supply system. Water was treated and water testing was conducted every quarter to confirm that the water was safe for drinking. Acceptable sanitation in the form of pit latrines were also constructed to make sure the ground water is not contaminated. The hygiene promotion aspect of the project was followed up be working closely with the environmental task force and health promoters from Ministry of Health and Social Services (MoHSS) by conducting cleaning and awareness-raising campaigns.

AHA provided quality services to the existing refugee population by implementing refugee project activities such as: WASH promotion, environment protection, shelter, community development and social services, youth and sport services, food security including self -reliance and livelihood activities. AHA also continued to facilitate income-generating projects, small business initiatives with technical support and targeted training for self-reliance and livelihood activities.

A total of one hundred and eighty trees were planted in five different sites. Fifteen oranges, one guava and two mangoes seedlings were planted in the demonstration garden as well as a variety of vegetables/crops grown such as spinach, okra, beetroots, green peppers, eggplants, water melons, maize, pumpkins.

Four types of skill development training were conducted: two on hair dressing, two on bead work, three on tailoring and one on computer; eighty trainees seventy female and ten male completed the courses and assessment was done to all four groups based on their training.

Shelter is provided to new arrivals and the project assists the situation of housing and distribution of materials within the settlement; an area of 3x3.2m2 housing is built for each new arrival and three rooms of this size for a family of five and above houses in Osire are made of mud bricks with a zinc sheet roof and cemented floor.

PUBLIC ADVOCACY:

AHA continues to work with other stake holders to improve problems raised with issues including protection, education, self-reliance and livelihood, sexual exploitation and violence.

AHA RWANDA

AHA has been working in Rwanda since 1994 and currently provides the services of primary health care, nutrition, HIV/AIDS and income generating activities in three Congolese refugee camps, 2 reception centers for Burundian refugees, 2 transit centers for Rwandan returnees and Burundian refugees in 2 urban setups.

POPULATION OF CONCERN

Approximately 75,000 Persons of Concern, mainly from the DRC and 100,000 Burundian refugees were targeted in the year 2015. In addition, with the invocation of the cessation clause in June 2015 and following the projections of the Return & Reintegration Program, additional 10,000 Rwandans are expected to return during this year.

OPERATIONAL CONTEXT

The Government of Rwanda continues to demonstrate a strong commitment towards economic development, with the ambition to transform from a low to a mid-level development country. While overall the security situation in Rwanda remains calm, the armed conflict on its border in North Kivu continues to destabilize the region. The government initiated the establishment of two new refugee camps in Kigeme and Mugombwa in 2012 and 2013 respectively. In light of the current situation in the Eastern DRC, there seems no prospect of, Congolese nationals, voluntary return in the near future.

On 31 March 2015, tensions related to the elections in Burundi prompted refugees to flee to Rwanda. The initial average arrivals were 300/day, but continued to soar to over 3,000/day in the third week of April 2015. As of 31 August, over 70,000 Burundians have been residing in the Reception Centres (RC) /camps in Rwanda as well as urban areas of Kigali and Huye.

There was unexpected influx of refugees and asylum seekers from Burundi (40,000 at the end of June). AHA was part of the emergency refugee response particularly in the reception centres and urban areas. Initially AHA redeployed its personnel from other programmes in order to conduct emergency services, and recruited qualified manpower at a later stage.

HEALTHCARE:

The project was aimed at improving the health and nutritional status of approximately 75,000 refugees - mainly from DRC and an anticipated 100,000 Burundian refugees in the newly established camp of Mahama and urban refugees in Kigali/Huye (including 10,000 Rwandan returnees) through the delivery of quality primary health care, referral, HIV/AIDS and nutrition programs. The overall urban refugee health care policy was established in September 2015 and provides health care for pre-identified vulnerable “target” groups.

