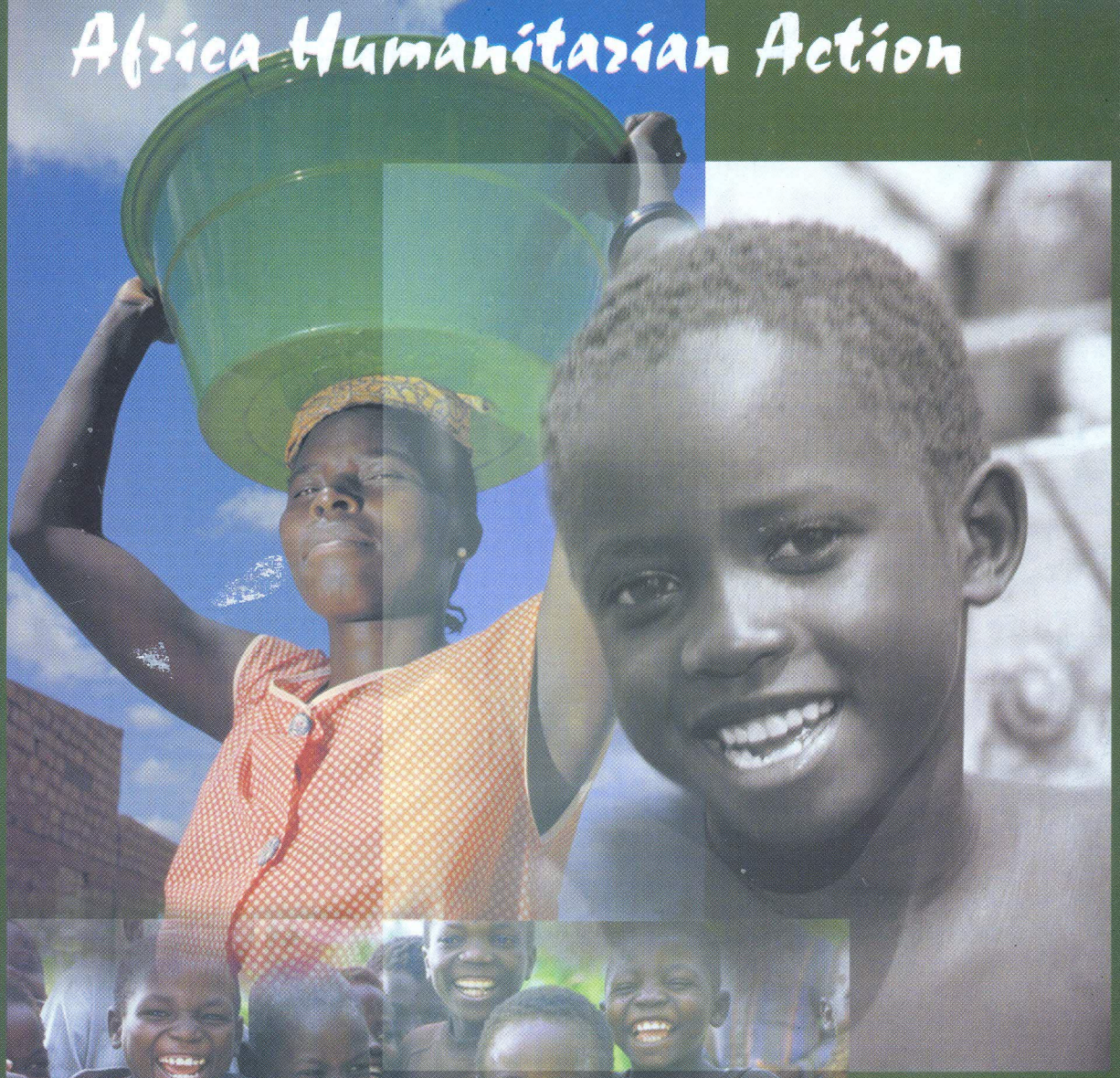
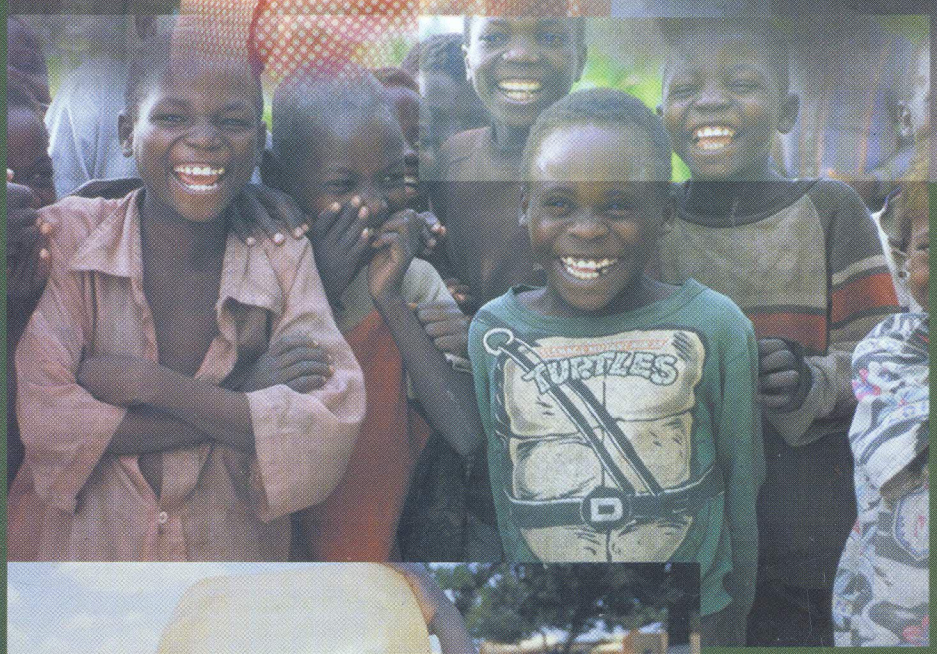
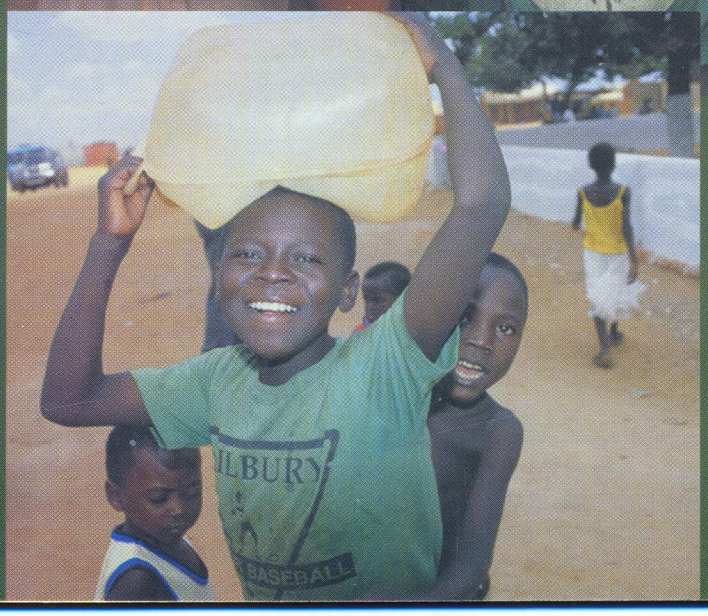
Africa Humanitarian Action







