Africa Humanitarian Action



Annual report 2002

June 2003

AHA - African In Spirit, Concept & Composition

Who We Are

AHA is one of the leading humanitarian assistance and development agencies in Africa. Our work spans the continent, and addresses a wide range of humanitarian issues, notably assistance and services to refugees, displaced persons and vulnerable communities in crisis situations and distress. We are expanding our contribution to the fight against HIV/AIDS, Tuberculosis and Malaria and other diseases of poverty. We will also address the problem of common injuries so frequent on our continent.

AHA's identity has been shaped by the belief of its founders that alleviating crisis in Africa is chiefly the responsibility of Africans. Being African, we strongly emphasise finding African solutions to African problems.

AHA has a nine-year record of comprehensive emergency, health and social services for refugees, displaced populations and local communities in eleven African countries. Most of its interventions are based on a long-standing co-operative partnership with the United Nations High Commissioner for Refugees (UNHCR). For eight consecutive years, AHA has received a clean bill for all its programmes by its partners and auditors alike.

Furthermore, AHA has spent nine years being an operational partner for major international organisations in countries as diverse, difficult and dangerous as Angola, Rwanda and Sierra Leone. AHA has shown the ability to fulfil both local and international expectations.

Now, we want to move on and become an autonomous, permanently functional organisation, with a long-term vision and the ability to formulate strategies responsive to Africa's needs. Potentially, we have the necessary resources – the leadership, the expertise and a growing credibility. Only one element is missing: the institutional funding 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. Such support can produce real and long lasting results, not least by empowering Africans to identify and implement the solutions to African problems.

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MESSAGE FROM THE PRESIDENT



A major event in the year was the AHA Second Assembly of International Trustees. New Trustees were introduced. Dr. Salim Ahmed Salim, a prominent African personality, was elected AHA's Chairman. Sheik Mohammed Hussein Al-Amoudi, a well known entrepreneur and philanthrop was named Co-chair.

A new feature of the Assembly was the invitation to 'Friends of AHA', from among the international humanitarian community, whose active participation in the discussions made the Assembly's deliberations particularly fruitful.

Among the Assembly's resolutions, the decision endorsing the formation of *AHA Country Associations* stands out as particularly timely. Accordingly, a revised AHA Charter and a model Statute for AHA Country Associations were also adopted. The Assembly decided to diversify AHA's activities more aggressively, to engage in HIV/AIDS, TB, and Malaria. In line with its new Charter, the Assembly also called for AHA's more active involvement in human rights and good governance in Africa.

2002 was a good year of operations in the care of refugees and displaced populations in Africa, in partnership with the UNHCR. The diverse programme activities are detailed in this report. Towards the end of the year, we returned to Burundi, to relaunch our field programme activities.

Our efforts at mobilising resources towards *AHA's Strategy for Institutional Development* continue to attract good hearings and reviews. All seem to agree that, only by actively involving and by strengthening African civil society can we address the multitude of humanitarian crises facing Africa. However, AHA's efforts to secure core funding for institutional development have not been fully met. When it comes to strengthening the institutional capacity of African civil society ... there is always a *'but'*.

Africa Humanitarian Action has gone hat-in-hand to the international fund holder community trying to explain this predicament. We are convinced that strengthening African civil society constitutes a crucial component in efforts to reduce and solve the myriad of problems confronting the continent. AHA is prepared to assume its responsibility in making this a reality.

We will continue with our endeavours to mobilise resources in the coming years towards our institutional development goals. We call on stakeholders and friends to contribute in pleading the case.

ANGOLA

2002 brought major changes to Angola. First a ceasefire, and eventually a peace agreement was negotiated between the warring factions.

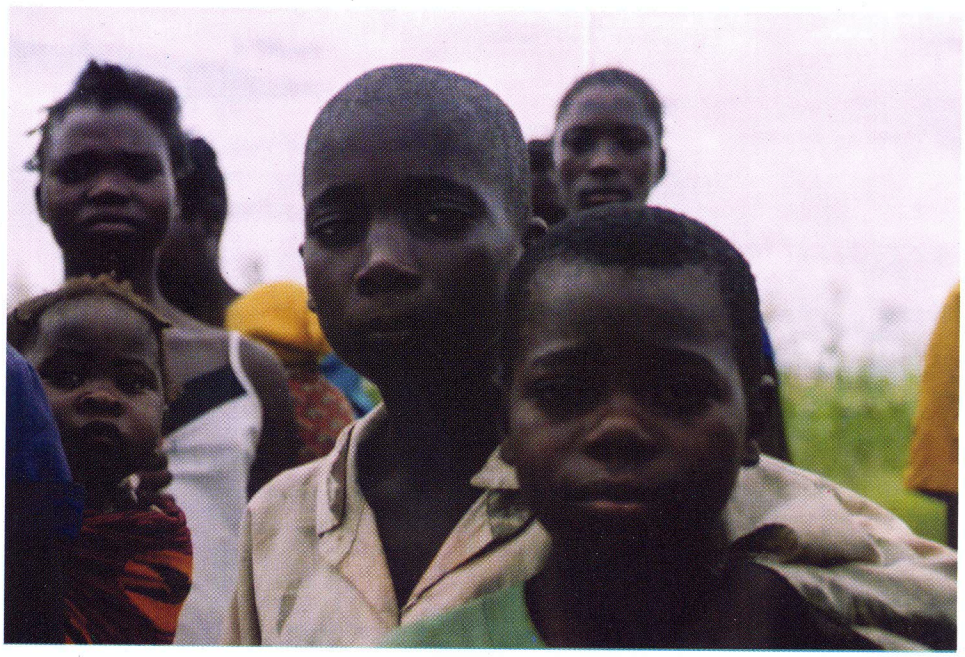
The subsequent assembly of UNITA soldiers and families into gathering areas presented challenging emergency problems, as there was severe malnourishment amongst both the adult and child population. However, due to the interventions of the Government, UN system agencies and NGOs, the situation was abated. The population located in the areas cut off from assistance due to the war suffered more severe health related problems, and continue to do so, as some of the areas were still unaccessible due to uncleared land mines.

