Africa Humanitarian Action



Annual Report 2005

"Africa Humanitarian Action's mission is to provide effective humanitarian assistance to alleviate human suffering through applying African solutions to African problems."

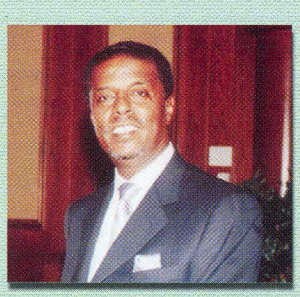
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ABBREVIATIONS & ACRONYMS

AHA Africa Humanitarian Action
ANC Ante Natal Care
ART Anti Retroviral Treatment
AIDS Acquired Immuno Deficiency Syndrome
CBRHA Community Based Reproductive Heath Agents
CPR Contraceptive Prevalence Rate
CSW Commercial Sex Worker
CYP Couples Year of Protection
DPPC Disaster Prevention and Preparedness Commission
DR Democratic Republic
EVI Extremely Vulnerable Individuals
FP Family Planning
IE/BCC Information Education/Behavioural Change Communication
FGC Female Genital Cutting
IDPs Internally Displaced Persons
IMC International Medical Corps
IOM International Organisation for Migration
HAPCO HIV/AIDS Prevention and Control Office
HIV Human Immune Virus
MOH Ministry of Health
NGO Non-Governmental Organisation
OVC Orphans and Vulnerable Children
PI-E Pathfinder International- Ethiopia
PLWHA People Living With HIV/AIDS
PNC Post Natal Care
STD Sexually Transmitted Disease
STI Sexually Transmitted Infection
RH Reproductive Health
UNHCR United Nations High Commissioner for Refugees
UNICEF United Nations Children Emergency Fund
WHO World Health Organisation
WFP World Food Programme

Message from the President & CEO



As we have done for a decade, it is once more our duty to our partners and stakeholders to showcase AHA's efforts in humanitarian action in Africa. It is also an opportunity to highlight our endeavours inline with building the humanitarian response capacity in Africa. We have also presented lessons learned as the Annual Report is one of our most important vehicles for communicating our progress and more broadly to reflect upon the challenges confronting the international humanitarian system.

Since we launched AHA in 1994 in the aftermath of the Rwanda genocide, we have constantly tried to improve the rapidity of our interventions, and our effectiveness in saving lives, improving the welfare and protecting the rights of people in emergencies. We have continually applied lessons learned to emerging challenges. This has been achieved against a backdrop of serious impediments to mobilise enough support to build our desperately-needed emergency response capacity.

Indeed, we are fully aware that we operate within a complex global and continental context where disaster management, health issues and development are closely interrelated. We have learned that we cannot act alone, and have placed great importance on building relationships with other actors, putting our inputs in an overall context of common efforts to limit suffering. We are deeply concerned about the difficulties facing African humanitarian organisations in raising funds in Africa, and about retaining and developing staff capacity for humanitarian action as an integral part of our emergency preparedness.

In addition, we believe in furthering the accountability to beneficiaries, which remains a high priority, and in improving practices in impact measurement. We have also sought partnerships to tackle resource constraints for institutional development. In this process, we have focused on a few key areas in which collaboration could significantly improve the quality of humanitarian action by linking up with the cluster approach.

On an important note, this would not be an AHA publication if we did not stress the key role, which African organisations must play in addressing humanitarian actions in Africa - and the importance of ensuring that they have both the resources and institutional capacity to do the job. While in most situations, an international response will be required to meet humanitarian needs, it is also necessary to work on building the capacity of local and national NGOs, as they are usually the first actors in the field to respond to humanitarian crises.

To that end, in 2005 we continued to pursue the creation of an African Centre for Humanitarian Action, an idea given overwhelming support by the International Symposium on Building the Capacity and Resources of African Non-Governmental Organisations that we organised in Addis Abeba in collaboration with the African Union.

Our achievements and the challenges that beset Africa and Africans inspire us to work harder and achieve more as we provide quality care to refugees and displaced persons, with active programmes in 12 African countries in 2005. Let me just note that for the 11th consecutive year, except for one under-performing programme in the Republic of Guinea, we have received a clean bill of health for our programmes by our partners and auditors, a tribute to the standards of our operations. I wish to assure our partners once more that we will always aim higher to maintain our values of excellence.

Dawit Zawde

Africa Humanitarian Action's Mission
Aiming Higher Always

In an era of increasing globalization, Africa faces new challenges that cannot be met by solutions invented and imposed by people outside the region.

Africa Humanitarian Action (AHA) believes that Africans have the skills and resources (albeit, abused and underutilised) to deal with crises that are facing the continent and as such advocates for African renaissance. AHA is determined to contribute to change this situation by promoting the capacity of African humanitarian organisation

Founded in 1994, AHA is a pan-African non-governmental humanitarian organisation dedicated to alleviating human suffering by implementing multi-sectoral relief and rehabilitation program for refugees, returnees and internally displaced persons (IDPs) as well as host communities.

AHA's mission is to:

- Deliver emergency and recovery health and related services
- Build and strengthen local capacities in disaster preparedness and conflict prevention
- Contribute to the fight against HIV-AIDS, TB, Malaria, and other communicable diseases of poverty
- Promote the role of African organisations in humanitarian action

To achieve these goals, AHA programmes are divided in six domains of intervention:

