

Africa
Humanitarian
Action

1997 Annual Report

AHA - The Organization and its Mission

Africa Humanitarian Action is a private, non-profit, non-sectarian and non-governmental humanitarian organisation based in Addis Abeba, Ethiopia. Its corporate mission is to provide emergency relief and sustained development assistance to distressed communities affected by disasters and conflict. AHA approaches this task directly; it also tries to empower communities to cope with adversity.

AHA was established, in the aftermath of the cold war, by African professionals with a proven track record in disaster relief, recovery, and management. It is one of the first regional voluntary agencies which is African in conception, in spirit and in composition. It is dedicated to serving the continent as a whole.

Its main objectives are the following:

- To provide humanitarian relief and sustained development support to distressed communities in Africa
- To equip displaced people and refugees with the basic skill necessary to deal with disaster situations
- To develop indigenous capabilities in disaster prevention, preparedness, relief management and recovery
- To create and assist independent, non-profit, non-sectarian and non-governmental organisations in the countries of Africa that embrace its own ideals and objectives
- To research, develop and disseminate information and policies - involving governments, institutions, and local communities - that are aimed at reducing the scope and scale of conflict, and the preven tion and resolution of conflict
- To set up a database of readily available African professional resources for relief and sustainable development initiatives

AHA came into existence in the post cold war years, at a time when the priorities of its traditional partners in the west seemed suddenly to shift in favour of central and eastern Europe. Africa appeared poised to enter the 21st century overwhelmed by donor fatigue, deeply marginalised and even more vulnerable than it already was.

AHA's founders are convinced that the fundamental responsibility of alleviating the worsening crisis in Africa belongs to Africans. They need to grapple more with the effects of calamities. Africans should not only be seen working alongside their international partners in humanitarian work; they should also take the lead in coming to the assistance of their fellow Africans.

The debate about Africa's failures and who is to blame has gone on for far too long. That debate has bred a sense of dread, despair and inferiority in the minds of Africans. In every facet of human endeavour, in science and technology, in economics and finance, and in the humanities, the African psyche is burdened by a sense of defeat. AHA intends to show that Africans on their own are capable of achievement. Success here will in some small measure restore to Africans their self-esteem. The opportunity provided by AHA to Africans from diverse countries and cultures to work together in crisis situations will doubtless contribute to the peace, harmony, and unity we all crave for our continent.

Since its establishment, AHA has been able to attract the support of the United Nations system, the Organisation of African Unity, and a number of bilateral and multilateral funding sources for its varied humanitarian activities.

AHA operates out of its headquarters in Addis Abeba, Ethiopia. Its core group of professionals in refugee and health care, disaster control, long-term development management as well as conflict prevention and resolution is ready for deployment at a moment's notice.

AHA is headed by a Board of Directors that maps out policy. The president, whom the Board appoints, conceptualises, articulates, plans and executes that policy. The president is assisted by two Vice-Presidents who coordinate the implementation of programme activities and supervise projects.

An International Assembly of Trustees advises and supports AHA's Board of Directors.

Message from the President

Recurrent socio-economic crises facing Africa have contributed to the advent of indigenous humanitarian organizations. Recognizing the relevance of these organizations, the international community and donor agencies have been providing them with financial aid and moral encouragement. This has created an opportunity for African organizations to play an active and positive role and thereby raise the standards of the service they provide. The momentum of their success guaranteed the continued support of the international donor community.

However, in recent years, donors' financial support to Africa has been gradually declining. Subsequently, indigenous organizations are beginning to face constraint and uncertainty.

At present, most of them cannot sustain their programmes alone and lack the funds to manage the humanitarian and development processes they have started. Besides, while one witnesses a decline in the flow of external funding, declarations are still being made by the international community which displays an inclination to establish closer ties in view of consolidated actions and the enhancement of social and economic development in Africa. But, on the other hand, it is becoming discouraging that only a small fraction trickles down to national organizations and NGOs who most need the funding backup.

Needless to say, the future of Africa lies in the hands of Africans who should be able to create the indigenous capacity that would enable them to sustain their programmes. However, the few African NGOs who have taken such initiatives feel and see their actions being undermined. Therefore, all future attempts to replace foreign aid by indigenous sources should receive the support of the international community, in conformity with its policy to build up national capacities.

True, the problems of African organisations and NGOs will not be permanently solved by receiving financial assistance and/or other forms of aid. However, at their current level of development, most of them do need sufficient and dependable funding backup that will facilitate the accomplishment of goals envisioned in programmes. However, the achievement of these goals face huge obstacles, emanating from the world economic order.