Refugees residing in the camps/reception centers are living in poor housing conditions and are exposed to overcrowding, lack of safe water and sanitation. As a result, they are vulnerable to upper respiratory tract infections, diarrheal diseases, intestinal parasitosis, skin infections and other serious but easily preventable communicable diseases. These illnesses contribute to the development of malnutrition and anaemia especially in the vulnerable population group of children, pregnant and lactating women. Lack of adequate infrastructure within the camps has made it difficult to provide proper PHC services in the camp based health facilities resulting in an increase of medical referrals to secondary and tertiary hospitals.

Cases, which cannot be managed at camp level, are often referred to appropriate higher-level medical facilities. UNHCR, in close collaboration with AHA, has developed clear referral SOPs.

HIV/AIDS

The HIV/AIDS prevalence rate in the camps is less than 1%, which is lower than the national prevalence rate at 3%. Despite this positive trend new infections are reported especially in Kigeme and Mugombwa. The high risk behaviors among youth needs further tailoring of HIV/AIDS and RH preventive measures. The disruption of social structure in the new camps and lack of income have forced some refugees into commercial sex which potentially leads to the high occurrence of sexually transmitted diseases including HIV.

In the reception centres there was no accurate data on the prevalence of HIV as testing was not conducted. However, IEC on HIV/STIs and use of condoms was disseminated to the refugees. Condoms are available and distributed at the clinic and by community health workers. PLHIV were identified by Community Health Workers (CHWs) and referred to the public hospitals for treatment continuation. Overall in 2015 health care services were accessible and made available to all persons of concern including administering measles vaccinations (90%), access to secondary and tertiary health care services, full access to HIV and RH services





NUTRITION

Both supplementary and therapeutic feeding programmes are running well for refugees residing in the camps and reception centers. Children between 6-23 months of age have also benefited from blanket feeding with CSB++. Community health workers were able to identify and refer children with moderate and severe acute malnutrition and refer them to the health center to be enrolled in Supplementary Feeding Program and OTP respectively. They also teach the population on Infant and Young Child Feeding Practices.

PUBLIC ADVOCACY

During the implementation, AHA has respected the visibility measures stated in the agreements with funders and partners. AHA regularly uses both AHA and partner logos on the T-shirts provided to CHWs, peer educators and other refugee groups during sensitization activities within the camps.

AHA SOUTH SUDAN

AHA has been operating in South Sudan (Abiemnom, Pariang, and Ajoung Thok Counties of Unity/Rowing State) since 2013. The beneficiaries of AHA interventions in South Sudan are IDPs that have been displaced consequent to the armed conflict that ensued in December 2013; including refugees from the Sudan Kordofan.

POPULATION OF CONCERN

In Abiemnom, AHA intervened in 2014 and 2015 as focal point of the International Organization for Migration (IOM) Camp Coordination and Camp Management (CCCM) project. The beneficiary population were IDPs outside of the Protection of Civilians (POC) camps. AHA intervened in the county to improve the living conditions of the IDPs outside of the POCs by facilitating effective and targeted delivery of food and non-food items and monitoring of the services provided to the IDPs. The project benefited 12, 617 individuals.

In the year 2014 and 2015, AHA, in pariang carried out IDP's Camps Management Coordination and Protection projects in partnership with UNHCR. The project aimed to improve the living conditions of 17,932 IDPs by ensuring the provision of multi-sectoral assistance and by enhancing a conducive protection environment. AHA also intervened to improve community awareness against Gender Based Violence (GBV) by addressing root cultural causes and behavioural factors that contribute to Sexual Exploitation and Abuse (SEA) by strengthening provision of coordinated services to GBV survivors through a functional referral system. In Ajuong Thok, AHA provided comprehensive primary health care services to 40,000 Sudanese refugees from Kordofan and 10, 000 host community members.

