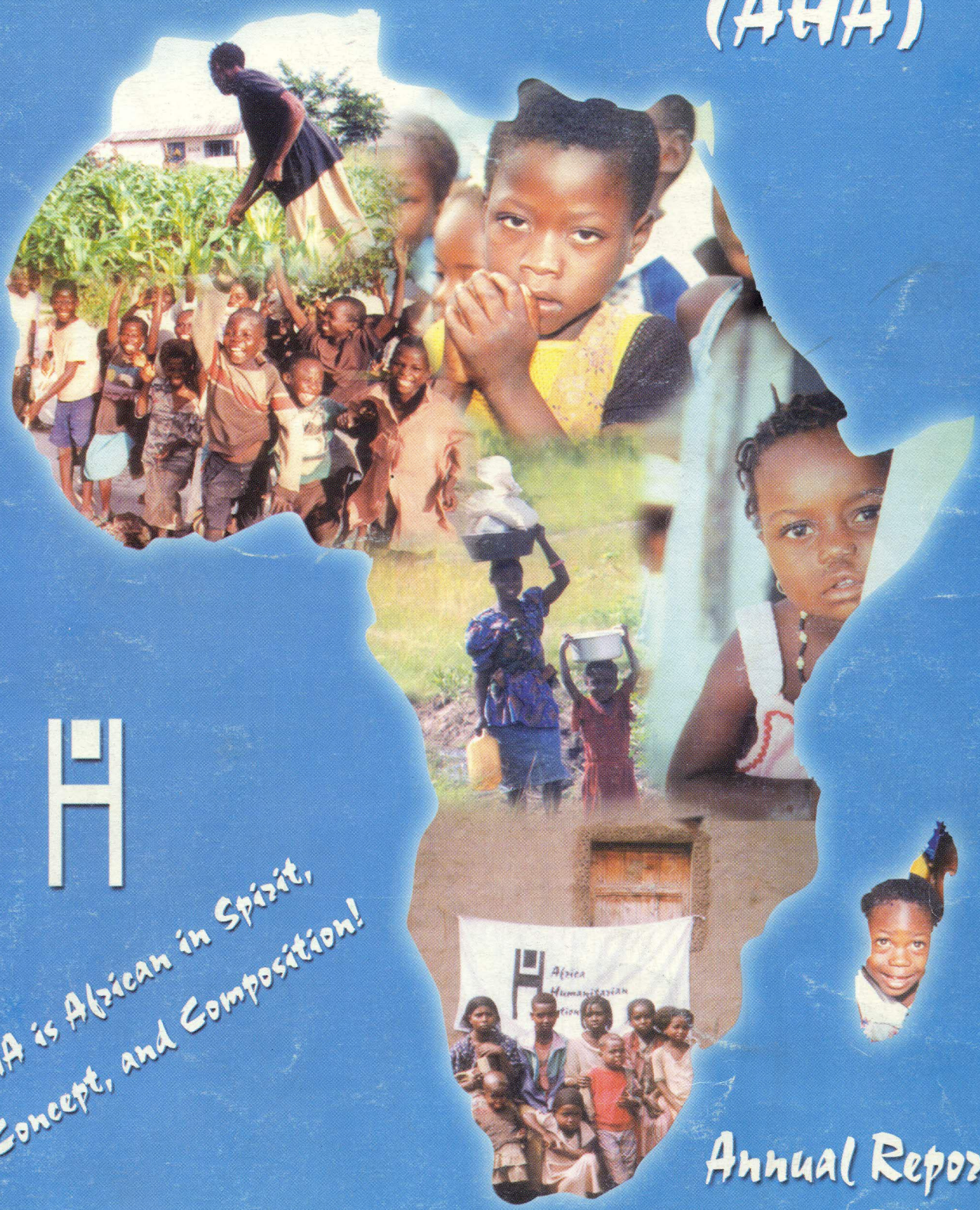
Africa Humanitarian Action (AHA)



AHA is African in Spirit, Concept, and Composition!