Beginning in May 2002, AHA implemented UNHCR and OCHA funded emergency programmes in the Moxico province and in Uige, to cater for the displaced and ex-combatants in the gathering areas as well as the surrounding catchment population. AHA programmes in Angola are comprised of the following key team members for each project - a medical doctor who serves as the project coordinator, a social worker, a water technician and a logistics administrator. The Luanda refugees and displaced programmes is comprised of a project coordinator, camp manager, assistant logistics, pre-school teachers, and a social worker.

PRIMARY ACTIVITIES

LUANDA PROVINCE

The DRC and Rwandan refugees in Angola are concentrated in the Viana and Kifangondo Camps. AHA is responsible for the distribution of food and non-food items to refugees living in these camps as well as in urban areas. AHA's activities include camp management, social activities, micro-finance programmes to instill self-reliance, and the provision of basic education. Other NGO partners in the camp are COSV, who provides health services, and JRS who provides educational services. A monthly meeting is held to coordinate activities between the organizations.



Internally displaced in Angola

The refugees at Kifangondo were previously settled at Boa Esperanca (Bengo Province) but returned to Luanda following military activities in May 2001. This camp is situated on a foothill making construction of homes impossible. As a result, the refugees live in temporary shelters while awaiting resettlement to a permanent site. Water access remains limited and until March, the refugees were collecting water from UNHCR water tanks. They are now using a fountain for domestic use. Latrines have been built for use in Kifangondo.



Internally displaced in Angola

While individual mud-adobe houses were built at Viana, heavy rains resulted in the destruction of many, as well as a 20% loss of the available latrines. As a result, a plan to further support individual house construction has been drawn up and additional latrines are under construction. Piped water has also been made available.

The most common causes of morbidity in the camps are malaria, diarrhea, respiratory infections, and intestinal worms. AHA distributed UNICEF-donated impregnated mosquitoes nets in the camps. General health and hygiene matters, including HIV/AIDS were discussed with the refugees; they were encouraged to seek medical attention from the UNHCR designated health posts. Community Programme projects, that specifically target women, were also initiated and monthly meetings were held with pregnant women.

A Children's Education Programme, which prepares them for more formal schooling by introducing them to elementary arithmetic, drawing, and reading has been set up. This service was given throughout the year with good attendance. In Viana, a primary school with six classes was constructed that was made up of three school shifts, while in Kifangondo the lessons were conducted in two shifts and focused on adult literacy.

Various income-generating activities were formed such as the husbandry of pigs, where the plan is to produce enough to use both as food and as an income generating activity. Other refugees were involved in a plan to buy dry fish from Bengo province and sell them in the refugee camps. In the last quarter of the year, youth were taught how to make bread and cakes, which they sell as an income generating activity.

Zaire Province

The AHA programme includes HIV/AIDS and malaria prevention, awareness of water borne diseases, agriculture, water

and sanitation, adult education, and school construction; it was aimed at IDPs, returnees, and the resident population.

AHA, with the support of UNHCR, works in the municipalities of Mbanza Congo, Mandimba, and Cuimba. AHA also works in partnership with the IEBA (Baptist Church) and IKA (Kimbaguist Church) where the doctor attends to patients once a week and provides medicines.

In Mbanza Congo AHA worked in the first quarter in the two IDP camps, Mbanaza Manzina and Nzolani, which were closed after the signing and implementation of the peace agreement. A few of the IDPs that did not leave were transferred to Kiowa camp where AHA continued to provide health services. Services were also provided to returnees at Kiowa camp and at Luvo, at the frontier.

HIV/AIDS awareness activities were carried out in Mbanza Congo among military personnel, school children, youth, churches, women's groups, pregnant women in antenatal care, and patients in hospitals. In Madimba these activities were held among UNITA's ex-combatants and their families, and in the *bairros*. In Luvo it was among the returnees and the military at the border.

A short-term cassava seed was introduced and distributed to the population. Four grinding mills were distributed to women groups from *IKA, IEBA, PROMAICA* and *AMPA*. Funds from the mills are to be used for the construction of a women's social hall.

A planned water protection programme for the *bairros* was delayed because of transport problems; however, by the end of the year, the material was on the ground, ready for the commencement of construction. Two water points will also be protected in the first quarter of 2003.

Uige Province

AHA's intervention concerned health, water and sanitation, IEC on sexually transmitted diseases, HIV/AIDS, water borne diseases, and micro-credit schemes.

AHA assisted in the transportation of the vaccination team to areas outside the hospital. While a large number of people were accommodated at the Kikobolo Health Post, serious cases were referred to the Maquela Hospital.

HIV/AIDS teaching sessions were targeted at the police and army and were held in the town, *bairros*, and military camps and reached over 20,000 persons.

AHA worked on micro-credit activities among the returnees, IDPs, and residents of Manquela. This was well received by the community as it added to the family income. There are two main groups involved, IEBA and Catholic Mission, and each group was advanced 2000USD (100USD per woman), with the group acting as guarantor for the loan.