Annual Report 2001

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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, or funds can be transferred to either of its bank accounts with the **Commercial Bank of Ethiopia,**

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MESSAGE FROM THE PRESIDENT



In 2001, AHA continued, in partnership with the UNHCR, its health and related support programmes for refugees in Angola, Liberia, Namibia, Rwanda, Uganda and Zambia. In Ethiopia, AHA also expanded upon its reproductive health and HIV/AIDS programme in co-operation with Pathfinder International. They are elaborated in this annual report. Let me just note that for the sixth consecutive year, we have received a clean bill for all our programmes by our partners and auditors alike.

The strengthening of AHA as an institution has remained the main priority and preoccupation for our Trustees and senior management in 2001.

AHA Strategy for Institutional Development 2001-03 was received positively by many organisations both in and outside Africa. In 2001, we pursued the funding of the Strategy with a number of agencies and the private sector.

When reviewing results at the end of 2001, we were disappointed, but not entirely surprised, having received only minor contributions from three sources. The critical constraint remains the difficulty of making our knowledge of essential African institutional requirements explicit for others to consider as a way forward.

Over the last two decades northern governments and UN agencies have been advocating the need for developing indigenous humanitarian organisations, which can assume a greater role and share in the response to humanitarian and other crises in Africa. Such a development is also seen as a contribution to strengthening democracy and civil society in general. However, actual donor response remains contradictory to such efforts by African-born organisations. Northern governments and agencies keep telling us that they are only able to support activities, not institutional costs even when clearly limited in time.

Furthermore, any institutional support, we are told, will only be forth-coming through a northern NGO partner. In reality, however, these organisations seem to shy away from such engagements despite their professions to the contrary. Besides, this approach may suit and work for organisations that are affiliated to or an extension of northern NGOs. It leaves independent organisations such as AHA without response.

However, we remain convinced that our analysis is valid and will pursue our efforts to strengthen AHA's institutional capacity also in 2002.

The Second Assembly of our International Trustees has been scheduled for March 2002, when we look forward to welcoming new members adding to the strengthening of our governance.

Dawit Zawde

ANGOLA

Introduction

The humanitarian situation in Angola did not improve in 2001. While the Government recaptured many areas, this did not bring more security or a free movement of people and goods. Humanitarian organisations, including AHA, had to continue providing emergency support in order to avert a catastrophic situation in the crisis areas.

The AHA remit was to assist the IDPs at Maquela do Zombo, (Uíge Province) Mbanza Congo, (Zaire Province); and Viana (Luanda Province), and refugees from the DRC and Rwanda living in two camps in the Luanda Province.

In addition, AHA carried out community education programmes in partnership with UNHCR, UNICEF, WFP, the British Embassy, and Save the Children UK. The programmes included HIV/ AIDS awareness, micro credit schemes, pre-school activities, and displaced women.

Luanda Province

The DRC and Rwandan refugees in Angola are concentrated in the Katanguese and Kifangondo camps.

Because of heavy rains many of the houses at Viana were destroyed and a project was started to support individual house construction for the refugees in the Katanguese camp. A similar project at Irmãos Coragem for the persons from Malange camp started in July 2001. By the end of the year, 160 houses of the 320 were completed.



Water Well Construction

AHA distributed food and non-food items to both urban and refugees living in the two camps. A pre-school programme was run for the children, introducing Portuguese and elementary arithmetic and drawing. Hygiene and health education courses were undertaken for pregnant women.

AHA also worked at Viana with the internally displaced persons from the Provinces of Malange, Moxico and Kwanza Sul (Mussende) and Mbanza Congo (Zaire) Maquela do Zombo (Uíge).

In 2001, the activities in the Moxico and Mussende camps included the construction of community laundries (12 washtubs) and latrines, micro credit schemes, education and advocacy of gender and HIV/AIDS issues. Although 130 slabs had been prepared, the latrines in the Moxico Camp were not constructed as the population prioritised houses over latrines.

M'banza Congo

AHA works in the Municipality of Mbanza Congo in the Province of Zaire where there are two IDPs camps (Mbanza Manzina and Nzolani).

The health programme serves both the IDPs and the resident population. At Nzolani returnees also attend. The programme includes HIV/AIDS and malaria awareness and basic vaccinations. Apart from serving the government facilities, the AHA doctor also attends patients and provides medicines to refugees administrated by the Baptist Church and the Kimbaguist Church.

Health promoters and a theatre group undertook several HIV/AIDS and malaria awareness campaigns and distributed condoms. The police, army and the youth were the main target groups of the project.

The provision of water and sanitation for both the displaced persons and the host population is a vital element of AHA's servives in Mbanza Congo. In April, six water points (three springs and three wells) were handed over to the Provincial Water Authorities.

As part of the food security, fast-maturing cassava was planted near the camp for the benefit of both the IDPs and the host population. A fishpond was built at Nkunga Paza with AHA funding and the collaboration of the local population.

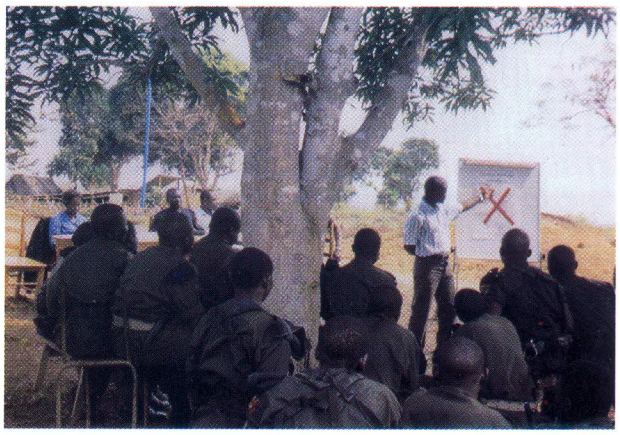
Chevron-Texaco funded a water and sanitation project for 15,000 persons at the Municipality of Mbanza Congo. It will improve six water points and six laundries. The project began in September 2001, and one of the three wells had been finished by the end of the year.