Annual Report 2000

Africa Humanitarian Action
Statement of Income and Expenditure
for the year Ended 31 December 2000

Income	US$	US$	US$
Head Quarters		118,124	
Angola		532,748	
Ethiopia		122,786	
Rwanda:-		818,596	
Uganda		565,089	
West Africa		100,000	
Zambia:		566,372	
			2,823,715
Expenditrue			
Headquarters			
Office Equipment	8,726		
Office running cost	90,426		
Geneva office support	16,060		
		115,212	
Angola			
Administration	74,585		
Health /sanitation	442,163		
		516,748	
Ethiopia			
Administration	16,222		
Reproductive Health	101,926		
		118,148	
Rwanda			
Administration	126,962		
Health & sanitation	695,585		
		822,547	
Uganda:			
Administration	93,782		
Health & Nutrition			
Sanitation	467,878		
		561,660	
West Africa			
Health		66,882	
Zambia			
Administration	86,762		
Health & sanitation	491,649		
		578,411	
Total			2,779,608
Excess of Income Over Expenditure			44,107

INSTITUTION BUILDING

AHA's new Institutional Development Strategy, formulated by the organisation's leadership and publicly released late in 2000, is available in a short document summarising the arguments for a new orientation.

"Strategy for Institutional Development 2001-03" explains why Africans need a home-grown organisation that is more than just an operating partner for international agencies, and spells out how much - or more exactly how little - this will cost.

A detailed implementation plan and budget is to be finalised in early 2001.

Watch our web-site.

SAMPLE AUDITOR'S REPORT RWANDA PROGRAMME

AUDITORS' REPORT TO THE BOARD OF DIRECTORS OF AFRICA HUMANITARIAN ACTION (AHA) RWANDA OPERATION

We have audited the financial statements on pages 1 to 4, which have been prepared in accordance with the accounting policies referred to on page 3 of the financial statements.

RESPECTIVE RESPONSIBILITIES OF DIRECTORS AND AUDITORS

AHA's Directors are responsible for the preparation of the financial statements. It is our responsibility to form an independent opinion, based on our audit, on those statements and to report our opinion to you.

BASIS OF OPINION

We conducted our audit in accordance with Generally Accepted Auditing Standards except that we did not conduct cash counts at 31 December 2000 or visit project sites in Rwanda.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statement.

We planned our audit so as to obtain all the information and explanations, except as indicated above, which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance as to whether the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements.

We believe our audit provides a reasonable basis for our opinion.

QUALIFIED OPINION

Except for the above, in our opinion, the annexed Balance Sheet and Income and Expenditure Statement together with the notes thereon, which have been prepared under the historical cost convention, present fairly under that convention the financial position of Africa Humanitarian Action's Rwanda Operation at 31 December 2000 and the results of its operations for the year then ended and are in agreement with the financial records of AHA's - Rwanda Operation.

A.A. Bromhead & Co.
U.K. Registered Auditors
and Chartered Accountants

P.O. Box 709
Addis Ababa
22 May 2001

A.A. BROMHEAD & Co.
Chartered Accountants
P. O. Box 709
Addis Ababa

EXTERNAL AUDITORS

AHA HQS, Angola, Ethiopia, Rwanda: A.A. Bromhead & Co. in Association with Pricewaterhouse Coopers, Chartered Accountants

AHA Uganda: Pricewaterhouse Coopers, Chartered Accountants

AHA

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Mr. Nicolas Bwakira
Dr. Getachew Demeke
Mr. Chefeke Dessalegn
Amb. Brownson Dede
Mr. Jean-Pierre Hocke
Chief Olesegun Olusola, mni
Mr. Anders Wijkman
Dr. Dawit Zawde

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THE PRESIDENT'S MESSAGE

In 2000, AHA squared its shoulders, took a deep breath and delivered a blunt message to the donor community. If its message is heard, the year will mark a turning point in AHA's history - and perhaps also benefit the handful of other indigenous organisations on the continent.

Very simply, AHA told donors, present and potential, that it wanted to grow. AHA has spent six years being an operational partner for major international organisations in countries as diverse, difficult and dangerous as Angola, Rwanda and Sierra Leone and has shown it can fulfil donor/recipient expectations.

Currently, it is present in six countries with emergency relief, refugee and health programmes. Now, it wants to move on, to become an autonomous, permanently functional organisation, with a long-term vision and the ability to formulate strategies responsive to Africa's needs.

Potentially, it has the necessary resources - the leadership, the expertise and a growing credibility among the authorities and the public. Only one element is missing: the funding for the institutional structures that will make it happen.