DEMOGRAPHICS

Name of Population Planning Group: AT Camp	**Refugees in South Sudan, Unity State**					
Age Group	Male		Female		**Total**	
	in numbers	in %	in numbers	in %	in numbers	in %
[0-4]	2,913	9	2,795	9	5,708	**18**
[5-11]	3,285	10	2,947	9	6,232	**19**
[12-17]	3,176	10	1,709	5	4,885	**15**
[18-59]	8,884	28	5,546	18	14,430	**46**
60and >	225	1	247	1	472	**2**
Total:	**18,483**	**58**	**13,224**	**42**	**31,707**	**100**

OPERATIONAL CONTEXT

The comprehensive primary health and nutrition project seeks to improve the health status and nutritional well being of the refugee population in Ajuong Thok refugee camp and the surrounding host community. It also aims at facilitating refugees and the surrounding host community to access optimal reproductive health services, including HIV and SGBV prevention and response. The transfer of refugees has continued and the population in Ajuong Thok refugee camp has increased from 15,153 at the beginning of 2015 and reached 31,707 by the end of December 2015. The project also serves an estimated 10,000 beneficiaries from the surrounding host community.

The project locality is characterized by poor health and access to basic health services. However, AHA adopted a strategy that would imperatively maintain and strengthen the achievements already made towards the three main objectives. 1) Improvement of Health status of the population 2) Promotion and improvement of nutritional well-being of the refugees and surrounding host population and 3) Facilitation of access to optimal reproductive health services including HIV/AIDS and SGB prevention and response to refugees and surrounding community.

The transfer of 40,000 South Kordofan refugees from Yida to Ajoung Thok stretched the health care services AHA provides in Ajoung Thok. The refugee population grew to almost 32,000 by end-2015. The service infrastructures originally planned for 20,000 refugees as per standard had to be revised to ensure that the facilities were able to cope with the anticipated population increment to 40,000.

HEALTH CARE AND NUTRITION

Chidren under 5yrs were screened during Mass MUAC screening in the camp, 20 children with malnutrition and complication were provided with treatment at the stabilization center. At the community level, 280 children with severe acute malnutrition have been provided with outpatient therapeutic care/program (OTP) and 1,334 children with moderate malnutrition were enrolled into targeted supplementary feeding program (TSFP). 8,568 children under 2yrs and 4,313 pregnant and lactating women were provided fortified enriched blended food supplements through blanket supplementary feeding program.





Mother support groups were formed to educate and promote key infant and young child feeding messages and practices to mothers, especially on breastfeeding. Infant and Young Child feeding programme that target caregivers of children 0-23 months was established. 960 pregnant and lactating women were educated on key messages regarding importance of breastfeeding during the postnatal clinic. 832 mothers were supported to breast feed their neonates within an hour after delivery. 6,066 children under 5 years were dewormed, 1,840 children of age between 6-11months and 7,520 children of age 12- 59 months were issued with Vitamin A supplement. All nutrition activities are monitored on a weekly basis; monitoring enrolment trends of beneficiaries to the OTP and TSFP programs. 530 children who had dropped out from the EPI program were reached and vaccinated.

REPRODUCTIVE HEALTH

The coverage of syphilis screening was 67% and complete antenatal care was 68%. Skilled health workers attended 97 % of 964 deliveries. 51 mothers were referred for obstetrical emergencies. 977 pregnant women were tested for syphilis and 6.3 % were diagnosed positive 23 cases of abortions were provided with Post Abortion Care (PAC) services. 454 new users of family planning were enrolled. 26 cases of rape were received of which 19 cases (73 %) were treated within 72 hours. UNFPA provided 600 dignity kits, which were distributed, to vulnerable women and girls of childbearing age in all the Payams of Pariang County.

HIV/AIDS

AHA also introduced TB and HIV/AIDS services and PMTCT program in 2015 in collaboration with the MOH and UNHCR. An assessment on TB services was conducted and AHA medical staff was trained on PMTCT, HIV care and management. TB diagnosis and referrals have also been strengthened. A TB/HIV officer has been recruited and trained on TB management. Counseling on HIV and carrying out of tests of pregnant women who come for their 1st ante natal care visit has been introduced, and those found positive were put on ARVS treatment. Community heath promoters were given intensive 3 days training that covered prevention and on site attendance of malaria, diarrhea and respiratory tract infection.

CAPACITY DEVELOPMENT

Capacity building training for AHA staff covered management of meningitis and an emergency epidemic response plan, management of severe malaria, waste management and infection control mechanisms, VCT/ PMTCT and TB management was implemented through on job training by the AHA senior medical team.