International organizations and agencies such as the UNHCR, UNDP, UNICEF, WFP, WHO, the OAU, the European Union and other bilateral and individual donors need to increase and improve the financial support that will help indigenous organizations to promote better humanitarian services to the vulnerable and needy people of Africa.

Such agencies need to be attuned to the needs of African organizations which are culturally and socially closer to the people they are meant to serve. In the final analysis, such support will bring positive returns and is vital to the long term socio-economic adjustment of countries in crisis, eventually leading to a sustainable cycle of development in peace.

The message of this year's report is an appeal for international support to the fledgling indigenous NGO sector in Africa.

Dawit Zawde

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OVERVIEW

The present 1997 report on Africa Humanitarian Action's (AHA) activities in countries that are marred by war and political turmoil will attempt to capture the essential elements of what AHA has done in Angola, Uganda and Rwanda where it has been providing health assistance for the last 3-4 years and its recent moves to set up services in Burundi, Liberia and Sierra Leone. The report will give a broad picture of AHA's pattern of intervention while highlighting, in concrete and practical terms, the experience AHA has gained in the process.

AHA's involvement concentrates on health care development which varies in scope and focus as it is conditioned by circumstances of the specific country of intervention as well as the type of urgent health needs and the required immediate actions. Its role and presence in countries that have/are still experiencing internal armed conflicts and its sphere of activity that tend to embrace vulnerable people (refugees/returnees), internally displaced people (IDPs) and host communities make its intervention extremely meaningful. In collaboration and/or partnership with government institutions, bilateral and multilateral agencies and national and international non-governmental organizations, AHA has been participating in national emergency responses and reconstruction phases.

Carrying out activities in crisis situations, AHA operates within an overall strategy or programme framework with budgetary funds provided by various donors. AHA's three pronged strategy, which includes medical services, carrying out rehabilitation/construction work and assuming managerial responsibilities, give a new dimension to its humanitarian operation in the Great Lakes Region as well as in countries of conflict such as Angola, Liberia, and Sierra Leone.

AHA has exerted all its efforts to consolidate its achievements, building up its ability to develop a comprehensive and integrated response. AHA has also been linking its modest humanitarian actions with peace building efforts. It is within this context that AHA is now expanding its programme in other post conflict areas in the continent (Burundi, Liberia, and Sierra Leone).

AHA has, during the course of 1997, registered a number of major accomplishments in preventive/curative health care; nutrition; immunization; family planning and reproductive health; prevention of sexually transmitted diseases/STD and AIDS; water, sanitation and hygiene; health education/information; rehabilitation/reconstruction; shelter construction; human resources development, training/mentoring; mine awareness and global humanitarian policy advocacy.

All AHA's country offices carry out their activities within the framework of programmes defined in concert with local and central authorities whose combined efforts have established a set of strategic objectives specific to the reality of each country of intervention. In turn, each office has developed its own indicators to measure progress in achieving set objectives and to report on progress annually. To ensure the success of its activities, AHA has developed systems for monitoring, evaluation, and reporting on its functions and also for follow-up purposes and to keep track of the effectiveness of its programmes and the performance of its staff.

An important aspect of AHA's programming process is that it includes people in the development and design of programmes and projects. In fact, AHA works with and learns from communities, mutually strengthening each other's capacity to bring about a process of positive change of attitude and performance. The key to its effectiveness is the commitment of its professional staff.

Over the years, AHA had the good fortune to attract the support of international agencies (UNHCR, UNICEF, UNDP, etc.) the Organization of African Unity (OAU) and other bilateral and individual donors. In 1997, the total health assistance aid that AHA received has more than doubled since 1994 and its commitments have also been greater. However, the bulk of its funding comes from the UNHCR.

AHA's performance has made a tremendous impact in health care delivery. However, its current challenge, to sustain these achievements while diminishing financial resources and decreasing donor support, is becoming a

harsh reality, thus limiting AHA's sphere of work, frustrating its efforts to cope with the mounting challenges in Africa.

AHA'S PROGRAMMES AND THEIR IMPACT

This report covers the countries and areas where AHA is concentrating its efforts. It also highlights the major areas of achievement which AHA can rightfully claim to have registered in bringing changes in people's livelihood. By improving access and quality of health services particularly in Angola, Rwanda and Uganda, AHA was able to contribute to the strengthening of health delivery systems and the improvement of services through training and technical assistance.

In promoting health development projects, AHA has been working within a framework of partnership and/or collaboration with donors and African Governments. In the process, AHA has involved itself in promoting government and public awareness, assisting countries in the development and implementation of multifaceted programme components. These are listed by country of intervention.