Adult Education was inaugurated with participants being taught Portuguese and mathematics. Portuguese was chosen as the refugees were from DRC and did not speak Portuguese. Mathematics was taught mainly to assist with commerce.

Moxico Province

AHA was working to reduce morbidity and mortality rates among the 17,750 inhabitants of Cazombo through the provision of medical assistance and improvement of the hospital's capacities. The hospital

underwent basic rehabilitation and health services were up and running. Although it has been refurbished with basic furniture and medical equipment, the operating theater was not fully equipped.

The AHA medical team worked with the municipal hospital team to provide on– the-job training. A ten day training course was held in November 2002 for traditional birth attendants. 20 of them were also trained in management of mothers during pregnancy, delivery, and post partum. Education on nutrition, prenatal care, delivery, handling of emergencies and referral, post natal care and reporting on the activities, was given.

Twenty activists were trained in Cazombo in health education and nutrition screening, using MUAC tape and community sensitization on sexually transmitted diseases, HIV/AIDS and other health related issues.

General briefings on health were held at Bento Mission while specialized programmes on HIV/AIDS, water and sanitation and others were held in the town and bairros.

BURUNDI

AHA has once again became in volved in Burundi during the last three months of the year, October to December 2002. During this period, AHA facilitated the repatriation of 100,000 Burundese refugees from Tanzania to Burundi. The intervention zones were the provinces of Muyinga and Makamba. Assistance provided by AHA ranged from transportation and accommodation to providing emergency health services, information, and education.

Services at these points included vaccinations against meningitis and other illnesses to ensure all refugees being repatriated were in good health. Efforts were made to establish a close relationship across borders to ensure better reception. Other problems that were addressed included symptoms like headaches, lumbago, and other general aches, all linked to fatigue caused by long trips.

The repatriated people benefited from the daily sessions of education and information on sexually transmitted diseases. More than 10,000 condoms were distributed and information was provided on how to access health services in some areas.

Apart from the consultations and emergency health care provided to the repatriated people, a daily sanitary education was started in December in order to make them aware of practices of environmental and personal hygiene. These sessions were also used to make them aware of parasites and diseases that result in diarrhea, in particular dysentery and cholera, as well as sexually transmitted diseases, especially AIDS. Children less than five years old who went through the centre were vaccinated against polio, tetanus, diphtheria and measles.

Once most of the repatriated people, mainly composed of children, pregnant women and older people, had arrived at the transit center of Mabanda, they were forced to walk for more than two days to cover a distance of 200 kilometers en route to their final destination. This left people weakened and heightened their susceptibility to further illness, straining the camp's resources. An issue that re-

quires addressing in the future is the improvement of the transfer method of the vulnerable people in order to bring them closer to their original community. It would also be desirable, to contemplate a particular follow-up of the older people and widows who have no one to assist them, once they have reached their destinations.

Ethiopia

In 2002, AHA Ethiopia started the second phase of its integrated Family Planning/Reproductive Health and HIV/AIDS prevention programme, expanding its coverage in the southern part of the country from two to seven *woredas* (districts). The project's main activities were to develop and strengthen community based services, to provide information, education, and communication services, as well as to strengthen Anti-AIDS clubs, and to work towards local capacity building.

The project covered 224 peasant associations (villages) and 5 work place programmes (Sodo and Arba Mich) in the seven *woredas*. The experience obtained from the original two project *woredas* (Gofa and Shashemene) has helped in facilitating, organizing, coordinating and mobilizing resources and community members. Thanks to improved systems and better administrative support, less start up time was required for the new projects.

Public gatherings, market places, programmed home visits, school mini media clubs and prison health service programmes have been used to sensitize people towards the prevention of sexually transmitted diseases, HIV/AIDS, and the use of quality reproductive health services.

Project Activities

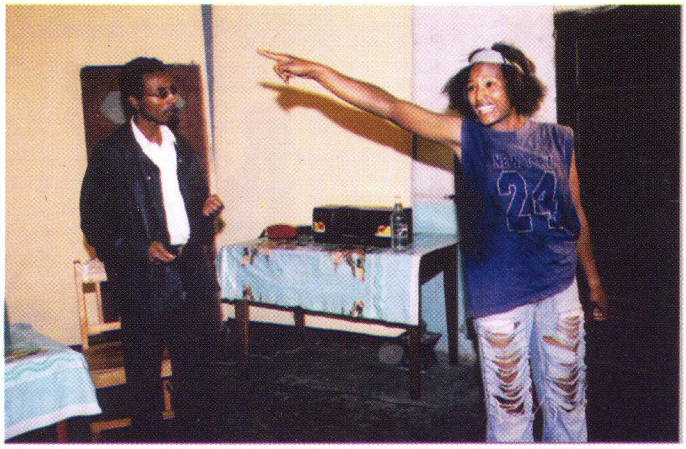
Community Based Reproductive Health Agents (CBRHAs), youth and women promoters paid some 80,000 home visits in the project catchment areas and conducted some 5,000 group meetings. In the course of the year, a total of 440,000 persons were informed on quality use of RH/FP services and prevention against STDs/HIV/AIDS. Out of the total number of people sensitized, 260,000 were adolescents aged 15 to 25 years old. In addition to the routine awareness creation programmes, special sessions were organized for adolescents, focusing on harmful traditional practices, sexual abuse and harassment, kidnapping and the effects of early marriage.

The number of trained volunteers (community based RH distribution agents, women educators and out promoters) has doubled.