In Merowe and Napata schools, 13 health education sessions were held and 1,930 students were reached out during the sessions. AHA trained 30 local jurors on GBV concepts and case management. The training focused on access to justice for survivors of GBV and handling of cases with a survivor-centered approach. eight theatre groups were also formed and trained on GBV Prevention and response. Songs, drama and 16 days of activism were used to pass messages against GBV during awareness sessions.

AHA identified and registered 429 persons with specific needs in Pariang County in 2015. Technical support was given to the beneficiaries by training them practically on seedbed preparation, transplanting and care for the vegetables, harvesting preservation (sun drying) as well as storage through the help of the members who were trained in the kitchen. The vegetable seeds and fishing kits greatly improved the living conditions of the beneficiaries (around 50) as the were able to supplement their diet and gain income by selling vegetables and fish.

PUBLIC ADVOCACY

In 2015, AHA also joined other partners in the celebration of International Women's Day, World Refugee Day, International Breastfeeding Day and World AIDS Day. This facilitated interaction, experiences sharing and raising of community awareness.

To mark 16 days of activism against GBV, AHA conducted awareness sessions following the 2015 theme "From Peace in the Home to Peace in the world: Make education safe for all".

AHA SUDAN

AHA has been working in Sudan since 2000 and has been the only continental African NGO to work in Darfur. Programs provided include relief and recovery protection, emergency general food distribution, improving quality and quantity of potable water, improving agricultural productivity/livelihood, and emergency livestock asset protection

POPULATION OF CONCERN

The complex humanitarian crisis in North Darfur in the last 12 years continued to disrupt livelihoods in the affected areas, as large-scale of IDPs and the poorest segments of the population remain essentially dependent on multifaceted charitable service to meet daily requirements both in basic human needs and psycho-social support.

In partnership with WFP and UNHCR, AHA has been offering humanitarian services including permanent general food distribution and sporadic seasonal support food distribution to host communities.

	GFD Area (IDPs Camp)	Distribution in MTs		Remarks	
		Achiev't	Plan	Achiev't	
Jan –	Shangal Tobay	18918	340.5	304.38	GFD
	Shadad	9709	174.76	153.53	GFD
	Korma	14114	254.05	194.85	EFD
	El Fasher Rural	7228	0	58.55	EFD
	Shangal Tobay	18918	340.5	306.45	GFD
	Shadad	9709	174.76	157.3	GFD
	Shangl new arrivals	700	0	12.05	EFD
	Korma	14114	254.05	246.7	EFD
Apr–2015	Shangal Tobay	18918	0	89.1	GFD
	Shadad	9709	0	43.37	GFD
	Shangl new arrivals	700	0	21.53	EFD
	Korma	14114	0	19.07	EFD
May- 2015	Shangal Tobay	18918	340.50	306	GFD
	Shadad	9709	174.76	157.75	GFD
	Korma	12517	254.05	202.8	GFD
	Kafot	3070	44	44	FFA
Ju	Shangal new arrivals	2195	0	37.6	GFD
	Kafot	3070	48	48	FFA
July -2015	Shangal Tobay	18918	340.50	306.45	GFD
	Shadad	9709	174.76	157.3	GFD
	Korma	12517	225.3	202.8	GFD
	DDR	3502	0	94.8	DDR
Sept-2015	Shangal Tobay	18918	340.50	340.50	EFD
	Shadad	9709	174.76	174.76	GFD
	Shangl new arrivals	2195	0	23.75	EFD
	Korma	12517	225.3	225.3	GFD
Nov-Dec15	Shangal Tobay	18918	340.50	340.50	GFD
	Shadad	9709	174.76	174.76	GFD
	Shangl new arrivals	2791	0	50.3	EFD
	Korma	14114	225.3	225.3	GFD
Total			**4529.85**	**4627.55**	**97.7**

AHA North Darfur, GFD and EFD to IDPs in last 12 months January-December 2015

CAPACITY DEVELOPMENT

Food for Asset (FFA) project encompasses food for recovery scheme, which enables communities to create assets, provides skills training, support communities acquire knowledge to improve their own food security, livelihood, and ownership and create sustainable public assets.