And there lies the problem. It takes real commitment to recognise that support for an organisation's infrastructure is not the unattractive proposition it seems. Infrastructure support can produce real and long-lasting results, not least by empowering Africans to identify and implement the solutions to African problems. Those with the courage and curiosity to take a closer look at what is needed are in for a pleasant surprise.



Infrastructure support is not a costly exercise. AHA is looking for only USD 350,000 per year for the next three years. If such an injection is guaranteed, AHA is confident it can not only effect the transformation of the organisation, but also pave the way for African financing once the three years are over.

The difficulties of raising funds in Africa are well-known and are at the origin of AHA's search for "start-up" funding. Nevertheless, AHA leaders believe that success breeds success: if the organisation is perceived as a growing, thriving body, with a solid, permanent presence, it will inspire increasing confidence among both the business community and government bodies.

Will AHA's call for support strike a responsive chord among those in the donor community who recognise that attitudes and approaches to international humanitarian action need rethinking? Or will it fall on deaf ears? If this happens, AHA will continue to exist. But a major opportunity will have been lost.

Dawit Zawde
President

COUNTRY REPORTS

ANGOLA

Overview

At the start of 2000, Angola was still in the throes of civil war and an estimated 3 million people were displaced. Although the government had retaken large areas, security remained poor, restricting the movement of people and goods.

With a humanitarian crisis looming, UN surveys were undertaken to identify those areas most in need of assistance. At UNHCR's request, AHA took on projects for internally displaced people (IDPs) in three provinces - at Viana in Luanda province, Maquela do Zombo in Uige, and M'banza Congo in Zaire - from July to December.



Viana, Luanda

AHA worked in three camps for the displaced, Malanje, Moxico and Mussenge, and a camp for Katangese refugees. Its mandate covered community mobilisation for water and sanitation; income-generation; housing construction; and the building of community centres.

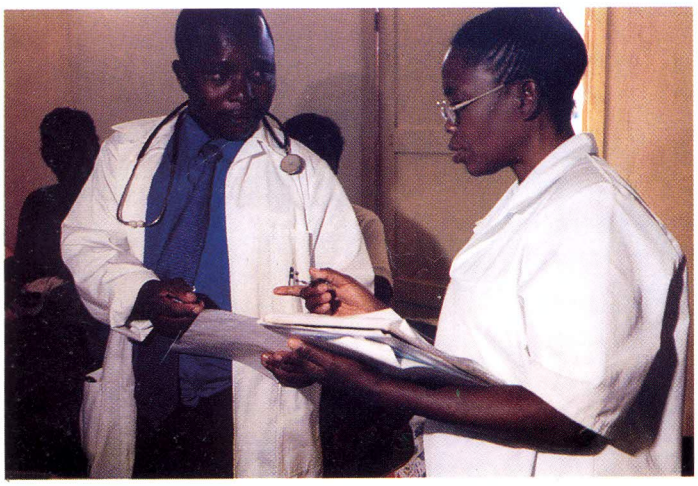
In Malanje camp, 419 families agreed to transfer to another site identified by UNHCR. By the end of the year 109 families had been relocated and brick-making process begun.

Although work on the construction of houses began only in mid-August, AHA had negotiated the title to the land in Mussende and Moxico camps beforehand, thus giving the 687 families that had been squatting for up to eight years, a stronger incentive to build. The installation of a water supply in both camps by the end of October was a further impetus.

By the year's end, 200 houses were close to completion in the Moxico camp. In Mussende, progress was slower: only 127 out of 300 families had begun making bricks. In Katangese, housing 700 families, 270 houses were constructed, another 100 were being built, and the remaining families were making bricks.

The community, using materials supplied by the project, built community education centres for children aged two to six, and their mothers. The centres in Moxico and Katangese were operational by mid-December, and that in Mussende was nearing completion. The project made available one pre-school teacher for each establishment and trained 4 assistants.

Micro-credit schemes offered by the centres, however, met with limited success, chiefly because the repayment time-frame was too short.



AHA health team members - Maquele do Zombo - Angola

M'Banza Congo, Zaire province

Supported by TROCAIRE, an Irish funding agency, AHA undertook a project that aimed at using the area's resources to rehabilitate the population, which in 1999 had fled rebel troops, and seen its homes first looted, then further damaged by a severe storm.