The 32 Anti-AIDS clubs in all project *woredas* have intensified their efforts towards the prevention of sexually trans-



HIV/AIDS Sensitization



A school mini-media club for HIVAIDS awareness

mitted diseases, HIV/AIDS and the use of quality reproductive health services. The Anti AIDS clubs are established mostly at schools, and they use diversified approaches, ranging from poems, sketches and role-playing, as well as the use of circus performances. In addition, billboards that provide information about HIV/AIDS have been erected at the outskirts of each town and at schools. On the *World AIDS Day*, the Anti AIDS clubs from each *woreda* coordinated a variety of presentations, songs and other awareness raising exercises.

As effective administrative and technical support is essential for field workers and project offices, due attention was given to ensuring timely action to address problems arising while implementing project activities. The required type and number of professionals were deployed to all sites, and community based reproductive health agents (CBRHAs) and peer educators were selected, trained, and deployed. Project advisory committees, that will assume an active advisory role in implementing project activities, were established in the new project areas. The country office provided the local project offices with administrative back-up and technical support, and regular monitoring of progress. Different follow-up mechanisms were designed to enable the effective exchange of information.

The four project advisory committees established in each *woreda* have undertaken their own regular sessions. At these sessions, they reviewed activity progress and the possible support they could provide for the effective implementation of project activities.

Their involvement and active participation in mobilizing concerned government offices, beneficiary communities, and other interested parties, was instrumental for the proper execution of project activities. Some even participated in monitoring and field supervision, in cooperation with the regional AHA Offices.

Human resources development, such as



At a Well-baby Clinic

capacity building and sensitization seminars, have also been given due consideration throughout the year. Understanding that investing in the available manpower and volunteers will contribute to quality FP/RH services, the programme has allocated money for training as a major component of the project. The short-term trainings have exposed trainees to the modern use of contraceptive technology and the means of introducing new techniques and procedures. New communication skills trainings have also been given to volunteers and to the staff.

Training of trainers (TOT) was given to 12 senior health professionals selected from MOH Institutions and AHA project offices for fifteen days. A training consultant was hired to do the job. It was an important event in the history of the project, which is intended to exert multiple effects in the field of community-based reproductive health agents training. Several training programmes were conducted subsequent to the TOT training and trainers were selected from the batch of professionals who undertook the TOT course.

Having recognized AHA's engagement with FP/RH activities in rural Ethiopia and its successful efforts so far, Family Health International/FHI has entered into a co-operative agreement. To this effect, FHI allocated to AHA Br 220,185 to strengthen evaluation and monitoring activities. The one-year programme is being phased out.

Feed back reports from the monitoring teams highlighted the good performance of the local AHA project offices. To give one example, the monitoring team expressed its findings on Shashemene thus: " AHA - Shashemene rural FP/RH services could be taken as a source of experience sharing for other NGOS."

Namibia

The 2002 AHA services included curative and preventive health, water and sanitation, nutritional rehabilitation, HIV/AIDS sensitization, health education and promotion, and counseling, in Osire and the Kassava transit camps.

With support from our partners, such as the Ministry of Health and Social Services (MoHSS), and UNHCR BO, AHA was able to meet 90% of the set implementation targets. MoHSS was particularly helpful in regard to the provision of referral services, medication supplementation, nursing staff, and programme collaboration, which had a positive impact on the overall health and sanitation services. Similarly, the ministry has facilitated the technical and logistical aspects of the work. The American Embassy in Windhoek and the *Africa Refugee Committee* (ARC) also provided valuable assistance.

While the peace in Angola seems encouraging, the refugees are still expressing doubt and a mass exodus for voluntary repatriation did not appear likely at the end of 2002. Indeed, we were still receiving new refugees, albeit at a much slower rate.

Primary Activities

Osire Refugee Camp

Infrastructure

The Osire Refugee Camp is situated about 240km from the capital, Windhoek in the central part of Namibia. Osire currently accommodates about 24,000 refugees, of which over 95% are Angolans.

At the beginning of the year, AHA had only a small clinic to operate from and two additional 2x6m cubicles to serve as maternity and administrative offices respectively. Two tents served as an observation bay and a nutritional supplementary feeding center.

During the year, a fully equipped 24-bed hospital, an office block , staff quarters, a nutritional rehabilitation center with storage facilities, a cubicle for the pharmacy as well as a store room for pharmaceuticals and general service facilites were added.

This has helped to ensure that AHA's expansion of its services from limited curative to all aspects of health services in the camp, including preventive medicine, HIV/AIDS services, and nutritional rehabilitation of the refugees, has been successful. In 2002, the staff at the camp numbered over 100.

The hospital had an average monthly admission of 230 patients which reduced referrals from about 45% to less than 5% of all patients. For the admitted cases, referral was reduced to about 9%, mainly surgical and complicated deliveries. The major cases referred out/or medically evacuated were related to ophthalmology, dentistry, or major surgical operations. 437 refugees were assisted, and had eye interventions in the course of the year. Two refugees received successful open-heart surgery.

Health Services

The high mortality rate in Osire had shown a downward trend as the camp population stabilized and the quality of health care continued to improve.

The female to male mortality ratio was male 43 [44.8%] and females 53 [55.2%]. The mortality rate among children under-five accounted for about 66% of all deaths - 53% were male and 47% females.

Malnutrition remained the highest cause of mortality in the camp accounting for about 19.79% of all mortality. It is followed by respiratory diseases such as pneumonia (15.6%). HIV/AIDS and related illnesses rank as the third highest cause of death with 13.5%. Comparing the five highest causes of morbidity at the end of the previous year, we note that the top five diseases remain the same with HIV/AIDS gaining significant ground in the course of the year.