The project also addresses promotion of income generating service from desert fruits such as Lemon, Guwaffa and Mango, prevention of climate change, environmental protection, consumption of fire wood conservation, etc.



AHA has been engaged in development schemes such as establishing fruit tree nurseries, provision of training for relevant community members and distribution of seedlings to the beneficiaries. The target beneficiaries in the project area were oriented about the entire handling and management of nursery, role of the community in the entire process so that volunteers were elected among the community members and have been involved in site selection for the nursery, collection of soil for the preferred soil for seedlings, and participation in other nursery activities (digging terrace /embankment for fencing water basin/ underground water tank/ storage for tools and seeds and preparation of the seedling beds and shelter).

Two reception centers at Shangal Tobay & Korma were established. Services including provision of community kits to emergency centers and support persons were provided in the centers.

RELIEF AND RECOVERY

During the first half of 2015, General Food (GFD) and Emergency food distribution (EFD) to the aforementioned IDPs camps and DDR sites was carried out as usual. To this effect, 2292.0 MTs of food was distributed to 51979 beneficiaries; in three IDPs camps and Elfasher Rural.

Around 44MT of food was distributed to 3072 beneficiaries in Kafot areas and the second package of 48MT was recently dispatched to the location for distribution while the disarmament, demobilization and re-integration (DDR) program of militias will be included in the second half of the year report.

AHA UGANDA

AHA began operations in Uganda in 1995 and operates a wide range of healthcare services to refugee and host communities first in the Adjumani District and then in 2010 extending to the Nakivale refugee settlement and in 2012 to Kyaka II and Rwamwanja refugee camps in Kyegegwa and Kamwenge districts.

POPULATION OF CONCERN

AHA provides accessible and integrated health services within 33 settlements and a transit camp in the Adjumani District.

OPERATIONAL CONTEXT

AHA currently operates 19 Health Centers in the region, each providing communities with access to essential medical services including: consultation and treatment, drug provision, laboratory testing, emergency response, reproductive healthcare, family planning, nutrition and therapeutic feeding and immunisation. The most common illnesses treated are malaria, respiratory tract infections, intestinal worms, wounds/traumas, skin and eye infections, and diarrhoea.



HEALTHCARE

AHA has been delivering health and nutrition as well as SGBV prevention and mitigation services to a large number of refugees from DRC settled in Kyaka II, and Rwamwanja Settlements. In the health sector, the main thrust of AHA's operations was focusing on preventive health services while attending to incidences of morbidity through provision of curative services using Grade 3 and Grade 2 health centers as its service delivery points.

The scope of health services provided includes: extensive health education through static and outreach posts, EPI, ANC and safe motherhood services, reproductive health, OPD and laboratory services, ART clinic and HIV /AIDS services including counseling and PEP, IPD admissions, referral services, and nutrition services including supplementary feeding programmes and food basket monitoring.

A mental health clinic also operated daily and the mental health nurses conducted home visits to selected cases: the visiting psychiatric specialist operated a mental clinic for four days every month and there was also visiting dental and eye specialist clinics for 3 days every month.

HIV/AIDS

HIV/AIDS remains a public health concern in Kyaka II – although the HIV prevalence in Kyaka II is not known, it is estimated to be lower than the national one of 7.2%.

AHA implemented a comprehensive HIV care program in Kyaka II and Rwamwanja refugee settlements. In addtion to this, AHA acquired HIV test kits & voluntary counseling and testing were conducted at static and outreach sites. AHA ran an ART clinic in the health centre in Rwamwanja serving both Refugees and Nationals.

CAPACITY DEVELOPMENT

Construction was completed for Bujubuli HC.III in the form of a kitchen, antenatal shade & Mukondo HC.II OPD shade. Accommodation housing for staff at Bujubuli H.C.III and Mukondo HC.II was also completed, construction for a four stance bathing shelter for the IPD was started. AHA also conducted training in camps for GBV prevention with funds received from the US government.