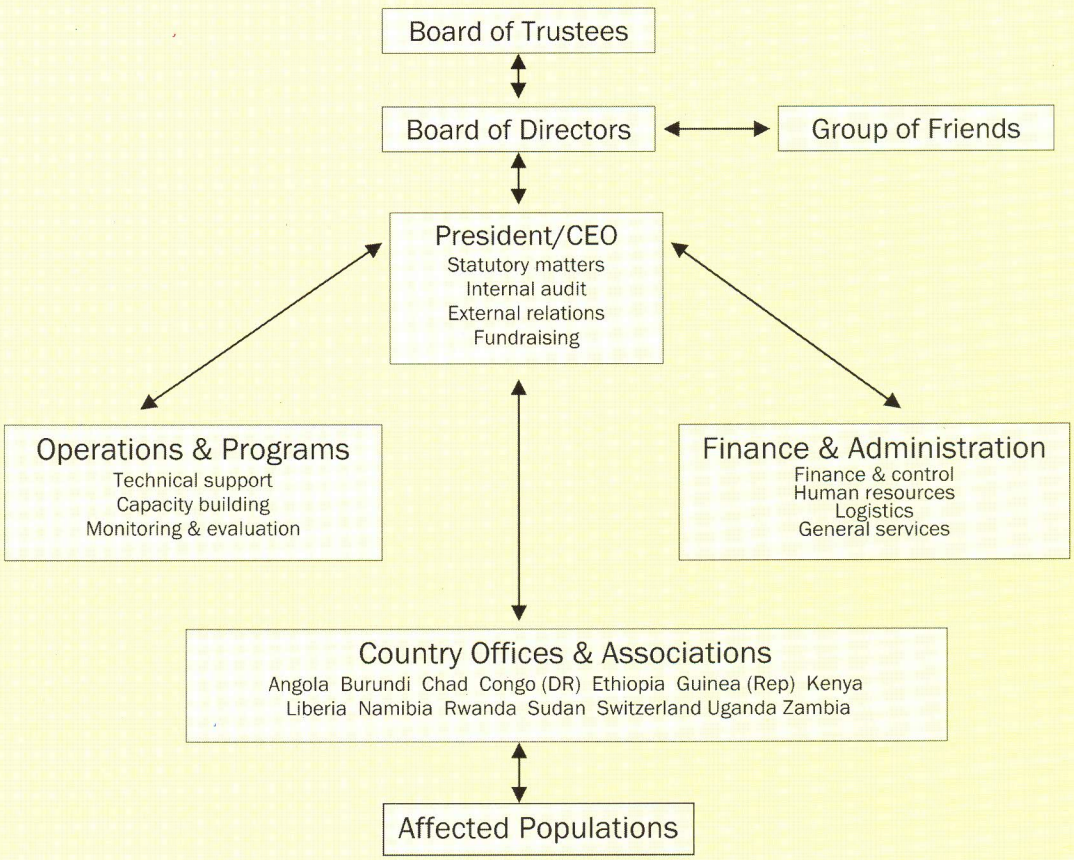
- Capacity Building
- Emergency Response
- Infrastructure and Rehabilitation
- Medical Services
- Training
- Water and Sanitation

In more than a decade, AHA has helped more than two million people restart their lives. Today, a staff of around 1,423 work in 12 African countries with the conviction that Africa must build its expertise and capacity to take control of its own destiny.

With its own small contribution, AHA aims to play a part in realising this renaissance for its continent.



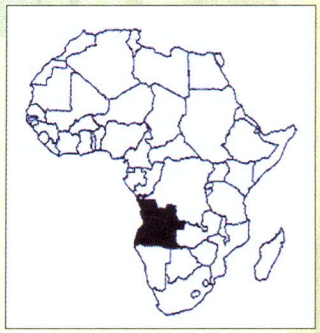
ORGANISATIONAL STRUCTURE



AHA is governed by a Board of Trustees, whose members have proven track record in the field of humanitarian assistance and act in a voluntary capacity at the highest levels. The assembly appoints a Board of Directors, which sets strategic priorities and monitors performance, standards and results. The Group of Friends of AHA provides, on an *ad hoc* basis, information, advice and support for strategic developments and fund-raising purposes.

AHA has 1,423 staff representing 18 nationalities. 19 at the Head Office and the rest at the Country Offices and field levels. 43 are in management positions of which 7 are at the Head Office. The male to female ratio stands at 3 to 1 on the average. About 85% of our field staff are recruited from local communities and affected populations.

ANGOLA



GENERAL SITUATION

Angola is slowly recovering from almost three decades of armed conflict that displaced more than four million people. Since April 2002, close to four million internally displaced Angolans have gone home following the signing of a ceasefire agreement. Yet, destroyed infrastructure, lack of transportation, poor conditions in areas of return as well as the presence of approximately six to seven million landmines scattered throughout Angola are major impediments for return. There are still an estimated number of 91,000 people who remain displaced. In Cabinda the massive presence of Angolan armed forces is an obstacle to the return of tile populations.

Total Population: 16 million

Number of refugees: 230,000 (originating from the country)

Number of IDPs: 60,000

AHA in Angola

Program start date: 1996

Locations: Provinces of Moxico, Uige & Zaire

Beneficiaries: 11.322 returnees
186,710 patients

Program:

Capacity Building
- Support to government program such as vaccination campaign
- Emergency Response
- Distribution of non-food items

Training of traditional birth attendants & community health workers
- Management course for health professionals
- Health education with special focus on HIV/AIDS, STDs & malaria
- Mine Awareness

Medical Services
- Primary health care to returnees and host community
- Mobile Team for least accessible areas
- Support to heath structures
- Mother Child health care

Water and Sanitation
- Protected water sources

AHA in Moxico

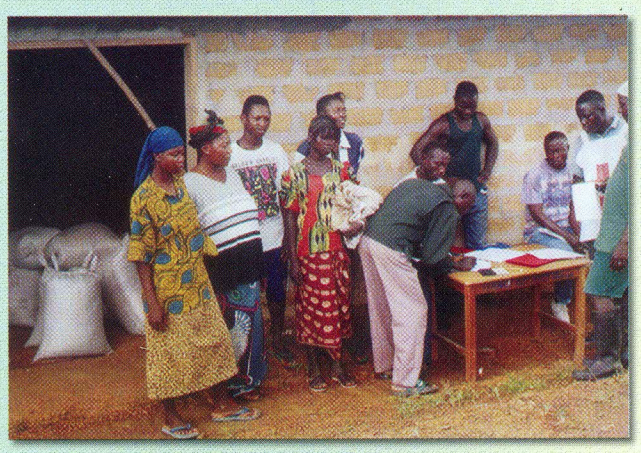
AHA assisted 1,045 returnees who came back through the UNHCR-led organised repatriation programme in Alto Zambebe. In 2005, AHA provided primary health care to 119,304 patients in its different health centres located in Cazombo. With the assistance of a mobile team, AHA was also able to treat patients in remote locations such as Macondo, Caianda, Lunachi, Nhanbangu, Canda, Calunda, Njamba, Missao Bento.

In the different centres, AHA offered water and sanitation services; distributed 2,067 educational brochures on HIV/AIDS and STDs; 21,282 condoms and 1,500 mosquito nets to 47,741 beneficiaries, mainly returnees. More than 10,000 emergency latrines were built complemented by hygiene education to improve sanitation and prevent outbreaks of disease.

AHA installed water points in Cuimba and in Ngombe ya Ngombe and trained local mechanics in maintenance. Delivery kits for safe birth services were distributed during AHA training seminar for medical staff.