Chevron-Texaco also funded an education project to benefit 320 children. Four new classrooms are under construction with the participation of the local community and the Government.

Maquela Do Zombo

The AHA doctor is responsible for the health services in the Municipality of Maquela do Zombo Uige Province. He works in the hospital and oversees the health post at Kibocolo. He is also responsible for daily paediatric consultations at the nearby Catholic Mission. The TB wing of the hospital has been rehabilitated and now accommodates 20 patients. The health post at Kibocolo was rehabilitated and supplied with drugs.

Maquela do Zombo is a border town and the need to promote HIV/AIDS/ STD awareness is paramount. Health promoters and social workers were involved in an information and education programme for both HIV/AIDS and malaria. Workshops were held for the armed forces, police and the youth. Condoms were also made available to the town population.



Open-air health education M'banza Congo

Short maturing cassava was handed over to the Catholic Mission for production and distribution.

Micro Credit

The project aims at improving the livelihood of displaced families, particularly those headed by women, by providing access to credit for small-scale trading. 140 persons received loans in 2001. There have been difficulties with the reimbursement of loans, but continuous meetings are held with the beneficiaries in order to overcome these problems.

Conversa No Jango

The project provides a physical space for displaced and refugee women to meet and relate their day-to-day problems. AHA implements this project with funding from the British Embassy, Save the Children UK and UNHCR.

ETHIOPIA

Introduction

The Family Planning/Reproductive Health and HIV/AIDS/STDs prevention project was initiated in 1999. It operates in 30 rural and semi-urban locations of the Gofa and Shashemene woredas with 260,000 target beneficiaries in 164 peasant associations.

The project activities include community-based service delivery, information, education and communication (IEC) provision, establishing and strengthening of Anti-AIDS clubs and institutional capacity building.

Service Delivery

In 2001, more Community-Based Reproductive Health (CBRH) project sites were initiated in Bolosso Sore and Sodo Zuria districts. Currently, 164 kebeles of the four districts have got CBRH services in place. Project activities are making steady progress with contraceptive prevalence rates showing strong upward changes along with AHA's interventions. CBRHAs, women educators, youth peer educators and established Anti-AIDS clubs in the project sites have become more motivated in their IEC activities.

For example, in the Shashemene woreda, the family planning service use rate has increased from 3.2% in 1999 to 19.9% by December 2001. Also in the Gofa zuria, a nearly 12% FP use was registered at the end of the year, up from 2.6% in 1999.

A quarterly average of 3,278 new clients was registered at the service delivery points, while the average number of clients reached 6861 in 2001. 51,882 strips of oral contraceptives, 118,152 condoms, and 4,296 injections were delivered. Norplant rods, IUCD and foaming tablets have been issued at service delivery and referral points.

Services to beneficiary communities have gradually improved in quality and quantity. A significant change in attitudes was registered. As a result, the demand for more contraceptives and protective know-how has increased. The provision of contraceptives has improved at AHA service delivery points, and clients have now ample choices according to individual preferences.

Information, Education and Communication (IEC) are the core components of the project, in which all partners, volunteers, PAC members, line departments, youth peer educators, CBRHAS, and women educators get frequently involved. It has been an everyday activity with replicate effect.

IEC materials were printed in Amahric and Oromifa. 68,777 leaflets and posters were distributed at the different project sites. The CBRHAS and women educators made regular home to home visits, which brought measurable change in attitudes.

The volunteers and staff paid 38,925 home visits and conducted 5,238 group meetings. In 2001, a total of 244,462 persons were informed on the quality use of RH/FP services and prevention against HIV/AIDS/ STD. 98,822 were adolescents aged 15 to 25. Special sessions were organised for adolescents, focusing on harmful traditional practices, sexual abuse and harassment, kidnapping and the effects of early marriage.

Youth peer groups worked through dramas, written novels, contests, panel discussions and mini-media programmes. Drama shows organised by adolescents attracted vast number of spectators and received national television coverage.

Capacity Development

22 Anti-AIDS clubs were established, mostly in schools. An Anti-AIDS club was organised in the prison at Saula. This set an example and encouraged government and other organisations to undertake similar activities.

AHA, in collaboration with Family Health International (FHI) and the consortium of family planning NGOS in Ethiopia (COFAP) conducted two workshops on monitoring and evaluation. 10 data collectors and two project supervisors were trained in rapid needs assessment.

The programme has emphasised human resource development and the training of volunteers and staff as a means of providing quality services. The number of trained volunteers has doubled. Train-

ees were exposed to modern contraceptive technology and learnt new communication skills.

Volunteer community-based distribution agents (CBRHAS) function as health development agents, focusing on FP/RH and HIV/AIDS prevention in rural areas. 64 CBRHAS were trained in 2001, and 30 were given refresher courses.

30 women educators were trained in the second quarter, and 15 youth peer educators received basic training and 30 took refresher courses. The main topics covered were FP/RH, IEC, maternal and child health, peer counseling, HIV/AIDS/STD, and traditional practices.

14 health professionals from the public and private sector participated in a seven-day clinical service providers training programme in Awassa.

Training on the principles of voluntary surgical contraception, Norplant insertion and removal techniques was provided for senior health professsionals.

NAMIBIA

Introduction

Initially, the Namibian Ministry of Health and Social Services provided curative health services at the Osire refugee camp and the Namibia Red Cross Society was responsible for preventive health care, as an implementing partner of the UNHCR. In May 2001, the management of curative health care services was transferred to Africa Humanitarian Action (AHA).

Prior to assuming responsibilities, AHA analysed the situation in the Osire camp and made a member of proposals for improvements which were accepted by the Namibia Government and the UNHCR.

AHA services included treatment of over 23,000 refugees in the Osire refugee camp; referral of patients to regional hospitals; ambulance transportation; and preventative medicine. AHA also provided services to refugees in the Kassava and Onambutu camps and in Windhoek and other towns. In 2001, AHA assisted 23,164 refugees.

The Angolan refugees still account for over 95% of the base population as well as of the new arrivals at the camp. AHA employed 15 professional staff - one expatriate medical doctor, four Namibians and ten refugee staff.

In November, the AHA President and two Trustees paid a working visit to the camp. In December, the UNHCR Inspector General and the Head of UNHCR Namibia visited the camp and reviewed the programme on the ground.

Health Services

The camp clinic was erected when the population of the camp was just a few hundred. The current structure was renovated by AHA in order to provide better services. Two cubicles and two tents were also added to increase capacity.

There was consensus among all parties that the long term solution was to build a health centre, co-ordinating the comprehensive curative and preventative programme for the camp. Such a centre would contribute to cutting the excessive number of referrals caused by the current lack of adequate facilities at Osire.