AHA's MAJOR ACCOMPLISHMENTS

Angola

The implementation of the Lusaka Protocol and the formation of the Government of National Unity and Reconciliation had greatly contributed to the emergence of a favourable geopolitical climate which paved the way for the increased involvement of the international community in the peace process. The UNHCR launched the repatriation of about 300,000 Angolan refugees and the settlement of a large number of internally displaced people/IDPs. As an implementing partner of the UNHCR in Angola since 1995, AHA addressed health care needs of the voluntarily repatriated and IDPs, particularly in the municipal districts of Lumballa N'guimbo and Cazombo in Moxico province.

The 1997 project was essentially a consolidated continuation of the health programmes that had been carried out during the course of 1996 in the two municipal areas of Cazombo and Lumballa N'guimbo. In conformity with the tripartite agreement AHA signed with the Government of the Republic of Angola and the UNHCR, focus was given to the enhancement of ongoing health activities in affected communities, to carry out the rehabilitation/reconstruction of health infrastructures and capacity building activities in both districts. Health care services included preventive/curative health care, general education/information and sanitation.

The voluntarily repatriated community (more than 100,000 people) and a sizeable number of displaced people resettling in the surrounding areas where the district hospitals are located benefited from the project. More than 56,000 patients have received medical care in both district hospitals. As women and children constitute the majority of the beneficiaries, the mother and child care / MCH service and family planning programmes constituted an important part of the services. About 4,000 mothers have attended MCH programmes. As a direct consequence, the number of pre-natal follow-ups grew from 2,493 to 4,451 women.

With hospitals being equipped with laboratory and surgical equipment, it was possible to carry out adequate examination and surgical interventions. However, due to logistics and security constraints, the supply and distribution of drugs was not as successful as it should have been. The rehabilitation work of health infrastructures in Lumballa N'guimbo and the Cazombo hospital was finalised and, in November 1997, the municipal hospital in Lumballa N'guimbo was handed-over to concerned authorities. In addition, national health workers in health units in both municipal areas have benefited from in-service training and capacity building programmes; this has guaranteed the sustainability of projects while ensuring the smooth take-over of projects.

The first half of the year was characterized by the successful implementation of programmes and the commendation of the UNHCR for AHA's successful achievements. Indeed, health services had reached large number of beneficiaries and rehabilitation activities had greatly advanced. In addition, as part of its preventative health service, AHA has, in the course of the year, provided Cazombo Town with distribution points of clean potable water, thus giving residents easy access to water, for the first time in decades.

The year was marked by a fall in the budget allocated by the UNHCR for 1997 and AHA's programme activity

had to be revised correspondingly. Furthermore, AHA's health personnel had to be evacuated repeatedly from their post in Lumballa for security reasons. In addition, protracted clearing formalities and prohibitive in-country logistics inhibited the smooth implementation of programmes.

By the end of 1997, under the new distribution of NGOs' programmes following a defined geographic coverage, AHA was to manage in 1998, health care services in the municipality of Alto Zambese giving particular attention to primary health care, immunization, mother and child health/MCH, nutrition, health education/information, outreach services in village health posts and capacity building programmes. While there has been mixed progress in the Angolan peace process, the chronic distrust between the two opposing parties is still causing strained local situations which are interfering with the implementation of planned activities.

BURUNDJ

Following the 1993 October crisis that engulfed Burundi, about 700,000 people became refugees, displaced/dispersed and "regrouped" people*. Moreover the economic sanctions imposed in 1996 by regional states affected the economic and social sectors, and particularly the health sector.

It is under such circumstances that AHA, as of November 1996, undertook successive preparatory missions aimed at assessing needs, thus laying the ground for emergency preparedness and health assistance programmes in Burundi. On the basis of dialogues with the Ministry of Foreign Affairs and Cooperation and the Ministry of Health as well as the UNHCR, UNICEF, OAU and ECHO, the province of Bururi was finally identified as AHA's area of intervention.

A bilateral agreement of cooperation was signed in October 1997 between the Government of Burundi and Africa Humanitarian Action. In accordance with this agreement which confers a general framework for intervention, AHA was to provide adequate health care services, carry out rehabilitation/construction activities and assume managerial responsibilities.

AHA has designed a project for reinforcing health care services in Bururi, aiming to cover the health needs of the population of the province (about 420,000) and more than 40,000 displaced/dispersed and regrouped people in 17 camps. The project was submitted to potential donors. AHA has received the approval of the authorities in Bururi. At present, AHA (the first medical oriented NGO to provide medical assistance in the area) is working on a second project, the mitigation/prevention of malaria in the most affected province of Bubanza. However, aid cutbacks at the end of 1997 and the still effective economic sanctions are making it difficult for AHA to obtain the required financial support.