AHA in Uige

In the Province of Uige, AHA provided primary health care to 6,000 returnees taking part in the second phase of the UNHCR-led organised repatriation programme.



AHA provided water and sanitation services and supported the national health care system through rehabilitating and reconstructing health centres and providing support in national vaccination campaigns as well as supplying drugs.

Health education with special focus on HIV/AIDS, STDs and malaria as well as mine awareness took place in 2005. AHA operated health posts and medical centres for the Angolan returnees in Maquela do Zombo Municipality at Quintino transit camp, Mbanza Sosso, Malele, Beu medical centre, Kuilo-Futa and Sacandica. Cuximane health centre is now fully operational. 41,106 patients were treated in the different health centres.

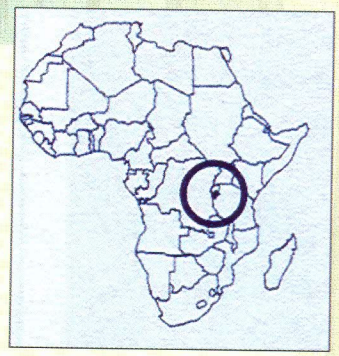
AHA in Zaire

In the Zaire Province, AHA attended returnees in the Municipalities of Mbanza Kongo, Cuimba, Tomboco, Nzeto, Noqui; in the Returnee Centres of Kiowa; Sumpy, Ngombe ya Ngombe and Diadia villages, Buela, Luvaca and Mpala Communes.

AHA continued with the construction of a health centre in Mpala and started in October to build a Vocational Training Centre for Women in Mbanza Kongo to be handed over to the government in early 2006. The Mbanza Mazina Health Centre is now administered by the Provincial Direction of the Ministry of Health. AHA also rehabilitated a health centre in Luvaca and is finalizing the construction in Mpala.

Through the UNHCR-led 'organised repatriation program', AHA assisted 2, 626 returnees in the Kiowa transit centre and 1,651 returnees who came back spontaneously. During their stay, returnees received medical care, training on HIV/AIDS and mine awareness. AHA also provided assistance to the host community. Support to health centres and medical staff with distribution of free drugs allowed AHA to attend 26,300 patients. To control malaria, one of the primary causes of death in Angola, AHA distributed mosquito nets to the affected populations.

BURUNDI



GENERAL SITUATION

Since 2001, following the signing of ceasefire agreements, at least some 200,000 internally displaced persons (IDPs) and some 285,000 Burundian refugees have returned home. 200,000 Burundian refugees have been repatriated, as of November 2005. UNHCR estimates that 15,000 Burundians are returning every month, mainly from neighboring Tanzania.

Yet, despite the general improvement of security, the pace of return slowed down at the end of 2005 and close to 117,000 displaced remained in camps.

According to UNHCR, 60,288 Burundian refugees still live in DR Congo and 2,000 Burundians in Rwanda. 4,000 Rwandan refugees, 3,500 Rwandan asylum seekers and 30,000 Congolese (DRC) refugees would reside in Burundi. About 8,000 of them in two refugee camps and the others in urban areas.

Total Population:	7,5 million
Number of refugees:	486,000 (originating from the country)
Number of IDPs:	118,000

AHA in Burundi

Program start date: 2002

Locations: Provinces of Muyinga, Makamba, Ruyigi, Rutana, Cankuzo, Gitega, Bururi

Beneficiaries:
Around 150.000 Burundian returnees from Tanzania
Rwandan asylums seekers
6,500 Congolese refugees

Programs:

Medical Services
Primary health care, treatments, vaccination, needs assessments

Training
Heath education with specific focus on HIV/AIDS, counseling for VCT

Emergency response
Detection and response to epidemics, supply of food & non-food items

Camp managements

Water and sanitation

Programs

By the end of March 2005, more than 10,000 asylum seekers from Rwanda crossed the border to Burundi some fleeing from the Gaccacca, local tribunals established to judge the perpetrators of the 1994 genocide and others supposedly running away from the persecution and discrimination that prevailed in Rwanda.

Considering the importance of the number of people crossing the border, AHA with UNHCR, provided assistance to the needy scattered along the border of the two countries and in some nearby provinces such as Ngozi, Kirundo, Muyinga and Cankuzo.

AHA organised mobile clinics and deployed its teams in the different provinces to provide health care assistance until departure in June 2005.



However, with the return of the Rwandan asylum seekers in July, the interrupted assistance regained momentum in the face of the important flow of people coming back to Burundi.

AHA was involved in supervision activities aiming at the provision of better health care services to around 150,000 returnees and the community as a whole in Cankuzo province.

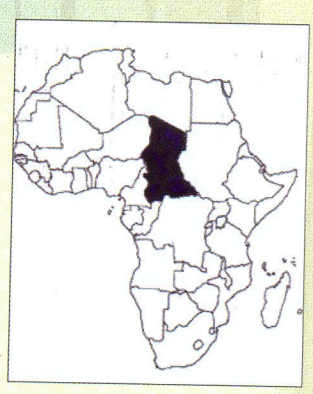
To that effect, AHA has benefited from WHO's support in its involvement in reintegration and long term development program in Burundi.

By the end of December 2005, after three years of successful management of the Gasorwe-Kinama refugee camp in Muyinga Province, AHA was unfortunately forced to phase out and hand over its activities.

All projects have greatly benefited to surrounding local communities.



CHAD



GENERAL SITUATION

Since 2003, the conflict in the Darfur region of Sudan has driven about 200,000 refugees into eastern Chad. The refugees reside in isolated and very poor region, completely dependent on international support for food, medicine and other basic supplies. Moreover, an estimated 40,000 refugees escaping armed groups in Central African Republic reside in Chad.

Total Population:	8.85 million
Number of Refugees:	50,000 (originating from the country)
Number of IDPs:	50,000-60,000

AHA in CHAD

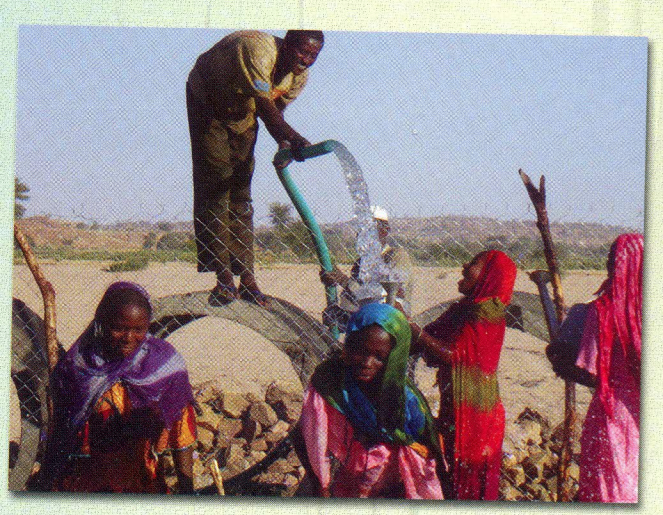
Program start date:	2005
Location:	N'Djamena and Hajer Hadid
Beneficiaries:	Host population of "Hajer Hadid"
Programs:	Water and Sanitation

Program

The project assisted the Chadian host population through opening a new Country Office. The office is headquartered in the capital N'Djamena.