The construction of the 24-bed hospital, funded by the American Government was under way and is expected to be completed by March 2002. The hospital includes a comprehensive diagnostic facility and maternity ward.

There was a 12% progressive increase of new arrivals in the Osire camp. The numbers ranged between 275 and 450 per month with a mean of around 350. The number of under-five children was 4,280 representing 20.3% of the total population. The number of women was 9,611, representing 45.5% of the total population.

There was also a progressive increase in the number of patients attending the clinic since the arrival of the medical doctor. Simultaneously, there was a decrease in the number of referrals to other facilities. The average percentage of patients (12.2%) agrees with the acceptable standard of 10-15% of total patients seen in the facility with trained screening nurses. The number of consultations per refugee and year was 2.17.

Increased demands for pharmaceuticals and clinical equipment lead to AHA's taking over the responsibility for this sector. Four companies were awarded orders for drugs and supplies. Remaining issues are a lack of adequate storage facilities and a trained pharmacy assistant.

The most prevalent disease conditions noted in the camp were reflecting conditions prevailing in the countries of origin; the age distribution of the refugees; and the various factors that displaced peoples face - hunger, lack of clothing, etc. The disease specific morbidity was measured for both under-five children and the population as a whole and comprehensive statistics are available separately.

The calculations of mortality rates were based on death certificates issued by the Ministry of Home Affairs, responsible for registering deaths in the region. The rates include the crude mortality rate (CMR), the under five mortality rate (U-5 MR), and the proportional mortality rate (PMR).

The crude mortality rate showed a downward trend which was attributed to the stability in the camp population, improving medical services, supplementary feeding, and health education.

The mortality rate for children under-five (U-5MR) is an important indicator for monitoring the child health and care services. The 2001 figures showed a higher mortality rate among the under-five group when compared to the crude mortality rate. While the CMR is taking a sharp downward trend, the U-5MR did so only with a small gradient. This calls for a closer look at the services and the need for integrating the management of all childhood illnesses.

In 2001, the number of deaths was reduced. Of the 111 recorded deaths, 69 (62.2%) were in the under-five age group and 42 (38.8%) were six-years and above. Malnutrition, gastroenteritis and pneumonias account for over 60 % of all the deaths in the under-five age group, and 38% of the total mortality.

The case fatality rate is the rate at which people who contract a particular illness die from it. The case fatality of most illnesses in the camp was low. For example, of the 2,838 people that contracted malaria, only two died of the disease, giving a case fatality rate of 0.7/1000. The figures for gastroenteritis were: 0.2/1000; for pneumonia 46/1000, while the malnutrition figure was very high at 87.62/1000.

Even though more people had malaria and gastroenteritis (high morbidity), the number of people dying from those illness were fewer than those from malnutrition and pneumonia (higher mortality). This information is very useful for the purpose of planning and allocation of resources.

Nutrition

Malnutrition has been, and continues to be, a major health problem and source of morbidity at the camp, especially in children under-five. The destruction of the Supplementary Feeding Centre temporary structsure was a serious setback. Feeding took place under a temporary tent structure where it often got disrupted by rain or strong winds. AHA contributed about N$ 18,000 to revitalise the ebbing supplementary feeding programme. The lack of adequate facilities for this programme remained a major handicap to be addressed in 2002.

Reproductive health

The reproductive health services in the camp were closely monitored through a

set of indicators covering ante- and post-natal, delivery, abortion, STD and other data.

In addition to information and education activities, 175 cases of sexually transmitted diseases were treated and 7,342 condoms were distributed in the camp. The incidence of STD was 8.2/1,000, and the contraceptive prevalence was 3.75%. No cases of sexual violence were reported.

The low level of contraceptive use in the camp is a cause for grave concern. The majority of the population argue that relations have died in the wars so they need to produce more children. There are many traditional beliefs which need to be tackled, e.g. that women never get pregnant again if they use contraceptives. Most men are against using contraceptives and women need the consent of their husbands to practice family planning. Information and education will be reinforced in 2002.

Immunisation and Communicable Diseases

The Community Heath Promoters continued their efforts to immunise eligible women and children after a survey of 2,364 children in August. The results showed coverage of over 80% for BCG, Polio, DPT; 85% for measles; and 90% for vitamin A.

There was a low prevalence of tuberculosis in the camp. Only six diagnosed cases were treated on the DOTS regimen. One new case was diagnosed in December and one MDR case was confirmed in Windhoek, and is under continued monitoring.

A case of measles was investigated in December and contacts were screened . The case was immediately notified to the Ministry of Health and Social Services. Due to the two cases of measles, an immunisation campaign was conducted for children between six-months and five years.

There was a Hepatitis E virus outbreak in the camp which not fully controlled, because some of the control mechanisms have not yet been put in place. The number of patients reporting to the clinic however decreased from 23 in July to 8 in December.

RWANDA

Introduction

Since 1995, AHA has been operating health activities, including surgery, nutrition, and sanitation and water projects for 12,845 Congolese refugees in the Kiziba camp, 500 Burundian refugees in the Kigeme camp and the local population in the Kibuye Prefecture and the Gikongoro Prefecture. AHA has also been providing a surgical unit at the Kibuye Hospital. The programme was carried out in collaboration with the Rwandan Government, the Région Sanitaire of Kibuye, the Région Sanitaire of Gikongoro and the WFP.

Health services

The health centre in the Kiziba camp provided in- and out-patient curative and preventive health services. The number of patient visits was 27,942, of which 15,106 were repeat visits and 12,836 new cases.

The total number of hospitalisations was 461, most of them due to malaria, gastro-enteritis and respiratory infections. 107 of the referrals needed surgical interventions. Patients with ophthalmology and psychiatric problems were referred to the hospitals in Kigali and Ndera respectively.

There were 3,689 consultations of which 3,249 were new cases at the health post in the Kigeme camp. 551 patients were referred to other health facilities. At the end of the year, health assistance to the Kigeme camp was phased out.

There were a total of 62 reported *deaths*, 21 of them occurring at the health units

and 41 in the community. The main causes of death were respiratory infections and malaria. No maternal deaths were recorded.

The major causes of *morbidity* were URTI, malaria, intestinal parasites, LRT, diarrhoea, trauma, skin diseases, eye and oral infections. The total number of cases was 27,593, of which 7,763 were under-fives, 6,266 between 5 and 14, and 13,564 over 15 years of age.

443 cases of *Sexually Transmitted Diseases* (STD) were detected and treated. The most common problems were gonococci and non-gonococci urethritis. Sexual partners of patients with STD were traced and treated. Health animators distributed condoms and gave regular information about the prevention of STD and HIV/AIDS.