HIV/AIDS is a fast-growing problem; it is estimated that about 25% of the camp population may have been exposed to the virus. Some of the other mortalities may also be HIV-related, but since not all patients were screened for HIV, we can only speculate. HIV/AIDS services will have to be intensified in the entire camp and all efforts presently going on should be strengthened.

Though there is a low prevalence of tu-



AHA In the Wards

berculosis in the camp (2.9/1000) families with positive cases are being screened, as it is usually a co-infection in cases of HIV/AIDS. Education, surveillance and contact tracing will need to continue.

The nutritional survey of the children in the camp in November/December 2002 revealed a reduction in both the global malnutrition rate (14.93% in 2001 down to 7.23% in 2002) and the severe acute malnutrition rates (4.49% in 2001 to 0.008% in 2002).

There has been a significant improvement in the contraceptive coverage from last year with an increase of 6% to 23.78%. Despite this improvement, major hindrances to utilization of the services are still occurring. Segments of the population argue that they need to have children to make up for those lost in the war. Secondly, there are a lot of traditional beliefs that need to be corrected through health education - e.g "that women never get pregnant again if they use contraceptives". Thirdly, some men are against it and their wives therefore will not practice family planning. These obstacles have contributed to the low usage and contraceptive prevalence rate despite the improved access and availability of services.

There were four general vaccination campaigns in the camp - a national immunization campaign 3,855 (97% coverage), and three measles vaccination campaigns. All yielded coverage of over 95% of the targeted population.

While there was a measles outbreak in March to June, the index case was rapidly identified as being a newly arrived refugee. An investigation was swiftly conducted and the case was reported to the MoHSS. Immunization of all children from 6 months - 14 years was conducted and over 19,000 people were vaccinated for measles. The last case was reported in October. The containment of the outbreak and the mopping up of residual pockets indicate the effectiveness of intervention strategies.

Training and health education continue to be an important part of the strategy for dealing with all these issues. Two Training of Trainers workshop were held in the camp for 45 participants. Consultants from overseas conducted these trainings, with local inputs.

In addition, a number of community training sessions were held. An important area is the training of students and school pupils, who become ambassadors to their families. As the empowerment of the community is paramount, the health team was aggressive in conducting training and health education in the camp. Apart from the general health education sessions, focus group discussions were held on:

- HIV/AIDS
- Sexually Transmitted Infections,
- Reproductive Health - Family Planning
- Nutrition / Breast-feeding
- Immunization
- Hygiene sanitation
- Diarrhea disease.

AHA has also worked to improve the water and sanitation facilities with good results. There has been a considerable improvement in the well being of the people in the camp. Cases of water borne diseases have been reduced drastically and the noted case of the rare hepatitis E has been controlled. With the new waste disposal system and fortnightly clean up campaigns, the camp is much cleaner and

more pleasant to live in. This has led to the reduction in the incidence of malaria and other vector borne diseases.

Kassava Transit Camp

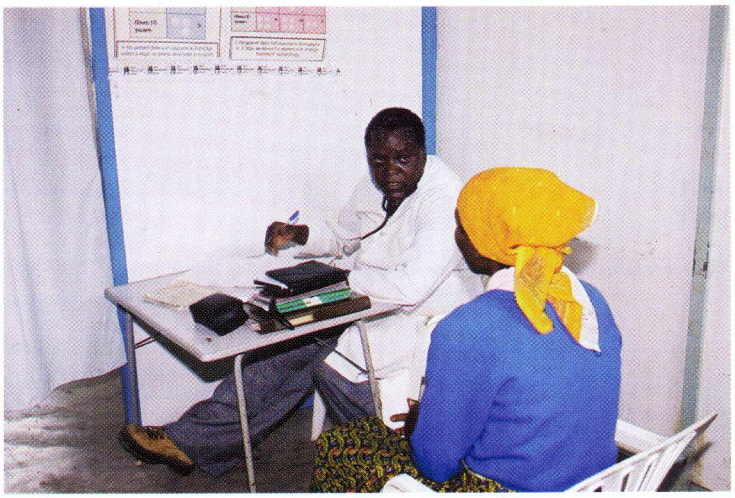
AHA's activities in the Kassava transit camp were in the startup phase in 2002. A notable achievement was the establishment of water and sanitation facilities for the refugees. The provision of water to both the human population and livestock helped in relieving some basic needs. All in all, the sanitation and water activities reduced inconveniences and ensured a more hygienic condition and better health standards for the refugees.

Major health activities carried out were: immunization, family planning, health education, and environmental hygiene. These activities enabled AHA to monitor the conditions and to offer appropriate solutions. When needed, patients were referred to the Rundu State Hospital, 70km away.

AHA is aware of the need to improve services further, and a more detailed and elaborate programme is planned for 2003. This programme will aim at building needed facilities to provide services to the refugees in the camp.

Rwanda

AHA Rwanda's primary activities took place at the Health Centre of the Kiziba Refugee Camp and the Surgical Unit of the Kibuye Hospital, both located in the Kibuye Prefecture. AHA provided general health and nutrition support and surgery for the



Clinic Consultation

14,000 refugees currently accommodated at the Kiziba Refugee Camp.

Throughout the year AHA had a total of 30,892 patient visits - mostly for malaria, respiratory tract infections, and gastro-enteritis. Almost all cases were handled on the spot with just over 1% requiring a referral.