The project in Chad operated in one of the most deserted regions alongside the border of Sudan in a village called Hajer Hadid meaning "The Mountain of Steel" in Arabic. AHA excavated a well close to the dry river bed to distribute water to the village using a fuel generator and a submersible pump to supply raised steel water tanks with a capacity of 75,000 liters. AHA provided the village with thirty taps, three water points scattered within three kilometers including a provision for animals to drink the spillover water. AHA completed 97% of the project and has handed over by the first quarter of 2006.

In addition, the project has constructed a vegetable garden around the tank premises and planted more than seventy five mango and other fruit trees.



The project also renovated the primary school located at the village by building the fence, the kitchen and the lavatory. AHA provided assistance to the NGO "RET" to construct a secondary school providing free technical and management support.

DEMOCRATIC REPUBLIC OF CONGO



GENERAL SITUATION

Since the mid-1990s an estimated 300,000 refugees and 2.3 million internally displaced persons have been forced to flee their homes as a result of armed conflicts. Displacement in DR Congo peaked in 2003, with an estimated number of 3.4 million people. Yet, with the establishment of a transitional power-sharing government in June 2003 and the strengthening of peacekeeping operations, hundreds of thousands of IDPs returned home. Armed groups continued, however, to attack civilians and to cause large-scale displacement throughout North Kivu, South Kivu and Ituri in the eastern part of the country.

Total Population:	58 million
Number of refugees:	463,000 (Originating from the country)
Number of IDPs:	1,664,000

AHA in DR Congo

Program start date: 2004

Locations: Province of Equateur

Beneficiaries: 1400 Congolese returnees — 4,434 patients

Programs:

Repatriation, Reinsertion
Nutrition
Infrastructure and Rehabilitation
Medical services
  Primary health care, drug supply, support to health structure
Training
  Health education, notably HIV/AIDS prevention campaigns, malaria



Programs

The UNHRC-led 'organised repatriation' program started in October 2004 entered in its second phase.

AHA worked in the municipalities of Batanga, Dongo, Monzombo and Lyonda/Mbandaka, Gemena, Libenge, Zongo, Mbandaka, Mawuya, Gbadolite, Budjala and Kungu to provide primary health care to around 1,400 Congolese returnees.

Returnees received food and non-food items, medical care and training in hygiene, HIV/AIDS.

To control Malaria, one of the primary causes of death in the region, AHA staff also organised preventive campaigns to sensitize the population and distributed mosquito nets.

AHA organised a nutritional survey in partnership with the Congolese government and the FAO. The survey covered the Province of Equateur (Libenge, Kungu, Bwamanda, Zongo and Gemena).

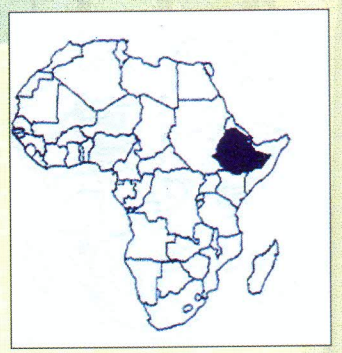
As a result a Nutritional Centre was opened in Libenge to promote the survival, protection and development of children. In total, 4,434 patients were treated in health centres supported by AHA in Libenge, Gemena, Boyabo, Batanga and Lebo.

The health centres received free drugs, medical supplies, training and support for their health workers.

AHA reconstructed and rehabilitated several health centres, notably in Libenge. By the end of 2005, only a few health centres (Lebo, Dongo and Gemena) were still in various stages of completion.



ETHIOPIA



GENERAL SITUATION

The war with Eritrea resulted in hundreds of thousands of displaced people, many of whom have now returned to their homes. Ethnic clashes have left nearly 100,000 Ethiopians internally displaced. Ethiopia also hosts about 115,000 refugees from Somalia and Sudan. Internal displacement due to conflict occurs in different parts of Ethiopia; caused mainly by ethnic tensions. In the absence of a coherent approach to internally displaced persons (IDPs), estimates of displacement vary from 100,000 to 280,000, including some 60,000 drought IDPs.

HIV/AIDS epidemic is of particular concern, considering the nation has one of the highest percentages of HIV/AIDS cases in its population. There have been nearly three million clinical cases of HIV/AIDS reported.

Total population:	77.4 million
Number of Refugees:	65,293 (originating from the country)
Number of IDPs:	Up to 250,000

Care Concern Commitment

AHA in Ethiopia

Program start date:	1997
Locations:	Oromia Region, Southern Nations Nationalities and Peoples Region
Beneficiaries:	800,000 Ethiopians
Program:	IE/BCC activities Family planning Trainings Support to AIDS orphans and PLWHAs Medical services

Pathfinder Funded Activities

1. IE/BCC activities

A total of 109,624 home visits and 48,907 group meetings were conducted to educate a total of 531,198 on Family Planning, Maternal Health, Child Health, Post Abortion Care, STIs/HIV/AIDS and Harmful Traditional Practices during the project year.

2. Provision of Family Planning Reproductive Health

The affected populations were served with oral contraceptives, implants and condoms. As a result 46,400 Couples Year of Protection (CYP) was generated. Similarly, the average Contraceptive Prevalence Rate (CPR) at the project sites reached 42.5%.

3. Training

Basic and refresher trainings were provided to 690 CBRHAs on various components of FP/RH services and HIV/AIDS/STIs Prevention and Control. Sixty persons were also trained on harmful traditional practices which included Female Genital Cutting (FGC), Tonsillectomy, Abduction and Rape. In addition 720 *woreda* officials, community and religious leaders and women representatives were sensitized on the basic CBRH concepts.

UNICEF Funded Activities

The project, which is implemented in Gotta *woreda*, provides different types of trainings focused on youth on the prevention and control of Sexually Transmitted Infections (STIs) and HIV/AIDS.