AHA supplied 200 families with zinc roofing, in exchange for surplus food, which was, in turn, given to another NGO for distribution to the displaced. Because of the project's success, AHA was asked to undertake a similar scheme on behalf of the World Food Programme.

AHA became the implementing agency for the water, sanitation, health and community mobilisation components of a UNHCR project. In partnership with OXFAM, it undertook the installation of six water points. Because of transport difficulties and resistance from the traditional authorities - since over-come - completion of the project was delayed beyond the year's end.

The rehabilitation of the health post at M'banza Mazina, delayed because of transport problems, was nearing completion by the end of the year. In the meantime, the AHA doctor treated patients in four temporary health posts in makeshift facilities.



In August, AHA, in collaboration with the National Programme for Essential Medicines, conducted a provincial workshop on drug dispensing for 49 health workers.

Micro-credit was extended to 10 displaced women, but repayment was slow.

The social worker, with the help of activistas, mobilised the community in the area of hygiene and sanitation. It has been an uphill task to persuade the displaced community at Nzolani to complete the relocation of the latrines near the waterpoint.

Maquela do Zombo, Uige province

For four months, health coverage in the area was carried out by monthly visits from a doctor based in M'banza, Congo. As security improved and the numbers of returnees increased, a doctor was stationed in the municipal hospital and by late December minimum services had been restored.

Outlook

Despite the many difficulties facing the projects - delivery delays because of security- related transport problems, poor quality materials, slow and erratic funding — AHA was able to accomplish most of its undertakings and expected to carry out other projects in 2001.

ETHIOPIA

In 2000, AHA continued a two-year programme to develop family planning, reproductive health services and STI/HIV/AIDS prevention in two woredas (districts). The programme, which began in October 1999, is funded by Pathfinder International.

One of the woredas, Shashemene, with a population of 229,000, is traversed by one of the country's main highways. A busy trading post, this is a town where commercial sex thrives and poses a serious health threat. The second area selected, Gofa Zuria, some 525 km from the capital, is an underserviced region with minimal infrastructure, low socio-economic development and poor health status.

Family health (FP) and reproductive health (RH) services in Ethiopia are limited in scope and coverage. The contraceptive prevalence rate is 8% and the estimated HIV/AIDS rate 8% overall - 21% in urban areas. The aim of the AHA programme is to create awareness of the services while improving their quality and increasing public access.

The project began first in Gofa Zuria, where FP/RH and HIV/AIDS/STI prevention programmes were launched in seven urban and eight rural communities, representing 55,000 people, or 28% of the population. It started three months later in Shashemene, where project sites covered 34% of the population.

In both areas the first move was to sensitise community leaders, before recruiting and training community-based reproductive health agents, women and youth peer-educators. Project advisory committees were then set up, bringing together line ministries and community groups, and anti-AIDS clubs were established or strengthened.

Training was provided for health professionals and institutional support, equipment and supplies made available to referral clinics.

In the course of the year the programme fully achieved its most important objectives and met with 50% to 75% success in others.



Individual counceling
Reproductive Health - Ethiopia



Family counseling,
Reproductive Health - Ethiopia

As planned, 120 community leaders from the two woredas participated in an orientation and sensitisation seminar; 30 CBRH agents, 30 women educators and 30 youth peer educators were selected, trained and deployed in the 30 project catchment areas (15 in each woreda). Their efforts were supported by 12 anti-AIDS clubs and the production and distribution of large quantities of I.E.C materials (some in Oromifa, the local vernacular).

In all, the programme reached an estimated 50,000 people through information and education activities. 2,504 new acceptors were recruited and there were 1,666 revisits for contraceptives and protectives.

Underachievement of a few targets was largely attributable to shortages - principally of contraceptive choice and availability, but also of audio-visual and other materials for the anti-AIDS clubs, and of staff, and hence staff availability for further training.

As a mid-term evaluation indicates, the programme now needs to know "what to address and how" through a baseline study of the motivations, barriers and perceived benefits among the target population. It also needs to reinforce the management information system, to provide a sound base for decision-making and impact evaluation.

The financial sustainability of the project, possibly through an income-generating initiative, calls for urgent examination and more capacity-building for staff. The issue of enhanced community participation should be tackled. Finally, it is clear that contraceptive use will only rise above the national average if the problems of limited choice and acute shortages of supplies are solved.