* These latter represent the population that had to leave their homes and communities and were regrouped as per the government's efforts to ensure their security.

ETHJOPJA

To promote family planning and welfare services in Ethiopia and make them available and accessible to the urban and rural people in the woredas (districts) of Shashemene in the Oromia Regional State and Gofa in the Southern Nations, Nationalities and People's Regional State, AHA has submitted a proposal emphasising community sensitization programmes. These will be undertaken parallel to the training of family promoters and the promotion of community-based distribution programmes (CBD), the formation and strengthening of anti-AIDS and environmental youth clubs, women's groups and family life/population education in schools.

The programmes in both regions will address the problems of sexually transmitted diseases/STD and HIV/AIDS through information/education sessions coupled with the distribution of condoms and contraceptives. Moreover, the projects will assist in building up the capacity of the regional offices of the Ministry of Health (MOH) and the clinics/health centres and/or hospitals located in project areas.

Both projects will concentrate on a target population of about 13,000 people aged 15 years and above. On the basis of the needs assessment undertaken on a region-by-region basis, cultural practices and problems related to family planning and their implications will be given due consideration.

AHA will carry out its activities jointly with indigenous NGOs such as LEM, the Environment and Development Society of Ethiopia, and other national and international NGOs already established in both areas. AHA was able to establish direct contact with concerned local authorities, gather background information in terms of people's age, sex, marital status, education and identify the extent of the problems and needs.

LJBERJA

As the result of the 1996 Abuja Agreement, the civil war that has been raging for the last seven years finally came to an end. Following which, in March 1997 AHA took the initiative to launch its humanitarian activities in the country. A preliminary survey was then carried out, followed by an assessment mission in April of the same year.

AHA - in consultation with relevant Government institutions and international agencies - has developed two projects that will be implemented in Maryland County.

These projects plan to cover the needs of 70,000 people and cater for 80,000 Sierra Leonian refugees and host communities in Upper Lofa County. Both projects are to be implemented in 1998.

In March 1997, AHA was accredited by the Government of Liberia, allowing it to operate as an international NGO for a period of one year. In this context the OAU has agreed to support AHA's efforts in both Liberia and Sierra Leone. Upon the signing of a partnership agreement between the OAU and AHA, this latter will carry out the rehabilitation work on damaged health infrastructures and purchase specified medical equipment.

Once it starts its operations on the areas already identified, it will also serve as a base for the activities to be carried out in Sierra Leone in 1998.

RWANDA

During 1997, AHA has continued ongoing activities and provided technical and material support for services in the health districts of Mugonero including the Kiziba Camp for Congolese refugees (Kibuye Prefecture), Rwinkwavu (Kibungo Prefecture) and Muhororo (Gisenyi Prefecture).

Four years after the genocide, Rwanda is still going through a period of unrest. The complex developments that followed the tragic events of 1994 are still affecting the whole population. Tension is focused particularly in the regions of Kibuye and Gisenyi where AHA is working under adverse conditions that tax its humanitarian work.

In the last four years, in spite of all the pressures resulting from fluctuating economic conditions and recurrent conflicts, AHA has continued to adopt a strategy that enabled it to promote health, social and economic awareness. This process of community based development which had a broader influence was instrumental in helping AHA improve the health of affected populations (about 600,000 people), and mobilize the commitment of communities and their leaders to use better methods for preventing diseases, alleviating unavoidable diseases and disability, and sustaining resulting gains.

In fact, in spite of the insecurity engendered by the sporadic actions of insurgents, activities in the four health districts continued as usual. More than once, AHA's staff had to be evacuated; at other times, only a reduced number of staff were assigned to carry out health services at field levels. In spite of the risks involved, AHA's national and international staff remained behind when others evacuated, assisting affected people in Gisenyi and Kibuye as well as the casualties of periodic skirmishes.

AHA's capacity and capability to promote participatory development programmes instigated the confidence and trust of government institutions and funding agencies who readily supported its intervention in Rwanda. Accordingly, AHA could crystalize a number of programmes targeting refugees/returnees and IDPs and give its activities wider geographical coverage.