Accordingly, more than 200 youth were trained as peer educators and facilitators in Life Skills, Community Conversation/ Youth Dialogue and Female Empowerment.

HAPCO Funded Activities

HAPCO funded activities are implemented in 8 woredas (Shashemene, Arsi Negelle, Sodo, Boloso Sore, Damot Gale, Arba Minch and Goffa woredas).

The major objectives of the project are:

- Create awareness and remove misconceptions about HIV/AIDs.
- Promote community participation in HIV/AIDS prevention & interventions.
- Improve the economic status of PLWHAs and provide support to AIDS' orphaned children.
- Promote safe sexual behaviour among the communities.

Activities Performed

Awareness creation workshops on HIV/AIDS prevention and control, stigma and discrimination were organised for over 100,000 community members and religious and political leaders.

Trainings were provided to over 400 commercial sex workers and peer educators on RH/FP, HIV/AIDS/STIs prevention and control and on stigma and discrimination.

Monthly financial support, for food, clothing and school fee was provided to 140 AIDS orphans and over 40 PLWHAs were given skill training and seed money for the establishment of their own income generating activities.

Eleven in-school and 12 out-of-school anti-AIDS Clubs were established and strengthened. Members of the clubs were also trained as peer educators.

LIBERIA



GENERAL SITUATION

An estimated 38,500 refugees have gone through the UNHCR-led voluntary repatriation program started in 2004. As of 2005, 210,000 Liberian IDPs have been assisted to return home. An additional 64,000 Liberian internally displaced have spontaneously resettled on their own accord.

Yet, around 130,000 Liberian refugees are said to remain in Guinea, 72,000 in Cote d'Ivoire, 67,000 in Sierra-Leone and 43,000 in Ghana.

Following Liberia's elections in October 2005, refugees and IDPs are returning home. Yet huge challenges clearly remain. Years of conflict have devastated Liberia's infrastructure and economy. Supporting the return of refugees and internally displaced persons is critical for the stability of the country.

Total Population:	3. 5 million
Number of refugees:	230,000 (originating from the country)
Number of IDPs:	464,000

AHA in Liberia

Program start date:	2004
Location:	Grand Cape Mount, Gbarpolu and Bomi Counties
Beneficiaries:	33,733 refugees
Programs:	Infrastructure and rehabilitation
	Medical services
	Training

CORRECTION

KINDLY NOTE THE NO. OF BENEFICIARIES IN LIBERIA STATED AS 33,733 SHOULD READ AS 333, 733. WE APOLOGISE FOR THE TYPOGRAPHY ERROR.

Programs

AHA has finalised the second phase of the reconstruction program started in 2004. AHA rehabilitated & reconstructed 14 health structures (2 health centres and 12 clinics) in Grand Cape Mount, Gbarpolu and Bomi counties that are now in full use by the population.

The program has a major component of primary health care providing the national healthcare system with the necessary support.

AHA has facilitated capacity building, provided free drugs, training and support for health workers as well as basic laboratory material, making health care accessible to the impoverished population.

AHA also offered services such as consultations, laboratory testing and vaccinations in different centres.

AHA increased access to preventive health services to mothers and children under five through providing pre-natal and pre-school consultations.

An important focus has been on prevention and early treatment of disease. AHA in total attended 118,840 patients.



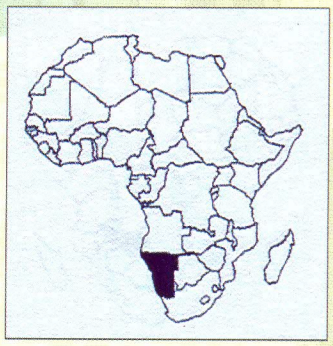
Through improving access to effective and efficient health services, AHA contributed to the reduction of morbidity and mortality among the resettling population as well as host communities.

AHA promoted safe sexual behaviour through awareness-raising campaigns on HIV/AIDS. AHA's objectives were notably to contribute to the elimination of misconceptions and to reduce the stigma and discrimination associated with HIV/AIDS. AHA also provided support to people living with HIV/AIDS.

In the different health structures, AHA worked at improving access to potable water and sanitation facilities. AHA also conducted hygiene training for communities.



NAMIBIA



GENERAL SITUATION

Namibia maintained an open door policy for refugees from countries such as Angola, Burundi, DRC, and Rwanda. During the Angolan civil war, the Namibian government gave approval to Angolan government troops to operate from Namibia against the Angolan rebel force. Angolans who fled from the recently concluded civil war make up ninety five percent of 30,000 refugees.

The conditions in Angola became conductive for refugees to return in safety and dignity following the April 2002 peace deal between the Angolan government and the rebels.

Angola and Namibia have signed an accord to repatriate Angolan refugees as well as a tripartite agreement with the UNHCR to pave the way for the return of Angolan refugees.

To date, already 4,300 Angolans have been repatriated by UNHCR while many more have gone back.

Total population: 2 million

Number of refugees: 12,618 Angolans

AHA in Namibia

Program start date: 2001

Locations: Osire refugee camp; Kassava transit centre
Border posts Katwitwui and Oshikango

Beneficiaries: 696 Angolan returnees
About 33 Namibian returnees from Dukwe refugee camp in Botswana

Programs: Medical services

Training

Repatriation

Water and sanitation

Water

Water is pumped from the six solar powered pumps into two 95,000 cubic meters tanks and three 10,000-litre tanks. The tanks are filled and distributed twice a day in the camp making a total volume of 420,000 liters available per day.

In addition, there are 23 boreholes that supply additional water to the community for laundry and gardening.

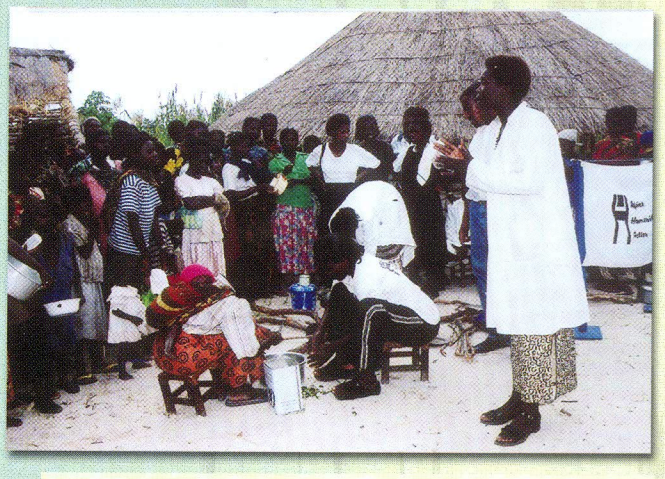
Three electrical pumps were set up to assist the solar panels to generate the energy needed. This has ensured continuous water supply throughout the year. The community can now obtain 31 litres of water per person per day.