107 cases of *tuberculosis* were diagnosed, and 89 completed their treatment. No *epidemiological* diseases were reported.

The *laboratory* carried out 1,402 stool examinations of which 755 were positive. Most common offenders were amoebae and ascaris. 1,761 blood films were examined and plasmodium falciparum was positive in 719 cases. A number of urine analyses, AFS and Gram stains were also done.

A new block for maternity and laboratory services is under construction at the *Kiziba* health centre. It is scheduled to be completed in 2002. A wire mesh fence has been fixed around the compound, and one warehouse was constructed at the water point.

The AHA *surgeon* at the *Kibuye Hospital* gave 922 consultations. 445 major and 121 minor operations were performed including 130 were emergency operations. The outcome of all operations was positive. Drugs and renewable medical supplies were provided by AHA.

AHA gradually reduced referrals to the Kibuye Hospital by establishing minor operation facilities in the camp. This has reduced inconveniences to patients and cut down referral expenses. Consequently, three auxiliary nurses who received on-the-job training in surgical techniques handled most of the minor operations at the health centre.

Reproductive health

There were 2,244 attendants at the *antenatal* clinics of which 775 were new cases. 268 high-risk mothers were identified and 60 referred to hospitals. 517 *deliveries* were recorded. 439 of these were delivered at the health units. Trained TBAs attended at 99 deliveries in the camp.

The acceptance of modern *family planning* is discouragingly low among the refugees. This is largely caused by children being used as a means of obtaining additional food rations. More innovative action needs to be introduced to promote family planning and to curb the number of women using childbirth as an entitlement for an extra ration card. The most preferred methods of contraception are injectables, condoms and contraceptive pills

The *immunisation* programme provided 517 children with BCG vaccine and 462 children were vaccinated against measles. 2,600 children were vaccinated against polio and measles in two mass campaigns. 151 pregnant women were given TT1 vaccine and 114 women TT3.

Information, Education and Communication

Health information was regularly given before the start of consultations and at the feeding centres. Health animators also provided information in the camp, taking advantage of social gatherings.

Topics covered major causes of morbidity and mortality in the camp; personal and environmental hygiene; prevention of malnutrition and best use of relief food; and prevention of STD, HIV/AIDS.

As part of the efforts to fight harmful traditional practices, 500 children were cir-

cumcised at the health centre. These interventions were used to circumvent genital mutilation of children by traditional healers.

The report on the baseline survey and assessment of HIV/AIDS programmes for refugees in Rwanda was completed. A project proposal is currently being drafted and will be submitted in 2002.

World Refugee Day and World AIDS day were celebrated in the presence of Government, UNHCR, and local officials. Dramas were prepared focusing on aspects of harmful traditional practices, HIV/AIDS and sexual violence.

Environmental sanitation

Following budget cuts, all latrine constructions were suspended during the first half of the year, causing unhygienic and unsafe conditions in the camp. To counter emerging health problems caused by the lack of adequate sanitation facilities, AHA installed temporary latrines. AHA also involved the community in preventing any outbreak of communicable diseases.

Following the release of funds in the second half of the year, 40 temporary, 40 durable latrines, and nine waste disposal pits were completed. Adequate amounts of clean and potable *water* were supplied. The community participated in the management of sanitation and water systems.

Nutrition

The *therapeutic feeding* centre (TFC) admitted 94 children and dis-charged 112. Nine children are still enrolled in the centre. 508 beneficiaries were enrolled at the *supplementary feeding* centre (SFC) of which 148 were expectant mothers in their last trimester; 141 lactating mothers and 219 children.

All children were screened and vaccinated according to age. Regular health education and demonstration sessions were held for beneficiaries at both centres.

The garden at the health centre was restructured and produced several harvests of vegetables and cereals during the year, supplementing the TFC food rations. The garden was used as a demonstration site and will produce a surplus for marketing in 2002.

Capacity development

32 health community workers participated in three HIV/AIDS work-shops. Six nurses participated in a workshop on STD and HIV/AIDS counselling. Training on the management of common health problems was organised for the paramedical staff.

In-service training of theatre nurses was provided at the Kibuye Hospital. The local health staff were trained in minor operative procedures. Under the supervision of the AHA medical team, the centre began handling minor operations.

UGANDA

Introduction

Since 1995, Africa Humanitarian Action (AHA), on behalf of the Government of Uganda and the UNHCR, has implemented health services to both the refugee community and the national population in the Adjumani district, which is located in the West Nile region of Uganda bordering Southern Sudan in the Northeast and Moyo and Gulu districts to the south and east, respectively.

AHA was part of the District Health Team (DHT), participating at all levels of developing the health services in the district. The main health centre is the focal point at sub-county level and serves a 20,000+ population, providing preventive, promotional, outpatient curative, maternity, in-patient and laboratory services. The AHA operation has gradually grown to a network of 23 permanent health units, which are equipped with VHF radios.

Beneficiaries

After a re-registration exercise carried out in the first half of 2001, the beneficiary population of AHA's assistance was estimated at 57,700 refuges and some 40,000 nationals.

A majority of the refugees are Christians like the local population, with a considerable minority being Muslim. Most of the beneficiaries are farmers and others are engaged in small businesses, and a limited group being employed by the programme and partner organisations.

7,563 (13.1%) of the refugee population were in the 0-4 age group; 23,337 (40.4%) in the 5-17 age group; and 26,810 (46.5%) were 18 years and above. 28,129 (48.7%) were females and 29,581 (51.3%) were males. The population is located in 34 settlements and one transit camp.

In 2001, a total of 1,753 births were registered and 291 deaths were documented. The birth and death rates were 30.6 and 5.1 per 1,000 giving an annual population growth rate of 2.55%. 14.8% were children under-five and 23% were women in reproductive age.

Assistance and Services

The AHA service delivery system was largely integrated with the national/district system. Particular emphasis was given to capacity building to maximise sustainability and continuity of the services and to prepare for a sound handover process.

The Mongula health unit reached health centre status and was anticipated to become a referral hospital. The centre carries out emergency surgery and blood transfusions.

With such capacity in place, and the launch of a Self Reliance Strategy, the Mongula health unit, together with three other health units, will be ready for handover to the district authorities in 2002.

Implementation

AHA had 209 employees, of which 132 (63%) were refugees and 77 (37%) were Ugandans. The majority was technical staff with expertise ranging from medical (119), finance (4), administrative professionals (8), and 78 were non-technical support staff.

Support and field staff was deployed for supervisory activities to all health units throughout the year. Health Unit Management Committees were in place and reporting in all health units.

Funds were forwarded to Madi AIDS Control Initiative for HIV/AIDS prevention activities in the district. Another local NGO, Health of Adolescent Project (HAP) was also funded by UNHCR through AHA. HAP worked through adolescents, mainly girls, to promote reproductive health.