RWANDA

With funding from UNHCR and inputs from other agencies, AHA provided health, nutrition, sanitation and water services to Congolese and Burundian refugees throughout the year, at the same time supplying staff and technical support to the surgical unit of Kibuye Hospital.

The programme maintained a health centre for 13,232 Congolese refugees in Kiziba camp, Kibuye Prefecture, and a health post for 500 Burundian refugees in Kigeme camp, Gikongoro Prefecture.



Kiziba Refugee camp

Health services

During the year the camp's health centre gave a total of 24,152 consultations and hospitalised 630 people. Regular health education sessions dealt with a range of common health problems. In addition, the centre followed up TB patients and promoted STD/HIV

AIDS prevention through awareness creation and the free distribution of condoms.

Ante-natal clinics saw 2,016 pregnant women and supervised 557 deliveries, the vast majority in the health centres. Family planning services were made available to 74 women.

Weekly immunisation sessions ensured 347 children were fully immunised and 76 expectant mothers were provided with the necessary vaccinations. AHA also participated, with staff and vehicles, in two national immunisation campaigns that vaccinated 4,946 children under 5, in the camps and neighbouring localities.

Nutrition

Nutritional intervention comprised both supplementary (dry) and therapeutic (wet) feeding programmes: 120 children under 5 were cared for in the therapeutic feeding centre and 308 in the supplementary feeding centre, which also catered for 444 pregnant and 499 lactating women.

In September, at the UNHCR's request, an AHA consultant conducted a nutritional survey in Rwanda's three refugee camps. A survey of urban refugees in Kigali was also scheduled for January 2001. The two reports will be considered together.

Sanitation and Water Supply

This component of the programme undertook the construction and management of latrines, shower rooms and waste disposal pits, the distribution of potable water and the organisation of regular cleaning campaigns. By the year's end there were 112 latrine blocks, 14 shower rooms and 60 waste pits in service. Despite its importance, this activity was constrained by budget cuts and the chronic problem of land issue.

Throughout the year, each refugee was provided, on average, with 20 litres of potable water daily. Water quality was tested regularly and repairs and maintenance carried out.

Assistance to Kibuye Hospital

An AHA surgeon was on call throughout the year. Of 1,566 surgical consultations, 234 patients were refugees, and 610 major operations were performed. AHA also provided drugs, materials for the operating theatre and funds for constructing extra facilities. On-job capacity-building was provided for the local staff in the surgical unit of the hospital.

Assistance to Kigeme Refugee Camp

At the request of UNHCR, AHA organised a health delivery system in the camp, assigning a local nurse for day-to-day preventive and curative health services and organising monthly visits to the camp by the AHA medical doctor in Kibuye. Over the year there were 3,275 consultations, with 484 patients referred to other institutions. Ante-natal care was given to 26 women and 22 deliveries were supervised. Immunisation, family planning and health education were also provided.

UGANDA

AHA's programmes in Uganda continued to deliver accessible, integrated health services to refugees and nationals living in Adjumani district through 24 health units under AHA management. Services provided included health education, nutrition, the expanded programme of immunization, reproductive health, control of endemic diseases, basic health care, essential drugs, capacity upgrading of staff, outpatient and inpatient treatment, special feeding programmes.

When the year began, AHA was targeting 71,392 refugees and 34,000 Ugandans living in the areas hosting the refugees. By the year's end, births, deaths and new refugee arrivals had brought refugee numbers to 73,590.



Harvest time in a refugee settlement - Uganda

As in preceding years, most beneficiaries were farmers, while a few were engaged in small businesses or by NGOs such as AHA, where refugees account for 70% of its staff.



Health and Nutrition

Two nutrition surveys were successfully conducted during the year, in the months of March and October. Technical support was given by Action Against Hunger (ACF-USA). In March the nutritionist recommended use of DSM instead of whole cow milk. To achieve this 750 kgs of DSM was provided by UNHCR in the month of November. DSM as opposed to whole cow milk is provided by UNHCR; whole cow milk is expensive in Adjumani.

Cost-sharing was suspended during the course of the year, however a consensus-building workshop was held in which an agreement was reached to reinstate it. This has been partially implemented. The Health Unit Management Committee still need additional training and encouragement on an on-going basis, to boost their commitment and understanding as stakeholders, in the successful implementation of cost-sharing as a move towards sustainability.