Education

Total number of 505 children registered and attended kindergarten classes (253 females and 252 males). Every child received one meal per day during school days.

Foreign language institute registered 305 of which 192 males and 113 females. 11 students were registered in Windhoek and Okakarara vocational centres under the sponsorship of AHA/UNHCR.



HIV and AIDS program in Osire refugee camp

AHA acquired 28,000 condoms 25,634 of these were distributed to the camp population.

Seven training programs were held, between August 2005 and December 2005, in which refugees' leaders, youth, women, church leaders and workers from all agencies were participated.

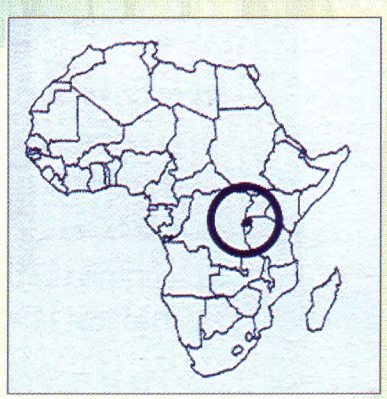
In home-based care program 10 TB and 11 PLWHA as well as 9 chronically ill patients were cared for.

Heath services

A whole range of health services ranging from HIV and AIDS, ante-natal care and family planning was offered by AHA. There was a major national immunization campaigns in the camp (June 2005 and July 2005) and had yielded over 99% coverage.

The immunization program was extended to the refugees who were being repatriated. Every child under five years of age, as well as women of reproductive age were vaccinated before departure.

RWANDA



GENERAL SITUATION

In 1998 and 1999 the Rwandan government and the UN recognised around 650,000 people in makeshift camps as internally displaced persons (IDPs). Most of them Hutus who have been uprooted when an insurgency was put down by the Tutsi-dominated government.

More than four years after the issue of internal displacement was taken off the agenda in Rwanda, conditions in the villages inhabited by the resettled IDPs call for renewed attention as required by the UN Guiding Principles on Internal Displacement.

The UN peacekeeping mission in the Congo (MONUC) gave an ultimatum to the remnants of the military groups responsible for the Rwanda genocide to leave the country by the end of September 2005. An organised repatriation process has begun, though there is still intimidation of those seeking to return by leaders trying to keep their resistance intact.

Total Population: 8.6 million

Number of Refugees: 45,460 (DR Congo), 100,244 (originating from the country)

Number of IDPs: 4,158

AHA in Rwanda

Program start date: 1994

Location : Kiziba Refugee Camp, Kibuye Province
Nyamure Refugee camp, Butare Province Kigali

Beneficiaries: 17,256 Congolese refugees
1,931 Burundian refugees

Program: Distribution of food
Medical services
Water and sanitation

Kiziba refugee camp

In the area of health and nutrition, AHA has provided curative services at the camp health centre to Congolese refugees and to the local community around the camp.

Screening children under the age of five, growth monitoring & vaccination were provided. Cases requiring specialized treatment were referred to higher centres.

Reproductive health services, particularly pre and postnatal care were improved. The HIV and AIDS awareness and behavioural change campaign have been conducted in the camp. AHA promoted use of condom and provided Voluntary Counseling and Testing (VCT).

AHA got authorization from TRAC (Treatment & Research AIDS Centre) that refugee community benefit from the ARV treatment program at Kibuye Hospital.

As the treatment require supplementary foods, they are also benefiting from the feeding centre.

Nyamure refugee camp

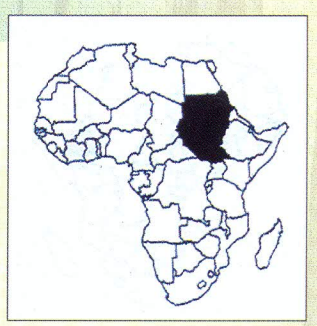
AHA has been providing the service of health, nutrition, sanitation, water supply, distribution of food and non-food items and camp management to Burundian refugees.

A total of 3,751 children under the age of five were screened for nutritional status and 11% of the children were found to have moderate to severe degree of malnutrition.

Medical supplies and equipments were in short supply, making the smooth health delivery to the refugees difficult and contributed to unnecessary referrals.



SUDAN



GENERAL SITUATION

Although on January 9, 2005 the government and rebel group signed a peace agreement that ended the 21-year civil war, Southern Sudan remains in the grip of one of the most severe humanitarian crises in the world and war rages on in Darfur.

2,610,000 million people have been affected by the violence in Darfur and some estimates put the death toll as high as 300,000 caused by the conflict between the government forces, the SLA, JEM and the Janjeweed military action, exposure, starvation and disease.

An estimated of six million of Sudanese citizens have been forced to leave their homes as a direct or indirect result of fighting between government troops and allied militias and various insurgent groups.

The UN estimates the return of 500,000 IDPs in the dry season. The challenges in the return areas are daunting; the civil war devastated the southern countryside, leaving practically nothing of the little infrastructure which was there before the conflict started.

Total Population:	41.3 million
Number of refugees:	693,267
Number of IDPs:	5,300,00

AHA in Sudan

Program start date:	2004
Location:	Locality, El Fasher Town and El Fasher Rural Administrative Unit, North Darfur State, Darfur
Beneficiaries:	26,000 IDPs and host community for PHC 34,000 IDPs for GFD in El Fasher Town 68,258 IDPs & Host Community for GFD in El Fasher Rural
Program:	Food distribution Medical services

Food distribution

In the period in review, a total of 102,000 inhabitants of North Darfur composed of IDPs and resident affected community members benefited from the food distribution project.

Food was regularly distributed to these beneficiaries on a monthly basis since April 2005. A total of 7,819 MT of food was distributed in the period in review.

The IDPs in Fasher Town are people displaced from different parts of North Darfur and are living among the host community. Since the IDPs are in a position to cultivate or generate no income to support themselves and are entirely dependent on relief food, they benefited full ration.

Resident population who did not leave their respective villages were provided with half ration.