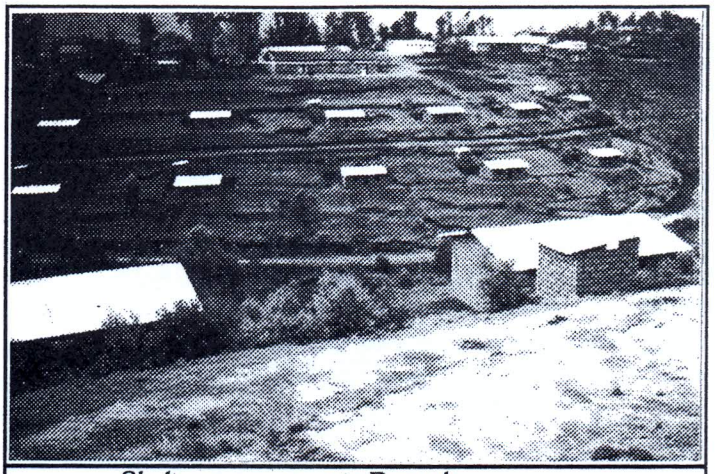
Overall health programmes continued to focus on general health services and, during the course of the year, about 115,000 patients were treated and/or hospitalized. Other health components of AHA's multisectoral health programmes included maternal and child health treatment (about 12,000 women were provided with the required treatment in gynecology and obstetrics); family planning; provision of appropriate vaccination (about 32,400 children were vaccinated against childhood diseases) and treatment of various acute and chronic illnesses. As an integral part of AHA's health management programme, the fully equipped laboratory and surgical sections have resumed their long interrupted service and were active particularly as regards the increasing number of casualties.

Throughout 1997, AHA was able to improve the physical condition of health facilities and restore essential services for refugees/returnees, IDPs and host communities living in the three districts. AHA has fostered local participation in the actual restoration work of the health units. In addition, it was responsible for the rehabilitation/reconstruction of damaged health infrastructures.

The rehabilitation/reconstruction activity included the restoration of destroyed infrastructures, septic tanks, expansion of kitchen facilities for nutrition programmmes, electric lines, water pipes, the installation of reservoirs and the construction of additional sanitary installations (latrines and wash slabs, waste disposal pits).

Aware that such a programme is key to moving beyond humanitarian assistance and towards more sustainable reconstruction, AHA has been involved in shelter/house construction activities, an appropriate response to the reintegration of uprooted populations. In line with this, it exerted all its efforts to resettle these populations, particularly addressing the needs of old case loads and IDPs while reinforcing the capacity of host communities to reintegrate the new comers. This enabled AHA to promote on-the-job training in mud-brick making and build-

ing houses, thus providing employment opportunities for a large number of community members and encouraging the development of income generating schemes. AHA's involvement in this activity has helped people regain their social stability and a normal and peaceful life.



Shelter programme in Rwanda

In North West Rwanda, AHA has been building houses for 360 households of old case loads. By the end of 1997, out of the 360 planned houses, AHA has completed the construction of 210 houses which were handed over to beneficiaries in Musasa, Rushashi, and Tare communes. Work is still in progress in Tare to complete the remaining 40 houses. The construction of the latrines attached to each house unit in Musasa (150), Rushashi (40) and Tare (20) was also completed. Most of the houses were plastered by the beneficiaries themselves who also organized their own individual gardens.

The construction activities fostered local participation, linking resettlement with development, peace and stability. Beneficiaries, people from host communities and local authorities were engaged - alongside AHA - in building houses and access roads with drainage canals (Musasa, Rushashi), enabling AHA to stimulate the self-help potential of target populations.

AHA's construction staff worked under duress, facing great risks. The constraints were man-made (delay in site selection, identification and mobilization of beneficiaries as well as the extremely dangerous condition of the roads and logistics problems) and natural (mainly heavy rains which damaged and/or slowed down the drying process of the mud-bricks).

Once the rehabilitation work was completed, hospitals and health centers were reasonably well-equipped with good theatre and laboratory services which functioned round the clock. Bedding was provided for in-patients. Referral cases were transferred by AHA, whenever necessary.

Throughout 1997, AHA ensured that health units' physical state remained satisfactory and that all equipment was in good working condition. It established its own control mechanisms that prompted immediate action to repair and/or replace as required.

AHA also contributed to the establishment of health district offices which were supplied with furniture, stationery and office equipment (computers, printers, photocopiers, electrical typewriters).

AHA's comprehensive approach to enhance people's capacity included more sustainable solutions, particularly as regards the lack of qualified personnel. Capacity building programmes were thus grafted to the already existing and functioning operation framework, taking into account the specific needs of the different districts. Training programmes emphasized staff's motivation and development. Subsequently, the improvement of people's capacity focused on the restoration of daily routines and the improvement of relationships and traditional/cultural ties between health units and community.