SEXUAL AND GENDER BASED VIOLENCE

AHA provided clinical management of rape through training and provision of medicine. Rape survivors were managed at the maternity ward, which is the SGBV focal site where they were counseled, examined & treated.

Necessary laboratory tests were also carried out (e.g. HCG, HIV, and RPR); ECP, PEP, STI drugs were acquired for the purpose. Condoms were distributed to the communities, through health centres, condom dispensers in the community, bars, shops & CHWs/VHTs.

PUBLIC ADVOCACY

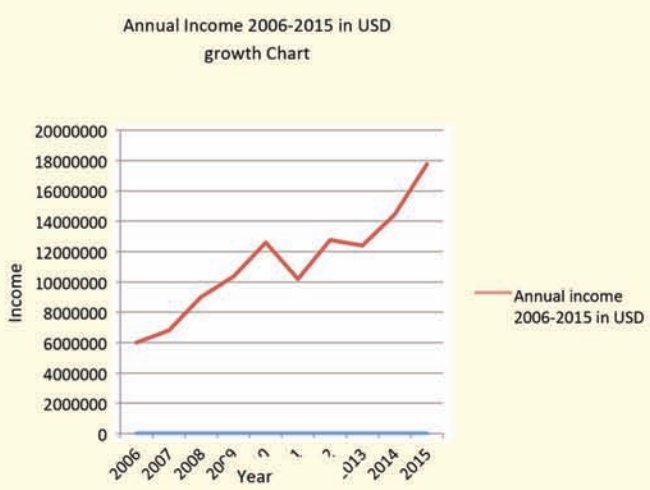
Nutrition health education, growth monitoring and promotion were conducted at static and outreach sites. New mothers were educated about feeding options.

Community screening for malnutrition and management of acute malnutrition cases in the community was conducted. HIV positive mothers and HIV exposed infants were also identified and necessary booster food were procured for them.


UNHCR
Africa
Humanita
Action

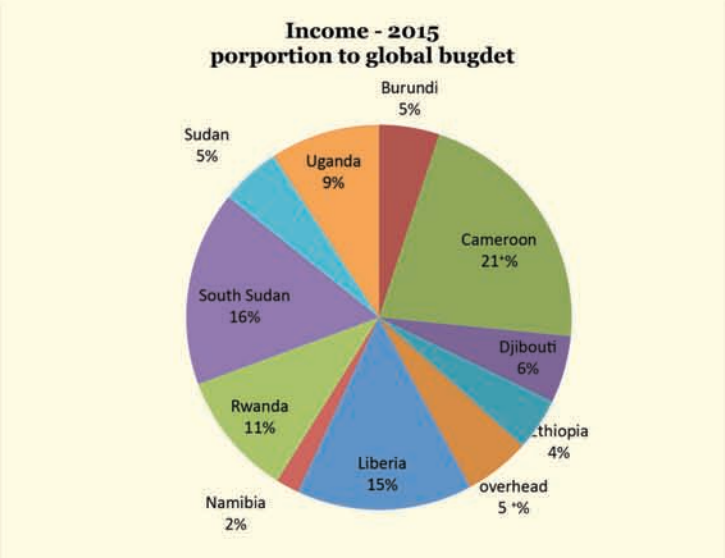
Funding and Finances

year	*Annual income 2006-2015 in USD*
2006	5,995,986.00
2007	6,798,846.00
2008	9,006,981.00
2009	10,364,921.00
2010	12,585,519.00
2011	10,184,491.00
2012	12,774,818.00
2013	12,380,479.00
2014	14,419,184.00
2015	17,263,882.00