Training was held for the medical staff at both the camp health center and at the surgical unit of the hospital. It ranged from practical on-the-job training for nurses in minor operative procedures to surgical nursing and surgical techniques for paramedics, staff, interns from Butare University and doctors. Training was also provided in the management of malaria, counselling of HIV infected pregnant women, the methodology of Health Education on HIV/AIDS, and on basic infection control & personal hygiene, as well as the prevention of sexual violence. AHA, in co-operation with the regional health bureau, organized a 3-day workshop on management of respiratory tract infection and diarrhea related illnesses, which were the major causes of morbidity in the camp.



Reproductive Health

The UNHCR distributed a report on sexual abuse and exploitation of refugee women and girls in West Africa, and organized a meeting to brief implementing partners. A task force, of which AHA is a member, was constituted so as to create a better mechanism to ensure the protection of refugees. In addition to serving on the task force, AHA has also implemented training for its own staff to ensure proper awareness of this issue.

Taking advantage of both special events like *World Refugee Day* and *World AIDS Day* and of general gathering places such as the feeding centers, health educators provided awareness and information sessions. Topics concentrated on major causes of morbidity and mortality in the camp, personal and environmental hygiene, prevention of malnutrition with optimal use of relief food, and ways to prevent the spread of STDs and HIV/AIDS. Better use of the different preventive services in the camp was also emphasized. Four community health education campaigns were conducted for different groups in the camp. These campaigns concentrated mainly on HIV/AIDS prevention, condom promotion and family planning.

World Refugee Day was commemorated in the Kiziba refuge camp on June 20, in the presence of high officials from Kibuye province, UNHCR, and NGO's working in the province. AHA displayed a photo exhibition on its activities and presented three short drama sketches on reproductive health, gender-based sexual violence, and HIV/AIDS. A drama on HIV/AIDS was also presented on *World AIDS Day*.

The AHA programme is currently facing several challenges. One example is that since PSI stopped its activity in March 2002, there has been no condom distribution in the camp. Distribution briefly resumed in September when UNCHR provided 12,000 condoms. However, two months later all distribution stopped due to an interruption in the condom supply. This has given rise to a series of problems affecting HIV/AIDS prevention and family planning programmes. In the face of the seriousness of this issue, repeated requests have been made for immediate action to either provide or allocate the necessary budget to purchase condoms.

The overall success of the programme can be attested to by the strong support and commendation received from a UNHCR auditor who, after examining AHA's operation, praised AHA as being one of the most successful African NGOs.

UGANDA

OVERVIEW

AHA Uganda's programme implementation continued with the provision of quality, accessible and integrated health service that allowed all to lead a relatively healthy and economically productive life. Adherence

to the expected programme outputs and their respective elements of the *Ugandan National Health Sector Strategic Plan* (HSSP), particularly to those pertaining to AHA's jurisdiction, was given due recognition.

Integration of health services as per national guidelines has seen two health centers handed over to the district in line with the Self-Reliance Strategy (SRS) plan.

Overall AHA' s set objectives based on the *Uganda National Minimum Health Care Package* (UNMHCP) have been appropriate and very relevant to the needs of the beneficiaries.

Description of beneficiaries

At the beginning of the year 2002, AHA had targeted about 59,664 refugees and 40,000 nationals.

There were a total of 1480 births and 233 deaths registered during the year. The natural demographic change along with new arrivals increased the target population of the beneficiaries.

The majority of the refugees, like the national population, are Christians with a considerable Muslim minority. Most of the beneficiaries are peasant farmers and small-scale petty business men. A small number are employed by the implementing partners. 60% of AHA's staff members are refugees.

Implementation Procedure

A Tripartite agreement of implementation was signed between *United Nations High Commissioner for Refugees* (UNHCR), *Africa Humanitarian Action* (AHA) and the Government of Uganda (GoU).

The first installment was received in the second week of March while the second was received in the second week of May. Delays in the release of funds and UNHCR financial constraints resulted in substantial budget cuts and omission, which affected the programme implementation virtually in all sectors.

Support and field staff were deployed with routine supervisory activities being conducted in all the health units throughout the year. Because of insecurity, one heath centre (Maaji C) has not been operational for the last half of 2002. Health Unit Management Committees were all functional.

Monthly and periodic reports on Health Management Information System (HMIS), Reproductive Health services, (RH), Food basket monitoring (FBM), weekly food reports as well as monthly food and drug consumption reports were submitted to all concerned. We also fulfilled our reporting requirements to the Ministry of Health (MoH).

Patients were referred to the Therapeutic Feeding Centre (TFC), Adjumani District Hospital, St. Mary's Hospital Lacor, Arua, Moyo Hospitals and Kampala, based on their medical needs and UNHCR guidelines. A total of 914 patients benefited from the referral services with 732 being referred to Adjumani district hospital, 51 to Gulu (Lacor), Arua, and Moyo hospitals. 18 patients were referred to Kampala.

EPI vaccines, anti–TB drugs, and contraceptives were obtained from the Directorate of District Health Services.

Four quarterly consignments of drugs were received from *GTZ Kampala,* and Basic Drug Kits from the *Danish Red Cross* through the Directorate of District Health

Services.

AHA continued with the intensive therapeutic feeding programme at the Maaji Therapeutic Feeding center, (TFC) which was later shifted to Ukusijoni Health Centre due to insecurity. The cure rate at the TFC has been 62%, defaulter rate 25.9% and death rate 4.1%, against the targeted <10% death rate.