AHA's involvement in enhancing people's skills was two pronged: on the one hand it responded to the needs of the national staff working under its supervision and, on the other, opened up possibilities for community members. AHA provided the required technical support that covered, beside in-service training in the different sections, training programmes on immunization, reproductive health, nutrition, family planning, health service management, store management and drugs management. Efforts to involve the community in health projects was successful as they appreciated and responded to AHA's attempt to improve their environmental hygiene.

AHA's basic health efforts have yielded positive results, bringing changes in the health of beneficiaries, and effecting a significant difference in health care delivery, contributing to the overall strategy of the country to enhance its health sectors. However, AHA's work is presently being thwarted by aid cutbacks. Consequently, it is sharply reducing its plans while handing over project areas ahead of schedule.

SIERRA LEONE

Pursuant to AHA's prospective plan to forward its humanitarian services to Western Africa, an in-depth assessment was undertaken in Sierra Leone in March 1997.

Based on findings and consultations with UN agencies, particularly the UNDP, UNHCR, HACO, WHO and the Ministries of Health, Economic Planning and Relief and Rehabilitation and Reconstruction, a project addressing the health care and related needs of 30,000 returnees and of an equal number of internally displaced people in Kambia District was developed and submitted to potential donors.

Events in May 1997 forced AHA to abandon endeavors to finalize registration formalities and establish a Country Office in Freetown.

UGANDA

AHA's involvement in Uganda concentrates on providing primary health care which focuses on the provision of health and sanitation services. AHA's action coincided with the Government's efforts to assist Sudanese refugees settled in permanent camps in East Moyo, in Northern Uganda. However, in June 1997, on two separate occasions, the settlement areas of Adidi and the Mongula dispensary - the epicentre of AHA's operation in Moyo - became the target of attacks by insurgents who abducted about 20 refugees and local people including AHA's medical assistant. They also molested and terrorized half a dozen staff members and looted property.

Nonetheless, the insecurity in AHA's operational zone did not deter its national and international staff from rendering health care services to the refugee population as well as to the Ugandan nationals living in the vicinity. In order to maintain ongoing activities, a contingency plan was designed to organize staff's daily commuting to and from Adjumani and Mongula.

The year 1997 ended in much safer conditions and with a number of positive developments. With the extension of AHA's activities to new settlements at Maaji, AHA embarked upon the construction of one dispensary and two sub-dispensaries, mobilizing the participation and collaboration of beneficiaries and members of the host community. In addition, through health services' support as originally envisaged when the operation was launched in 1995, AHA has continued its efforts to facilitate the integration of the refugees into Ugandan society. Accordingly, in collaboration with the District Medical Officer (DMO), AHA has been trying to validate refugee health workers' testimonials. To activate this process, AHA and the DMO have jointly organized - with the Training Department in the Ministry of Health - a three-month training programme; upon completion, refugee health workers will be centrally registered in Uganda.

During the year, AHA's radius of activity widened to include the Maaji settlement located in a new sub-county in the west. Accordingly, the number of refugee beneficiaries of ongoing health and sanitation programmes grew from 18,369 in early 1997 to 30,485 by the end of the year. Morevoer, the number of Ugandan nationals, living in the catchment areas who also benefited from its health services, reached 20,763. Health care delivery points also evolved from 3 to 9, bringing health units within an easy reach of a 5 km radius.

By the end of the year, all but one of the 9 health points were converted into permanent health posts. With the addition of the in-patient wing and the opening of the laboratory service, Mongula and Ukusijoni dispensaries were promoted to health centres. A total of 107,446 refugees (3-4 consultations per refugee) were treated. About 30,253 Ugandan nationals were also provided with the required treatment. At times, the number of Ugandan nationals outnumbered refugees.

AHA's work in the different health posts has improved people's health. Following an analysis of the health response, birth rates of 38.8% have contributed a 4.1% increase to the annual population growth in settlement areas. According to mortality data, the death rate has decreased. During the whole year, only 113 deaths (0.37%) were registered. A total number of 16,561 children were vaccinated against childhood diseases, and AHA's staff actively participated in national campaigns against polio. Ante-natal care for expectant mothers were given particular focus since women in child bearing age (ages 18 - 45) constituted 49.3% of the total refugee population.

General health information was also provided. Continued medical education programmes were conducted as part of measures to develop health workers' capacity. Community health education sessions, sensitization and discussion were coupled with practical demonstration sessions. Through outreach programmes, communities were mobilized to dig waste disposal pits and pit latrines and build bath shelters. Most renovation and construction works were completed.

On the whole, most of the activities were carried out as per signed agreement. However, AHA's work was not devoid of obstacles as, during the period in review, the implementation of the Uganda programme was hampered by funding problems. The gap between the rising cost of drugs and the budget, and the responsibility of undertaking activities with limited facilities (transportation and communication equipment) are few of the factors that hindered AHA's work in Uganda.