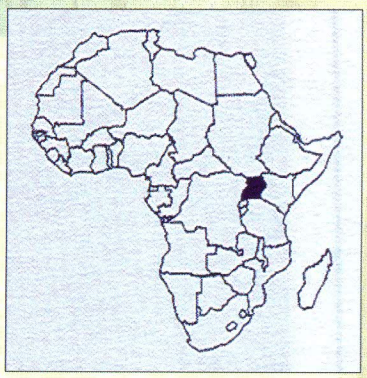
Primary health care

Mellit Primary Health Project was implemented in partnership with the Ministry of Public Health of the Government of Sudan and UNICEF. The project benefited about 26,000 inhabitants of Mellit town that are composed of IDPs from the surrounding locality and vulnerable host community.

Consultation, Immunization, Growth Monitoring, ANC, PNC, Family Planning, IEC, Nutrition Screening and Referral of cases were provided.

In the period in review, there were a total of 15,692 consultations, among which 6,828 (44%) were under the age of five.

UGANDA



GENERAL SITUATIONS

Since the late 1980s Uganda has rebounded from the abyss of civil war and economic catastrophe to become relatively peaceful, stable and prosperous. But the lives of hundreds of thousands of people in Northern Uganda remain blighted by one of Africa's most brutal rebellions commandeered by the Lord's Resistance Army (LRA).

An estimated 228,700 Sudanese refugees are housed in south-western and western Uganda. 40,000 others who are not registered have been living in Ugandan border towns, while others are in the capital Kampala.

Other refugees who are residing in Uganda are from Democratic Republic of Congo (DRC), Rwanda, Burundi, Somalia, Eritrea and Ethiopia. 23,000 Rwandan refugees that are residing in Uganda are one of the largest groups of exiles still remaining outside Rwanda.

Total Population:	28 million
Number of Refugees :	228,700 (Sudan), 23,000 (Rwanda), 14,982 (DR Congo)
Number of IDPs:	1.3 million

AHA in Uganda

Program start date:	2005
Location:	33 major settlements One transit camp in Adjumani District
Beneficiaries:	52,543 Sudanese refugees
Program:	Medical services Training Water and sanitation

Aiming Higher Always

Health services

Lack of reproductive health care and support particularly affects women and adolescents. These groups are who have been identified as one of the most vulnerable groups in refugee situations.

Family planning education and including child spacing for women was provided to more than 50% of the expected pregnancies enrolled in ANC. Post natal care is also included.

Specific health services targeting children including growth monitoring, therapeutic feeding and immunization services received top priority in our service delivery.

Adolescents constitute a big proportion of the entire population of the Adjumani district. Teenage pregnancy and sexually transmitted diseases including HIV/AIDS were reduced and prevented. A user-friendly service is being offered with full respect and confidentiality.

About three percent of the population are elderly refugees targeted as part of the EVIs (Extremely Vulnerable Individuals) for receiving immediate medical attention whenever they fall sick .

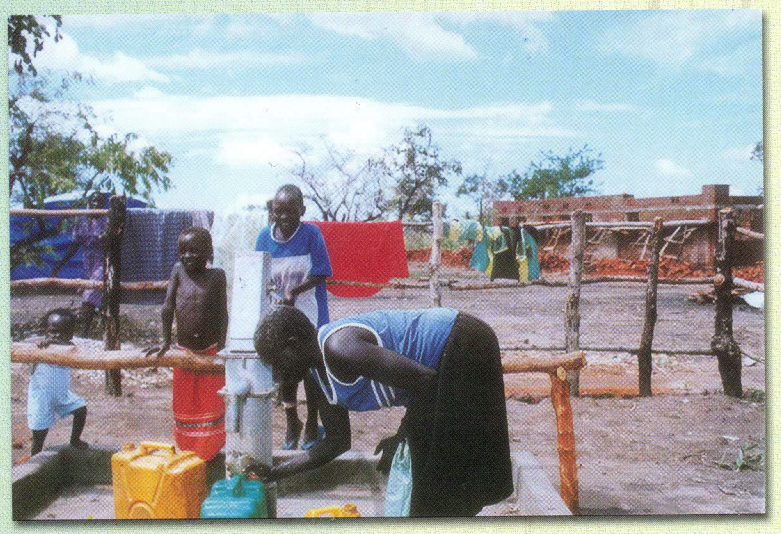
Increased community awareness of HIV/AIDS through sensitization of vulnerable groups like the youth and VCT services were offered at established sites within the district.

Condom use was promoted and more condom outlets established in the communities. The communities own resource persons trained in HIV/AIDS prevention and control as well as in the home based care of HIV/AIDS patients.

Sanitation

Health education on sanitation and environmental hygiene was provided so that refugees understand the inter-relationship between health and the environment.

Community health awareness campaigns and good community health practices - proper waste disposal and good homesteads reducing chances of environmental degradation and outbreaks of epidemics - continued to be areas of emphasis.



ZAMBIA



GENERAL SITUATION

At the end of 2002, Zambia hosted approximately 250,000 refugees. This included about 190,000 from Angola, about 50,000 from DR of Congo, and nearly 7,000 from other African countries, mainly from Rwanda and Burundi.

In July 2003, the first 20,000 Angolan returnees departed from Zambian refugee camps. Angolan refugees in Zambia make up approximately half the number of Angolans in the region.

There have also been new arrivals from the Democratic Republic of Congo since January 2004.

Total Population: 11.5 million

Number of Refugees : 88,842 (Angolan), 66,248 (DR Congo)
5,791 (Rwanda)

AHA in Zambia

Program start date: 2000

Location:
Mayukwayukwa Refugee settlement in Kamna district,
Nangwesbi Refugee camp in Shangombo District
Meheba refugee settlement
Makeni in Lusaka

Beneficiaries:
19, 347 Angolan refugees from Meheba Settlement
7,227 Angolan refugees Mayukwayukwa settlement
23,000 Nangweshi Camp, also Angolan refugees

Program:
Medical care, nutrition, water, SGVB and

Sanitation services to Angolan refugees in Mayukwayukwa settlement and in Nangwesbi camp

Assisted repatriation

Medical screening and medical escorting

HIV/AIDS awareness and prevention

Voluntary testing

Condom distribution

Repatriation

AHA has been rendering medical care, nutrition, water, SGVB and sanitation services to Angolan refugees in Mayukwayukwa settlement and in Nangweshi camp since the beginning of 2003.

The year 2005 saw quite a number of refugees repatriating back home. This led to a number of refugees to fall in the three camps (Mayukwayukwa, Meheba and Nangweshi).

By the end of the year 2005, 2,871 refugees from Mayukwayukwa, 8,961 from Nangweshi and 5,827 from Maheba had been assisted to return back to Angola.