Monthly reports on the Health Management Information System (HMIS), Reproductive Health services, (RH), Food basket monitoring (FBM), weekly food reports and monthly food and drug consumption reports were submitted to all concerned. The Ministry of Health received monthly health unit reports and weekly surveillance reports on epidemic diseases.

Internal financial reports were prepared monthly. Quarterly sub-project monitoring reports were submitted to UNHCR. The second of these reports was accompanied by a mid-year narrative report. Plans and budgets were submitted for 2002.

691 patients were referred to the Adjumani hospital, 75 to the Gulu hospital, and 26 to Kampala according to UNHCR guidelines.

EPI vaccines, anti-TB drugs and contraceptives were supplied by the district. AHA conducted, in collaboration with Action Contre la Faim, two nutritional surveys in April and October.

Project inputs

Some of the AHA assistance and services were carried out as sub-projects in co-operation with or on behalf of specific partners. They included

- Community-based AIDS control *(Ted Turner/UN Foundation)*
- National Health Sector Strategic Planning *(MOH/PAF)*
- District Health Support Project *(MOH/ World Bank)*
- Emergency Preparedness *(HMIS/ MOH)*
- UNEPI Immunisation Programme, STD, TB control, Nutrition, Health Education, School Health, HIV/ AIDS (prevention, mitiga tion , advocacy), Integrated Management of Childhood Illnesses (MOH)
- Family Planning and Reproductive Health.

HIV/AIDS

Training activities included

- Training of 20 Health workers in counselling and Home Based Care to PLWAs which was conducted in co-operation with TASO.
- Training of 50 Traditional Healers in HIV/AIDS prevention and the use of herbal medicine by THETA and AHA.
- Training of 16 PLWAs in Health education techniques and counselling services by MACI and AHA staff.
- Training of AHA Laboratory Assis tants in diagnosing HIV by the Adjumani Hospital.
- 20 health workers attended a one-week workshop on clinical diagn-osis of HIV/AIDS
- The MS-Adjumani Hospital con-ducted VCT related awareness work shops for the CHWs and po litical leaders in the district.
- PLWAs gave HIV/AIDS related health talks in secondary schools
- A five-day IEC workshop for the Arua, Moyo and Adjumani districts was organised by AHA and UNHCR.
- HAP and the PLWAs were given project motor cycles to carry out HIV/AIDS activities.

World Food Programme

Based on the monthly food utilisation and weekly consumption reports, WFP supplied food for therapeutic feeding and TB patients.

UNEPI/UNICEF

The Uganda National Expanded Programme on Immunisation and UNICEF provided vaccines for all health units in the district.

UNFPA

Pending activities of the UNFPA project (Sensitisation workshops for Community Health Workers, teachers and community leaders, and training of TBAs) were both completed in April.

PAF

AHA was handling grants to 11 lower-level health units, providing Minimum Basic Health Care Packages on behalf of the Poverty Alleviation Fund. Other ma-jor activities included

- Training of health workers on ma laria case management.
- Refresher course on Integrated Management of Childhood Illness.
- Workshops for Heads of health units, local Council chair persons, and members of the Health Committees.
- First aid training in schools.
- Purchase of drugs, clinical equip-ment, first-aid kits for schools.
- Repair of bicycles to facilitate out reach services.

Internal Dispensary Association

54 IDA drug kits were distributed; seven were given to Alere, Keyo and Magburu health centres respectively, and nine each to those in Elema and Agojo.

GTZ

Quarterly consignments of drugs were received from GTZ Kampala. With abolition of cost sharing, the number of consultations and the drug consumption at the health units went up considerably.

Kikagati

At the end of 2001, Tanzania expelled some 2,700 Ugandans, living illegally in the North Western parts of the country. They were resettled in a camp in Kikagati, which is characterised by a low water table, making sanitation conditions in the camp appalling. AHA responded by donating a 2,000-liter water tank, 30,000 malaria tablets and one cartoon (1,680) condoms.

West Africa

Background

In 1997, Africa Humanitarian Action, in line with its post conflict humanitarian engagements in Eastern and Southern Africa, prepared to extend its interventions to Western Africa, especially Sierra Leone and Liberia.

Shortly after the installation of a civilian government, AHA undertook an assessment mission to Sierra Leone. Complimenting the early efforts of the UN agencies and the government. AHA presented a health service project to its traditional funding partners. AHA's Sierra Leone project targeted some 40,000 potential returnees and the same number of internally displaced persons in Western Sierra Leone.

However, despite AHA's readiness and the positive attitude shown by partners, the second wave of rebel insurgency and resumption of the civil conflict in 1998 curtailed the project.

In 1999, AHA diverted its attention to Liberia, where humanitarian and social needs were mounting. Based on a comprehensive assessment and consultations with government agencies, the UN Country offices, NGOs engaged in refugee and returnee assistance, AHA produced two separate projects: one targeting Liberian returnees to the Maryland County and the other Sierra Leone refugees in the Lofa County.

AHA's efforts to secure the necessary funding met with positive response only from the Organisation of African Unity (OAU) backed by the Government of Japan. The OAU made available USD 100,000, earmarked for the Lofa project, which, however, only constituted 10% of the original project budget.

AHA was forced to scale-down the project to match the funds available. A project, providing post emergency rehabilitation packages to some 2,000 heads of households among the Sierra Leone refugees in the Lofa County was developed and subsequently implemented in collaboration with the Liberian Red Cross Society (LRCS).

Implementation

The project objectives were to provide packages of shelter materials, agricultural tools and seeds thus contributing to a successful settlement of the 2,000 families of refugees over a three-month period.

Since the project was designed to be executed within a time frame of three months, a number of pre-implementation preparations had to be undertaken. A review of specific objectives, actual numbers of beneficiaries size and their most urgent needs, kind and quantity of supplies, were carried out in 2000.

This work was conducted in co-operation with the International Federation of the

Red Cross and Red Crescent Societies' delegation in Liberia and the LRCS. An agreement between AHA, as the supervising and monitoring partner, and LRCS, as the implementing agent in the field, was signed in December 2000.

AHA purchased shelter materials and agricultural tools on the basis of competitive bids, quality of products and time of delivery. Subsequently funds for clearance, transport, purchase of seeds, fertilizer and administrative overheads costs were transferred to an AHA bank account in Monrovia. AHA appointed a prominent personality to countersign fund withdrawals in accordance with the approved budget.

Ahead of the implementation in June 2001, AHA and LRCS secured the awareness and collaboration of the beneficiaries, the local authorities and the UNHCR.