Conclusion

This report has highlighted the fact that African organizations and AHA, in particular, have faced growing assistance needs at a time when funds were short.

Subsequently, in spite of its international experience in the medical field and its track record, AHA had difficulty in expanding its programmes (Rwanda, Angola, Burundi). However, during the course of 1997, AHA has been playing a major role in satisfying the health care needs of refugees, displaced/dispersed persons and communities at large in the Great Lakes Region and Southern Africa where it is actively involved in providing humanitarian relief and emergency assistance.Because community development can be instrumental in bringing sus-

tainable changes, AHA has concentrated on bringing people to adopt behavior patterns that match prevailing customs and traditions. Accordingly, AHA has exerted all its efforts to involve stakeholders in the planning and decision-making process regarding their own health and environment, increase their awareness of health issues and equip them with skills they could easily incorporate in their daily life.

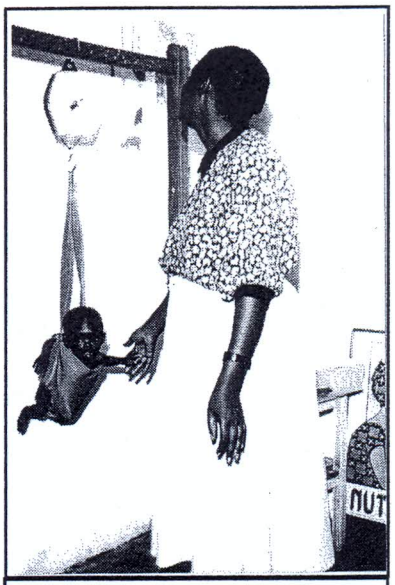
With the restoration of a general climate of peace and stability, AHA has largely contributed to national efforts to improve the health of an ever increasing flow of vulnerable and needy people. This was achieved through education centred on existing health problems and methods to prevent and control them; promotion of food supply and proper nutrition, adequate supply of safe water and sanitation; education in family planning; control of local diseases; treatment of common diseases in appropriate ways and the provision of essential drugs.

For obvious historic and economic reasons, AHA, like most sister organizations and NGOs in the continent, does not have the necessary resources to organize an adequate funding base for sustaining its programmes.

It is in this context that the international donor community must share the responsibility of promoting the health and socio-economic development of the socially underprivileged.

AHA believes that providing health care for people living under duress is of vital importance just as the involvement of the international donor community is crucial for guaranteeing the sustainability of efforts to empower people to extricate themselves from poverty, poor health and sanitation and disease.

Overall, AHA's basic health efforts are yielding positive results, though they are small in relation to the challenges. Having proven its efficiency and effectiveness for the last 4 years, AHA will - as of 1998 – embark upon the arduous path of creating an endowment fund to ensure its programmes a longer viability. However, AHA is aware that this will not be an easy task.



Nutrition programme in Uganda

AHA is most appreciative of the continued support of the UNHCR, which, for the last four years, has provided the bulk of its funding that has guaranteed the successful implementation of its programmes. The UNHCR has enabled AHA to ensure the success of its projects as well as their expansion in the Great Lakes Region and other Southern and Western African countries. In its endeavor to honor the PARINAC Agreement, the UNHCR has consistently offered AHA the resources needed to perpetuate its health activities in Rwanda, Angola and Uganda.

AHA will endeavor to further consolidate its relation with the UNHCR, while liaising with the international community as a whole. On the basis of the proven commitment of the UNHCR to enhance its capacity, AHA is convinced that, jointly with the other donor agencies, the UNHCR will – when the time is ripe – assist AHA in its struggle to build its own resource base. AHA is ready to enter into mutually supportive agreements that will engender joint actions while ensuring stronger partnerships.