Based on the monthly food utilization and weekly consumption reports, *WFP* supplied food for the therapeutic feeding programme. A consignment of DSM (Dry Skimmed Milk) was received from *GTZ*-Kampala, and cow milk was purchased for the feeding programme whenever DSM was out of stock.

Capacity Building/ Information, Education and Communication

Training of different cadres of staff continued throughout the year. The beneficiary community was also provided with group and individual health education messages which were reinforced with visual aids.

Partnership with local NGOs

Funds were forwarded to *Madi AIDS Control Initiative* (MACI) and *Health of Adolescent Project* (HAP) both local NGOs, for HIV/AIDS prevention and reproductive health activities among adolescents.

General Information

Health services rendered to the beneficiaries included the following:

- Provision of outpatient services in 22 health units from January to March and 20 health units from April to date, after the handing over of Mongula and Arra health units. In-patient services at the grade III Health Units.

- Out patient consultations for the period January – December totaled 129347 patients. Of these, 91473 (70.7%) were refugees and 37874 (29.3%) were nationals. 1537 new admissions were registered for the inpatient service of which 1330 (86.6%) were cured. Inpatient death rate was at 2.8 (38 deaths registered).

- Maternal and Child Health Care services at both the static and outreach centers. These services include: antenatal care, prenatal care, postnatal care and family planning. The EPI services, BCG coverage was 80.8%, DPT III cov-



Nutrition surveillance

erage was at 86.4% while measles was at 84.0%.Growth monitoring services were also given priority.

- Community Based health care service delivery continued through the Community Health Extension workers. 11 static and 10 outreaches were conducted monthly.

- All the Health units were supplied with medical and other supplies.

- Laboratory services in grade III health units were carried out.

- Ambulance services were provided for both refugees and nationals.

- Emergency surgical and comprehensive essential Obstetric services provided at the District Referral Hospital.

Other Related Activities

HAP/MACI and the Adjumani hospital implemented the HIV/AIDS programme under the UNF (TT) project. Adjumani Hospital continued with counseling, voluntary testing for HIV, and post-test counseling.

PAF Activities

The district released funds from the MoH to support the Lower Level Health units, including 11 AHA run units. These funds totaled Shs 102,845,147 for various project activities such as construction, renovation of some facilities, training and purchase of drugs.

Nutrition Survey 2002

AHA carried out nutrition surveys in April and October 2002. The aim was to determine the prevalence rate of malnutrition in the settlements of the Adjumani District. Specific objectives included determination of breast-feeding and weaning practices, immunization coverage, and latrine coverage.

The prevalence rate for malnutrition in April was 8.3% and 6.8% in October 2002. This marked a significant drop of 1.5% in malnutrition.

Zambia

AHA's activities in Zambia focused on providing health nutrition, and sanitation activities in Nangweshi and Mayukwayukwa refugee camps. The project, which is responsible for over 22,000 refugees in each camp and about 5000 local residents in the surrounding area, was supported by a wide variety of local and international organisations - *UNHCR, ECHO, UNICEF, WFP*, the Italian government, and our local partners at the Ministry of Health, and in the field. The services offered were in line with the Zambian Ministry of Health, *UNHCR* guidelines, *WHO* standards and the Primary Health Care approach with a Minimum Health Services Package (MHSP).

AHA started 2002 with a rather high refugee caseload, due to the large number of new arrivals during the last quarter of 2001. However, with a well-defined set of objectives, AHA managed to keep the health and nutrition problems under control.

Through the use of lectures and discussions, staff at MCH, TBAs and CHA were involved in health education. The topics



On the fence - coming out of malnutrition

covered included personal hygiene, nutrition, and the importance of antenatal attendance, family planning, HIV/AIDS, and immunizations.

There are currently three types of nutrition programmes under AHA Nutrition Center. They are: therapeutic feeding, wet or supplementary feeding, and dry feeding programmes. Therapeutic feeding caters to the severely malnourished and those with medical complications.

AHA provided nutrition services to its beneficiaries based on the admission protocol, (MSF Nutritional Guidelines 1995 Edition). Based on the annual plan, two nutrition surveys were conducted. The results showed that the level of malnutrition has been reduced. This was achieved through intensified nutrition programme activities and an encouraging level of community participation. Even though the results show a declining trend in prevalence, the nutrition programme has to continue. Another survey will be conducted next year to evaluate future need.

In Mayukwayukwa, top priority was given to the construction of a rural health center and nutrition feeding centers, and accommodation for national and international staff. In addition to completing the nutrition centers and drug store, the Outpatient Department of the health center was renovated and a satellite clinic at Shibanga was completed.

In Nangweshi, the Health Center is fully operational and equipped with all the required clinical and laboratory equipments. Fully equipped with facilities for delivery of children, labs, and a capacity of up to 24 inpatients, it has been proven to be a valuable resource. To assist the local economy and provide activities, furniture was produced on site using experienced refugee and national labour forces.

A new clinic was constructed at Kanja (Nangweshi Extension Camp). It provides consultations, allows for deliveries, and can house a small number of patients. The clinic has provided outpatient, emergency and MCH services for 6,148 recently



AHA health workers

transferred refugees.

All four components of the reproductive health programme: Safe Motherhood, Family Planning, Sexually Transmitted Diseases including HIV/AIDS and Sexual & Gender Based Violence (SGBV) were implemented in 2002.