The project was implemented between June and September 2001. Project-related "task teams," composed of representatives from UNHCR, the local LRCS Chapter, the refugee community and NGOs serving within the community were con-stituted and assigned with individual responsibilities, and monitored by AHA.

Shelter units were erected and allocated among the beneficiary families. The distribution of agricultural tools and seeds were incorporated into the UNHCR food security programme in the settlement. 850 farming groups benefited from the farming implements and seeds.

ZAMBIA

Background

Since January 2000, Africa Humanitarian Action has provided emergency, health, nutrition and sanitation services to the Mayukwayukwa settlement, in the Kaoma District of the Western Province. In July 2001, AHA also assumed responsibility for the Nyangweshi refugee camp.

AHA operates through a community-based referral system and early identification of cases by community health workers (CHW), trained traditional birth attendants (TBA) and outreach primary health staff, sanitation cleaning campaigns, and health related education. AHA also supplies drugs/medicines, clinical equipment and consumable materials.

AHA employs four international and 22 national professional staff . It has 15 national staff members in finance and administrative positions, and 120 semi-skilled refugee support staff. The UNHCR financial contribution was USD 600,000 in 2001.

Mayukwayukwa

At the end of 2001, the refugee population, almost exclusively from Angola, had reached 25,000. The population of the surrounding communities benefiting from the programme was estimated at 9,500.

Health services

The health centre provides around the clock services. The satellite clinic in Shebanga provides outpatient consultations and emergency inpatient services. Mangango Mission and the Kaoma Hospitals serve as referrals for diagnostic purposes, blood transfusions, and surgical interventions.

Malaria was the leading cause of morbidity followed by respiratory infections, gastroenteritis, skin infections and worm infestations. Diarrhoeas increased due to the scarcity of safe water i.e., under ten litres per person per day. Malaria was also leading mortality cause followed by severe malnutrition and gastroenteritis, and dehydration and ARI. The mortality rate was kept in check through preventive outreach services.

The TB situation was stabilised through health education campaigns, defaulter tracing and BCG vaccinations. An increase of cases was registered after the influx of new refugees in October.

The STD clinic operates both at the health centre and the clinics, tracing of contacts being done by the CHWs. Reproductive Health information and services, including ante-natal care, safe delivery, post-natal care, and family planning were given regularly at the centre and the clinics. TBAs attended to home deliveries.

The Expanded Programme for Immunisation (EPI) and Growth Monitoring operates at the centre and at five posts in the settlement. The growth monitoring followed a total of 2,204 children of which 1,550 children gained weight and 654 lost weight. AHA participated in the National Polio Immunisation Campaigns.

Nutrition

Shortage of staff and the lack of proper structures for food distribution affected the food basket monitoring negatively.

Two nutritional surveys were conducted showing a global malnutrition rate of 5.1% and 3.7% respectively.

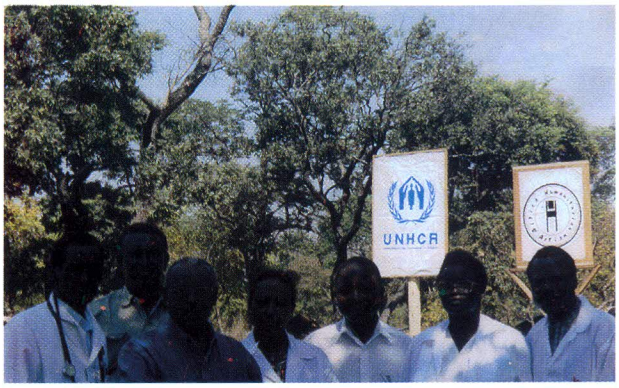
The nutrition field workers ran the dry blanket supplementary feeding programme at five distribution sites. The average number of monthly beneficiaries was 1,300 composed of under-fives, pregnant and lactating mothers and TB patients.

Over 200 children with severe malnutrition and patients with chronic illnesses benefited from therapeutic feeding.

Sanitation

CHWs help refugees to build family and garbage disposal pits. They also organise regular cleaning campaigns, vector control and surveillance of communicable diseases. The coverage of latrines and disposal pits was nearly 100%. However, the recent influx of refugees has led the coverage rate to decline. AHA constructed 318 latrines and disposal pits for highly vulnerable families.

The shortage of water in the settlement was serious. New settlers were unable



The AHA team at Mayukwayukwa

to access safe and adequate water in their vicinity. They are now getting their water from the river which has led to more patients calling at the clinics.

Manpower and Training

Information and education were daily activities of CHWs/home visitors/ health animators/TBAs in the settlement. Topics included personal hygiene, skin health nutrition and dietetics, antenatal care, post-natal care, family planning, STD/HIV, prevention of diarrhoea diseases, malaria, eye health and vaccine preventable diseases. CHWs and TBAs received in-service training throughout the year

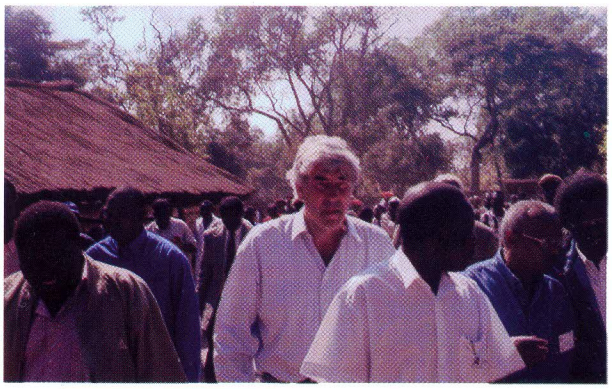
Nangweshi

The Nangweshi camp was opened in 2000, and is situated 760 km to the West of Lusaka in the Shangombo District, Western Province. In July 2001, AHA took over the health and nutrition services in this camp from MSF-Holland.

The mainly Angolan population numbered 14,000 in July but rose steadily to reach over 23,000 by the end of the year. The surrounding Zambian community was estimated at 5,000.

Health services

In the first two months, the medical team started off with what could be described as care and maintenance. As more refugees started to arrive in large numbers, a satellite clinic was opened to reduce



High Commissioner for refugees at Nyangweshi

the congestion at the main clinic, calling for recruitment of more staff and intensified health education campaigns.

The construction of a health clinic in the camp was mobilised since the existing structures were inadequate and dilapidated; referrals to Senanga were high, and the transfer of patients to the district hospital during the rainy season difficult. The United Nations High Commissioner for Refugees, Mr Ruud Lubbers, laid the foundation stone on 7 July 2001.

Outpatient consultations and morbidity

Outpatient services were managed by three clinical officers with an average caseload of 200 consultations per day. The most common causes of morbidity were malaria, respiratory infections, diarrhoea malnutrition and pneumonia. In August, skin infections mainly due to chickenpox were rapidly brought under control.