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AHA Headquarters

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P.O. Box 6398
Addis Ababa, Ethiopia
Tel. 251-1-51-35-41
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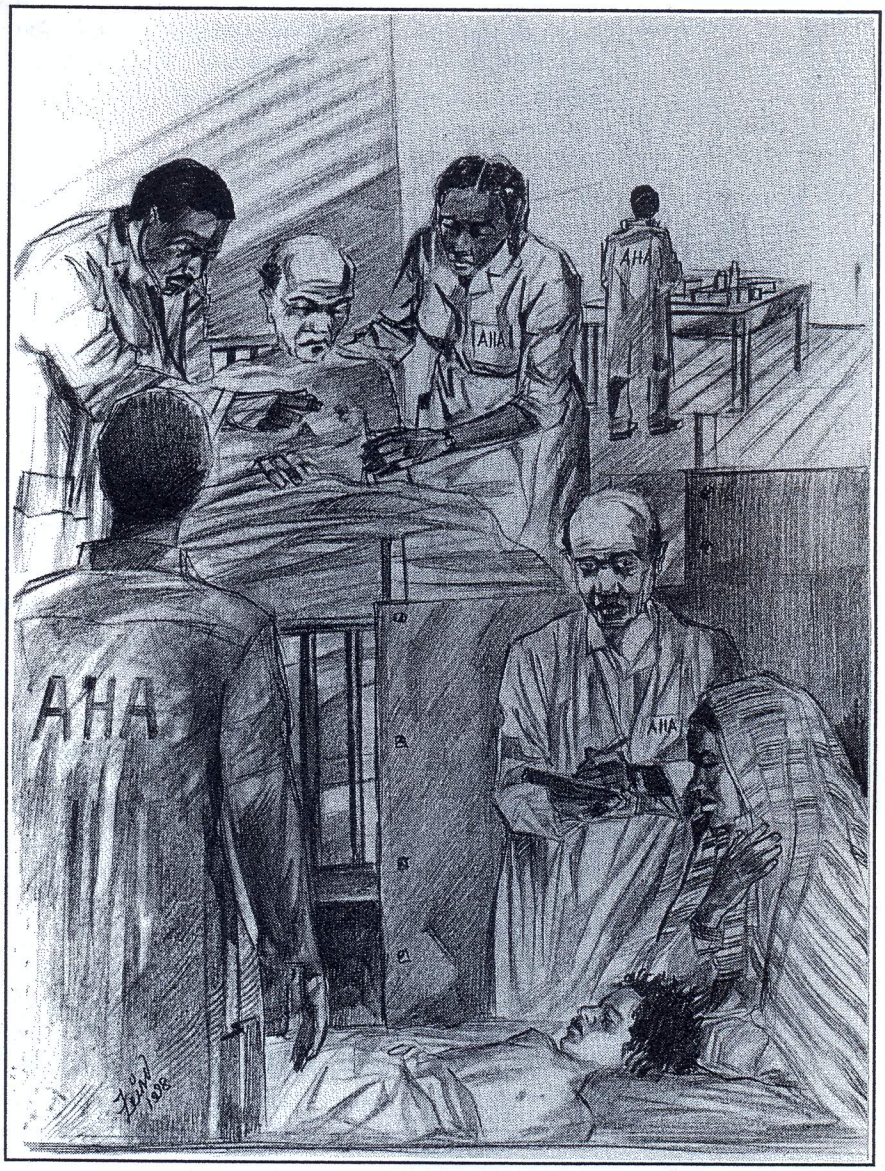
Antennae

Mr. Taffesse Belete
71, Rue de Lyon
1203 Geneva, Switzerland
Tel/Fax. 4122 344 1485

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B-1060 Brussels, Belgium
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Africa Humanitarian Action Statement of Income and Expenditure for the Year Ended 31 December, 1997 in USD

Income		
Head Quarter		
Excess cash from 1996	1,162.61	
Contributions		
Organisations	292,368.29	
Rwanda		
Contributions		
Organisations	1,854,810.00	
Uganda		
Contributions		
Organisations	722,175.00	
Angola		
Contributions		
Organisations	633,060.00	
Total		**3,503,575.90**
Expenditure		
Head Quarter		
Office furniture & equipment	9,114.92	
Office running cost	110,995.91	
Sierra Leone	63,559.96	
Liberia	39,037.33	
Burundi	70,822.78	
	293,530.90	
Rwanda		
Administration	168,956.00	
Health & nutrition, housing & Rehabilitation	1,659,504.00	
	1,828,460.00	
Uganda		
Administration	99,517.00	
Health / nutrition & Construction	622,658.00	
	722,175.00	
Angola		
Administrative	180,630.00	
Health/nutrition & rehabilitation	421,086.00	
Demining project	18,404.10	
	620,120.10	
Excess of Income over Expenditure		**3,465,286.00** **38,289.90**



AHA is a non profit, non governmental organisation dependent on institutional and individual support for its operations. If you would like to support AHA's activities, donations can be sent to P.O. Box 6398, Addis Ababa, Ethiopia or funds can be transferred directly to the following bank accounts:

c/o The Commercial Bank of Ethiopia
Addis Ababa
Africa Hall Branch
Account number C/A 3712-609-6470-4 (Birr)
or to
The International Banking Division
Account number C/A 6050092-2 (Foreign currency)