Campaigns aimed at preventing the transmission of STDS including HIV/AIDS were conducted on a regular basis. Drama groups performed at selected sites in community gatherings and at schools on related topics. *World AIDS Day* was commemorated in the camp with entertaining and educational programmes, in collaboration with all implementing partners. The AHA Nangweshi medical coordinator gave lectures on STDs, on different occasions, to teachers and youth peer educators, as well as during workshops organised by *CORD*, and to youth groups, during a workshop organised by *Care.*

As part of its activity, AHA participated in the national campaign for polio mop-up by providing both technical and logistical support to the district. It involved house-to-house search and vaccination against polio of all under-five children.

Information, Education and Communication (IEC) materials in both Portuguese and English were prepared and distributed, carrying messages related to HIV/AIDS, family planning, sanitation and other health issues. The health promoters and home visitors were the main actors of health education activity. They used different public gathering areas like the market and health centres to give health education through lectures and discussions.

AHA continued to offer on the job training to its staff on health and nutrition services. Rational drug use by prescribers and management of diarrhea cases were emphasised to ensure quality service delivery to the beneficiaries. During the second quarter of the year, 30 community health workers were trained in a variety of topics while fifteen Traditional Birth Attendants were trained in safe delivery practices in the community.



Good Cheers

In June, there was a measles outbreak at Mayukwayukwa. After an increase in July it gradually decreased and vanished in September.

Community health workers led health education in the form of lectures, discussions, drama and songs, as a way of sensitising the community to the signs and symptoms of measles, ways to manage those affected, and also ways to conduct surveillance. The community was very responsive. With timely assistance from the District Health Office, the field

staff, and other supportive agencies, the epidemic was controlled during the first week of September. Later an epidemic preparedness committee was put in place to make the community aware of any further outbreaks and to ensure that any such incidences are reported on time.

Sanitation programmes were in effect throughout the year. The major activities were community mobilization through health education, construction of sanitary facilities, food quality control and cleaning campaigns. While AHA provided the community with technical knowledge and tools for digging the facilities, community members were both understanding and willing to participate in the programme. The proposed construction of sanitary facilities for the extremely vulnerable could not take place due to lack of funds. However, the community was mobilised to assist and 20 latrines and waste pits were constructed.

Cleaning campaigns played a major role in this programme. The figures for villages participating steadily increased throughout the year. This is a clear indication that the health education messages were effective and that the community appreciated a clean environment.

Our Strengths

- **AHA has developed from a one-project sub-contractor to a full-fledged institution, recognised for its quality performance and accountability. It has sustained a focussed approach and kept the size of its organisation proportionate to the scope and volume of its activities.**

- **AHA has played a paramount role in tackling policy issues of concern to both refugees and the organisations assisting them. It has consistently advocated the role and responsibility of African organisations in the search for durable solutions.**

- **AHA's policy of consistently involving refugees and local people alike has helped reduce tension and defuse crises, created equal opportunities, and contributed to safeguard ing human rights and self-esteem.**

- **AHA's concern about sustainability has repeatedly helped to fill the critical gap between emergency and reintegration. Its emphasis on capacity building has had an impact on local economic and social development.**

- **AHA's services have been recognised as both professional and caring by partners and clients alike. Its performance and achievements have demonstrated the contribution that can be made by African civil society to resolving African refugee problems and other similar issues.**

AHA Statement of Income and Expenditure for The Year 2002

Income	**USD**
Head Office	222,104
Angola	1,198,162
Burundi	48,706
Ethiopia	233,397
Namibia	885,201
Rwanda	422,466
Uganda	490,948
Zambia	1,075,639
Total	**4,576,623**

Expenditure	**USD**
Head Office	
Operational Cost	177,510
Capital Investment	2,100
Geneva Office Support	6,077
Angola	
Health and Sanitation	896,944
Ops. & Admin. Expenses	298,549
Burundi	
Health and Sanitation	31,867
Ops. & Admin. Expenses	16,717
Ethiopia	
Reproductive Health	204,026
Ops. & Admin. Expenses	18,767
Namibia	
Health & Nutrition	705,174
Ops. & Admin. Expenses	165,307
Rwanda	
Health & Nutrition	344,894
Ops. & Admin. Expenses	104,965
Uganda	
Health & Sanitation	322,024
Ops. & Admin. Expenses	137,582
Zambia	
Health & Nutrition	813,203
Ops. & Admin. Expenses	173,672
Total	**4,419,378**

Excess of Income over Expenditure 157,245

External Auditors

Head Office, Ethiopia	A.A. Bromhead & Co.
Angola	Chartered Accountants
Rwanda	Associate firm of KPMG
Zambia	
Uganda	Price Water House Coopers
Namibia	Chartered Accountants

Scenes from...
AHA's Assembly of
International Trustees
Sheraton Addis











Addis Abeba
February 2002

***Chair,* Dr. Salim A. Salim**
***Co-Chair,* Sheikh M.H. Al-Amoudi**
***President & CEO,* Dr. Dawit Zawde**

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Care,

Concern,

Commitment



AHA IS AN INDEPENDENT, NON-PROFIT HUMANITARIAN ORGANISATION, WHICH DEPENDS ON INDIVIDUAL AND INSTITUTIONAL SUPPORT FOR ITS ACTIVITIES. IF YOU WOULD LIKE TO SUPPORT US, PLEASE SEND YOUR CONTRIBUTION TO ONE OF OUR ACCOUNTS WITH THE *COMMERCIAL BANK OF ETHIOPIA*, ADDIS ABABA

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- INTERNATIONAL BANKING DIVISION, ACCOUNT NO. C/A **6050092-2**

Text: AHA Information Unit
Photographs: Gedion Kifle
Layout: Shebelle Productions
Print: Central Printing Press