Procurement of kerosene and the refilling of gas-cylinders were facilitated accordingly and the necessary medical equipment and laboratory reagent provided. Office supplies were catered for while printing costs and uniforms were covered from their respective budget lines. Payment for the registration of the Health Units and their respective managers, was effected according to Uganda Medical Practitioners and Dental Surgeons Registrar requirements. Costs of maintenance and repair of premises were also covered in this budget line.

A total of 202,688 outpatient consultations were made, Of these 54,523 (27%) were Ugandan citizens. 1,744 patients were admitted and discharged in AHA's in-patient grade III unit, before in-patient feeding was halted due to financial constraints. 1,050 patients were referred to Adjumani, Moyo, Lacor, Arua and Kampala hospitals. 17 patients were referred to Kampala for further assistance by INTERAID.

A memorandum of understanding was signed between AHA and Madi AIDS Control Initiative (MACI). The annual programme was discussed, the relationship between the two parties formalised by the MoU and funds forwarded for programme implementation. Support and field-based staff were deployed and their salaries and incentives covered.

A therapeutic feeding programme was run from one centre at Maaji B. The total enrolment increased from 6 at the beginning of the year to 200 at the end of the reporting period. 163 were discharged cured, 13 died , 7 defaulted and 7 transferred for different reasons.

Reproductive Health

Ante-natal care(ANC), Peri-natal care, Post-natal, Family planning, Adolescent sexuality and monitoring of gender-based sexual violence activities were conducted throughout this period via both static and out-reach service delivery points . Of a total of



Beware of mines! Well-worn foot path.

1,942 deliveries, 87% were assisted either in the health units or by a TBA.

WEST AFRICA - LIBERIA & SIERRA LEONE

With inputs from OAU, AHA provided short-term assistance to Sierra Leonian refugees relocated in Sinje, south-western Liberia by the UNHCR.

A three-person team assessed the most urgent needs that had not been met by other agencies. In collaboration with the local authorities and in consultation with refugee representatives, a lack of shelter and a shortage of agricultural tools, seed and fertilisers were identified, as priority needs.

On the basis of this assessment and available funds, a rehabilitation package was developed, providing shelter for 2,000 families and agricultural tools, seedlings and fertilisers for 460 farming groups.

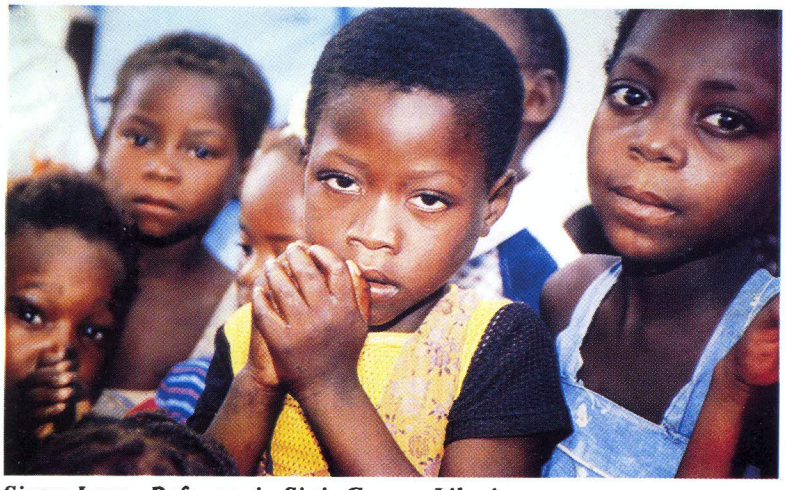
By the end of the year, 50,000 square meters of polythene-sheeting shelter materials with accessories and 7,400 agricultural hand tools had been procured and shipped to Monrovia. Other agricultural inputs, 3,850 kg of rice, 5,300 kg of peanuts, 6,900 cuttings of cassava and banana suckers, and 12,000 kg of fertilisers were procured locally.

Delivery of the materials is expected in January-February 2001 and the project will be implemented before the start of the rainy and plantation season, beginning in April.

Considering the prevailing situation in Sierra Leone and in order to save on overhead costs, AHA entered into an agreement with the Liberian National Red Cross, which will assume responsibility for the implementation of the project.