Income & Expenditure statement -2015 in (USD)

	country	Income	Expenditure
1	Burundi	1,074,599.00	1,071,017.00
2	Cameroon	3,439,038.92	3,205,579.18
3	Djibouti	1,152,037.00	1,148,544.00
4	Ethiopia	988,044.72	953,287.50
5	External offices Geneva	521,632.51	512,843.66
6	Head office Addis Ababa	209,377.93	180,469.97
7	Liberia	2,475,587.58	2,475,587.58
8	Namibia	624,257.44	620,309.50
9	Rwanda	1,857,470.00	1,857,469.00
10	South Sudan	2,697,280.00	2,549,074.00
11	Sudan	1,079,375.00	1,079,375.00
12	Uganda	1,666,814.00	1,613,275.00
	Total	**17,785,514.10**	**17,266,831.39**



Auditor's Reports-sample



KPMG

Independent Auditors' Report

UNHCR representation South Sudan
Ministries Road, Hulak Area
Juba, South Sudan

Country Representative
AHA South Sudan County Office
Thow/Ping, Hai Juba-suburi
Juba, South Sudan .

Audited Project: Comprehensive Primary Healthcare and Nutrition Services in Ajoung Thok
Period covered by the audited Project Financial Report (PFR) statement: From 1 January to 31 December 2015 (up to end of liquidation period to 31 January 2016)
Project Partnership Agreement Symbol to identify the PFR:
UNHCR/SHO01/2015/PiLlar 1/A0000001371000
Name of the Partner: Africa Humanitarian Action, Ethiopia (AHA)
Partner Code: 1073021
Location: Juba, South Sudan

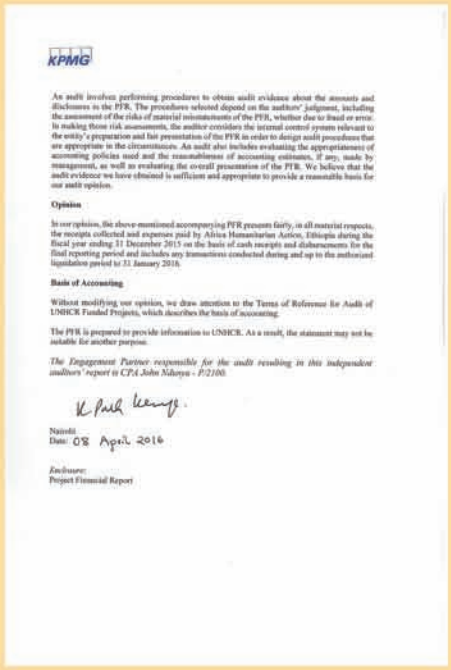
We have audited the above-mentioned accompanying PFR submitted by Africa Humanitarian Action, Ethiopia reflecting cash receipts and disbursements for the above-mentioned Project Partnership Agreement relating to the reporting period from 1 January 2015 to 31 December 2015 including the liquidation period up to 31 January 2016. The project financial report statement has been prepared on the basis of cash receipts and disbursements and includes eligible costs transactions during the liquidation period up to 31 January 2016.

Management's Responsibility for the Project Financial Statement

Management of Africa Humanitarian Action, Ethiopia is responsible for the preparation and fair presentation of the PFR in accordance with the cash receipts and disbursement basis of accounting. This includes determining that the cash receipts and disbursements basis of accounting is an acceptable basis for the preparation of the PFR in the circumstances, and for such internal control as management determine is necessary to enable the preparation of the PFR that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those Standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurances about whether the financial statement is free of material misstatement.



KPMG

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the PFR. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatements of the PFR, whether due to fraud or error. In making those risk assessments, the auditor considers the internal control system relevant to the entity's preparation and fair presentation of the PFR in order to design audit procedures that are appropriate in the circumstances. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates, if any, made by management, as well as evaluating the overall presentation of the PFR. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a reasonable basis for our audit opinion.

Opinion

In our opinion, the above-mentioned accompanying PFR presents fairly, in all material respects, the receipts collected and expenses paid by Africa Humanitarian Action, Ethiopia during the fiscal year ending 31 December 2015 on the basis of cash receipts and disbursements for the final reporting period and includes any transactions conducted during and up to the authorized liquidation period to 31 January 2016.