Mortality remained within WHO standards in a refugee set-up. The most common causes of mortality were malaria, pneumonia, mal-nutrition, and diarrhoea.

Tuberculosis

When AHA took over, all diagnosis and treatments were carried out at the Senanga Hospital. A laboratory, with the capability to diagnose TB cases by sputum checks was put in place.

Home visitors instituted the directly observed treatment system and did defaulter tracing. This ensured improvement in compliance. Anti-TB drugs were supplied by the district health authorities. BCG vaccinations were carried out as a preventive measure.

Reproductive Health

The reproductive health services (antenatal clinic, delivery and postnatal services); Family Planning; Sexually Transmitted Diseases, including HIV/AIDS; and Sexual and Gender Based Violence. Family planning and attendance improved markedly as shown below. Condom use was at 10% and the contraceptive prevalence rate at 14.8%

Sexually transmitted diseases were diagnosed and treated. Those with suspected HIV/AIDS received symptomatic treatment and counselling. Campaigns aimed at preventing STDS and HIV/AIDS were done on a regular basis. 1,200 leaflets were printed and distributed to the adolescents. The prevalence of STD was very high among the new arrivals. Because of the campaign, the number of cases dropped in December.

EPI and Growth monitoring

The expanded programme for immunization was conducted in collaboration with the district health board, and WHO provided the vaccines. Immunisation was carried out against measles, diphtheria, whooping cough, TB, polio and tetanus. AHA the national campaign for eradication of polio by providing technical and logistical support to the district.

Vitamin A supplement was given as a routine to under-fives. One case of suspected measles was identified at the satellite clinic but responded to treatment. AHA staff was deployed at Shagombo, the boarder entry point, to vaccinate new arrivals. By the end of the

year the vaccination indicators for measles were 100%, polio 99%, BCG 92%, and TT 81%.

Growth monitoring of children 6-59 months continued throughout the year.

Laboratory activities

Since the camp laboratory is the only one in the Shangombo district, it is serving the entire community. Blood was tested for malaria, RPR for syphilis, sickle cell disease, white blood cell count and differential, and haemoglobin level. Stool tests were carried out for intestinal parasites. Urine was tested for epithelial cells, granular casts, red blood cells, pus cells, sugar and protein. Cerebrospinal fluid for meningitis and sputum for TB bacilli. were also examined.

In-patients

AHA recruited additional staff, both refugees, and Zambians. As a result, the number of referrals was cut. It is anticipated that the service will improve further after the completion of the clinic. The most common causes of admission were malaria, pneumonia and diarrhoeas.

Training

Training started at the very onset of the project. 30 community health workers were trained in community-first aid, the use of basic anti-malarial, oral re-hydration salts and analgesics, health education, and STD/HIV AIDS prevention.15 Traditional Birth Attendants were trained in safe delivery practices.

The co-ordinator held briefings every morning with the CHWS supervisors to monitor developments in the community.Training on the rational use of drugs was conducted once a month.

Information, Education and Communication

IEC materials in Portuguese and English were printed. The health promoters and home visitors held 1,023 sessions for 16,585 participants.

Nutrition

A nutritional survey was conducted in July and revealed a global malnutrition prevalence of 2.1%, and 0.35% for severe malnutrition.

The dry supplementary feeding catered for 28 TB patients, 84 lactating mothers, 23 pregnant mothers, and 205 cases of moderate malnutrition, including vulnerable unaccompanied minors. HEPS were provided for preparation at home.

The wet supplementary feeding catered for those discharged from the therapeutic feeding centre. They were fed with highly nutritious food at the centre.

The therapeutic feeding catered for the severely malnourished who were admitted for intensive care. After improvement they were transferred for day care. The rate of recovery was 88% and the average total stay was 16 days. In addition cooking demonstrations were conducted on a regular basis at the clinic and the community kitchens.

Food monitoring

The adequacy of food rations and the efficiency of the distribution were monitored regularly. 30 families were randomly chosen at every distribution and rations weighed and compared with the targeted quantity and for calorie content.

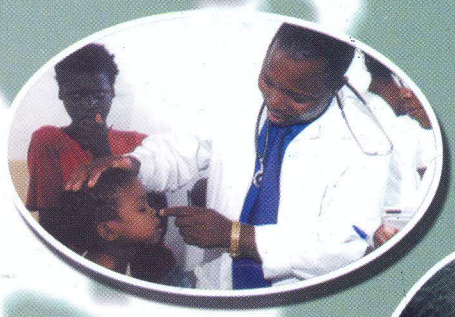


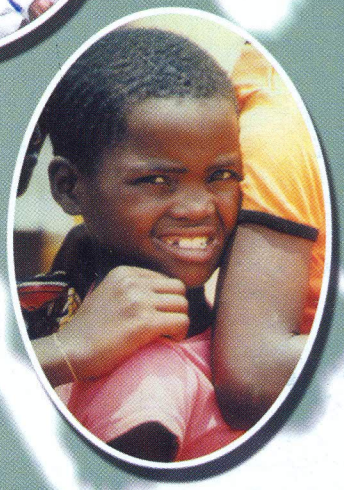
AHA Statement of Income & Expenditure for 2001

Income	USD	
Head Office	208,653	
Angola	1,006,140	
Ethiopia	184,847	
Namibia	89,508	
Rwanda	665,235	
Uganda	491,708	
West Africa	33,118	
Zambia	931,839	
TOTAL		**3,611,048**

Expenditure			
Head Office	Operational costs	175,357	
	Capital investment	19,675	
	Geneva Office support	6,672	
Angola	Health & Sanitation	754,116	
	Ops. & admin. expenses	252,024	
Ethiopia	Reproductive Health	142,954	
	Ops. & admin. expenses	33,180	
Namibia	Health & Nutrition	81,895	
	Ops. & admin. expenses	7,613	
Rwanda	Health & Nutrition	535,776	
	Ops. & admin. expenses	124,341	
Uganda	Health & Nutrition	373,945	
	Ops. & admin. expenses	112,962	
West Africa	Rehab. assistance	33,118	
Zambia	Health & Sanitation	787,788	
	Ops. & admin. expenses	136,704	
TOTAL			**3,578,120**
EXCESS OF INCOME OVER EXPENDITURE			**32,928**

External Auditors	
Head Office Angola Ethiopia Rwanda West Africa Zambia	A.A. Bromhead & Co. Chartered Accountants Associate firm of KPMG
Uganda Namibia	PricewaterhouseCoopers Chartered Accountants





Africa Humanitarian Action

African in spirit, concept and composition

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 fore-most, the responsibility of Africans. Not only should Africans be seen working alongside their international colleagues, they must take a lead role in assisting fellow Africans.





The Way Ahead...