AHA continued to seek funding for two health projects in support of Sierra Leonian refugees in Maryland and in Upper Lofta counties.

AHA also seeks to establish a more settled presence in West Africa with long-term sustainable programmes.



Sierra Leone Refugees in Sinje Camp - Liberia

ZAMBIA

Overview

AHA, acting as the implementing partner of the UNHCR, has been providing emergency health, nutrition and sanitation services to refugees in the Mayukwayukwa settlement area since January 2000. The programme began in response to the serious conditions created by the influx of refugees from Angola, Burundi, the Democratic Republic of the Congo, and Rwanda - the great majority being Angolans. It caters both for refugees, whose numbers rose from 12,000 to well over 18,000 by the end of the year, and some 9,000 Zambians in the local community.

AHA's expatriate medical team and national health staff had to deal swiftly with an emergency situation of high mortality rates, especially among small children, the result of widespread malnutrition and debilitating illnesses. The situation was brought under control through the delivery of health services built on a community-based referral system and the combined efforts of Community Health Workers (CHWs), Traditional Birth Attendants (TBAs) and outreach primary health staff.

By the year's end, the prevalence of malnutrition had been reduced from 36.2% to 2%; the crude mortality rate was down from 2/10,000/day to 0.21/ 10,000/day, and the under-five mortality rate had dropped from 6/10,000/day to 0.29/10,000/day.

Overall, AHA was able to meet its emergency objectives. Now that the situation has been stabilised, preventive and reproductive health services need to be reinforced, and more TBAs, CHWs and outreach assistants trained.

Other priorities for 2001 are to maintain supplies of supplementary food to prevent any malnutrition relapses, and to increase funding of drug supplies, since current morbidity trends indicate that drug consumption will almost double.

General Health Activities

AHA's main target was to set up a primary health care delivery system, responding, with appropriate technology, to problems identified through community participation. Over the year, it made health care available to all, through five outreach posts and a clinic with a 24-bed in-patient capacity. Hospital referrals declined as the services expanded. Laboratory services are now included.

AHA made extensive use of local and refugee health workers and conducted training throughout the year to increase their numbers. It has so far trained 18 CHWs and 8 TBAs, and held three in-service seminars on community services.



Nutrition

A three-pronged nutrition programme of dry supplementary feeding, wet and therapeutic feeding was launched to combat a malnutrition mortality rate of 36%. Therapeutic feeding for the severely malnourished was given on an in-patient basis. Dry feeding took place at four distribution sites. Wet feeding, for the moderately malnourished, was stopped in August when a survey showed the situation had stabilised.

Mother and Child Health

Vaccination campaigns achieved 80% coverage in infants for BCG and 95% coverage for measles. Immunisation is done on a routine basis at the clinic, in collaboration with the district EPI programme.

Antenatal coverage improved from 20% at the beginning of the programme to 80% by the year's end. Qualified midwives at the AHA centre now handle most of the deliveries, previously conducted by TBAs in the community.

Reproductive Health

Condom use rose from below 1% to 12% and the contraceptive prevalence rate from 2% to 16%.

Health education campaigns took place throughout the year and the STD/HIV clinic registered increasing numbers of clients.

Sanitation

This service, a key preventive health measure, made extensive use of CHWs and large-scale community participation. Besides organising village health and sanitation committees and conducting sanitation and hygiene campaigns, AHA constructed family pit latrines for 300 vulnerable families and supervised the building of another 2,000, representing 87% coverage. The building of 2,940 refuse pits met all community needs.

The water supply is less than adequate in some settlements and should be improved. It would make sense for AHA to handle both sanitation and water services.

Information and Education

Community sessions on a wide range of health topics, backed by the printing of 1,000 brochures, were welcomed by the population and produced a high level of participation.



Mother and child refugees - Zambia

AHA is committed to restoring Africa's self-esteem - to change its image from that of a global backwater to a continent capable of dealing with crisis through a credible, African designed agenda!



Alleviating crisis in Africa is, first and foremost, the responsibility of Africans!

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In formation

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 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
or to
The International Banking Division
Account number C/A 6050092-2 (Foreign Currency)

All Photos by Gediyon Kifle

Design: MY, 52-06-15/16

Master Printing Press