Basis of Accounting

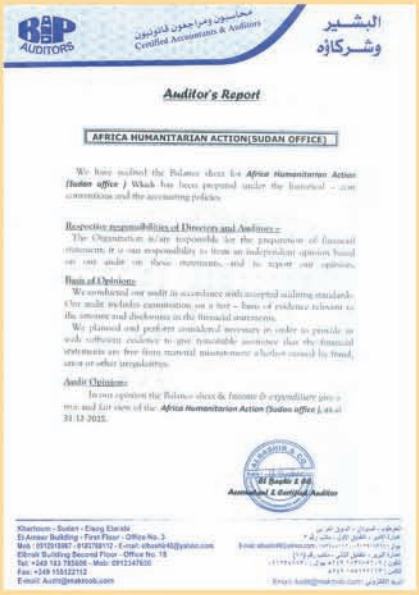
Without modifying our opinion, we draw attention to the Terms of Reference for Audit of UNHCR Funded Projects, which describes the basis of accounting.

The PFR is prepared to provide information to UNHCR. As a result, the statement may not be suitable for another purpose.

The Engagement Partner responsible for the audit resulting in this independent auditors' report is CPA John Nduya - P/2100.

Nairobi
Date: 08 April 2016

Enclosure:
Project Financial Report



BDP AUDITORS
محاسبون ومراجعون قانونيون
Certified Accountants & Auditors
البشير وشركاؤه

Auditor's Report

AFRICA HUMANITARIAN ACTION(SUDAN OFFICE)

We have audited the Balance sheet for ***Africa Humanitarian Action (Sudan office)*** Which has been prepared under the historical – cost convention and the accounting policies

Respective responsibilities of Directors and Auditors :-
The Organization is/are responsible for the preparation of financial statements, it is our responsibility to form an independent opinion based on our audit on these statements, and to report our opinion.

Basis of Opinions:
We conducted our audit in accordance with accepted auditing standards. Our audit includes examination on a test – basis of evidence relevant to the amounts and disclosures in the financial statements.
We planned and performed considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement whether caused by fraud, error or other irregularities.

Audit Opinions:
In our opinion the Balance sheet & Income & expenditure give a true and fair view of the ***Africa Humanitarian Action (Sudan office)*** as at 31.12.2015.

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Independent auditor's report

To UNHCR IPMS, Geneva

Name of the Country Operation: Namibia

For the period 1 January 2015 to 31 December 2015

Africa Humanitarian Action, Ethiopia

Report on the Project Financial Report

We have audited the accompanying Project Financial Report statement for the above-mentioned project provided by Africa Humanitarian Action, Ethiopia, which comprises cash receipts and disbursements as well as instalment payments between the contractual parties for the agreements as at 31 December 2015, including the liquidation period. The Project Financial Report statement have been prepared by management of Africa Humanitarian Action, Ethiopia, in accordance with the Signette Project Agreement dated 09 February 2015 and Annex 1 (hereafter common referred to as "the Project Agreement").

Management's responsibility for the Project Financial Report statement

Management is responsible for the preparation of these Project Financial Report statements in accordance with the Project Agreement and for such internal control as management determines is necessary to enable the preparation of Project Financial Report statements that are free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on these Project Financial Report statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the Project Financial Report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the Project Financial Report statement. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the Project Financial Report statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the Project Financial Report statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of cost accounting principles used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the Project Financial Report statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion the Project Financial Report statement for the above-mentioned project provided by Africa Humanitarian Action, Ethiopia, for the year ended 31 December 2015, including any transactions conducted during the liquidation period up to 31 January 2016, is properly prepared with the receipts and expenses paid, in all material respects, in accordance with the Project Agreement.

PricewaterhouseCoopers
Registered Accountants and Auditors
Chartered Accountants (Namibia)

Per: Carl van der Merwe
Partner

Windhoek, 27 April 2016

Purpose:

Copy of the signed Project Financial Africa Humanitarian Action, Ethiopia, for the period 1 January 2015 to 31 December 2015.

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TAKE ACTION!
Please join us in helping refugees, the internally displaced and others in need of humanitarian assistance such as survivors of war and natural disasters, to start anew.

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