Health care

In order for AHA to deliver quality health services in the year 2005 and other health related activities, AHA had to run a full fledged 24 bed capacity Health centre in both camps. Each health centre in the camp had the following departments:

- In and outpatient departments
- Laboratory services
- Pharmacy services
- Midwives
- Heath programs including immunization
- Reproductive health, sexually transmitted infections, HIV/AIDS
- Home based care
- Voluntary counseling

Medical screening & escorting

By December 2005, AHA had assisted 63,324 Angolan refugees to return home by providing medical screening and medical escorting since 2003.

AHA was identified for its commitment to project implementation for the provision of medical escort to all the Angolan caseloads based in Mayukwayukwa, Nangweshi and Melleba and to do medical screening prior to departure.

By mid December AHA had provided medical screening and medical escorts to a total of 17,659 refugees of which 5,827 were from Melleba, 2,871 of Mayukwayukwa and 8,961 from Nangweshi.

AHA also undertook the overall provision of medical escorts for the entire Angolan caseload .

Republic of Guinea

We regret that the brief on the Republic of Guinea Country Office has not been included in this Annual Report. The Office under-performed by mid-2005 due to lack of monitoring capacity. Hence, no complete report has been received. Appropriate corrective measures are being taken.

FINANCES

AHA would like to extend its warmest thanks to its donors and partners, who, through their financial and political support, have helped and demonstrated their confidence in the challenge AHA has set to itself: making the search for African solutions to African problems assumes a concrete and realistic meaning.

Recognizing that transparency is essential in generating confidence in African civil society, AHA has established sound financial controls and has a firm commitment to accountability.

AHA has succeeded in balancing its accounts for 2005.

AHA has been able to respond to humanitarian needs of people in Chad through opening a new office in N'djamena and has contributed to peace building in DR Congo thanks to a substantial increase in its budget.

Notwithstanding the fact that AHA does not have institutional support from international sponsors or overseas associates, it is struggling hard to mobilize funds. General operating costs are not, or only rarely, covered. For African humanitarian organisations such as AHA, this situation leaves them vulnerable. AHA appeals to the donor community to finance and support humanitarian NGOs from economically fragile and less developed countries.

AHA Partners

Action Against Hunger – ACF-USA

African Education Fund

African Refugee Foundation (AREF)

African Union (AU)

African Women in Crises Umbrella Programme (UNIFEM-AFWIC)

Advanced Learning Network for Accountability and Performance (ALNAP)

American Joint Distribution Committee (AJDC)

Angolan Government

Burundian Government

Chevron-Texaco

Congolese Government

Danish Red Cross Society (DRCS)

Danish Refugee Council (DRC)

European Community Humanitarian Office (ECHO)

Environment and Development Society of Ethiopia

Ethiopian Government

Euro Health Group (EHG)

German Technical Cooperation (GTZ)

Guinean Government (Republic)

Health of Adolescent Project (HAP)

Individuell Manniskohjalp (IM)

International Council of Voluntary Agencies (ICVA)

International Federation of the Red Cross and Red Crescent Societies (IFRCS)

International Planned Parenthood Federation (IPPF)

Japanese Government

Japanese International Cooperation Agency (JICA)

LEM Ethiopia

Liberian Red Cross Society

Madi Aids /Control Institution (MACI)

Namibian Government

Namibian Red Cross Society

Norwegian Refugee Council (NRC)

Overseas Development Institute (ODI)

Office for the Coordination of Humanitarian Affairs (OCHA)

Operation USA

OXFAM

Partnership in Action (PARinAC)

Pathfinders International

Poverty Alleviation Fund (PAF)

Rwandan Government

Save the Children (SCF-UK)

Swedish International Development Agency (SIDA)

Sierra-Leonean Government

Sphere Project

Sudanese Government

Swedish Refugee Aid (SWERA)

TED Turner/UN Foundation Trocaire

Ugandan Government

Ugandan Red Cross Society

United Nations Agency for International Developments (UNAIDS)

United Nations Development Programme (UNDP)

United Nations Economic Commission for Africa (UNECA)

United Nations Fund for Population Aid (UNFPA)

United Nations High Commissioner for Refugees (UNHCR)

United Nations Children Fund (UNICEF)

United Nations Development Fund for Women (UNIFEM)

World Food Programme (WFP)

World Health Organisation (WHO)

World Bank

Zambian Government

STATEMENT OF INCOME & EXPENDITURE FOR THE YEAR 2005

	Income	In USD	Expenditure
ANGOLA	1,195,795.00	Programs Operation costs	949,094.00 246,701.00
BURUNDI	923,056.00	Programs Operation costs	811,600.00 111,456.00
CHAD	341,939.41	Programs Operation costs	233,283.38 108,656.03
CONGO, DR	701,959.26	Programs Operation costs	623,959.26 78,000.00
ETHIOPIA	308,231.00	Programs Operation costs	299,475.49 23,333.23
LIBERIA	580,978.90	Programs Operation costs	487,756.78 65,186.91
NAMIBIA	871,354.92	Programs Operation costs	752,534.63 118,300.00
RWANDA	547,643.00	Programs Operation costs	446,343.84 93,916.00
SUDAN	362,000.00	Programs Operation costs	227,922.57 92,812.67
UGANDA	485,768.00	Programs Operation costs	381,728.21 20,967.57
ZAMBIA	593,052.00	Programs Operation costs	494,865.00 93,977.00
HEAD OFFICE	421,816.00	Operation costs Liaison	382,461.77
Total income	7,333,593.49	Total expenditure	7,144,331.34

External Auditors

A.A. Bromhead & Co.,
Chartered Accountants (Associates of KPMG)
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Cabinet S.G.I.G
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Delloite & Touche
Congo (DR), Uganda
KPMG
Zambia
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Angola
Stiier Vente Associates, Chartered Accountants
Namibia

AHA Operations and Programs 1995—2005

Country Office	1995-2002	2003	2004	2005	Total
ANGOLA	4,561,092	1,137,343.00	904,305.00	**1,195,795.00**	7,798,535.00
BURUNDI	48,584	508,240.00	725,067.00	**923,056.00**	2,204,947.00
CHAD	-	-	-	**341,939.41**	341,939.00
CONGO, DR	-	-	173,525,00	**701,959.26**	875,484.00
ETHIOPIA	491,510	192,808.00	390,147.00	**299,475.49**	1,373,940.00
LIBERIA	100,000	-	537,010.00	**552,943.69**	1,189,954.00
NAMIBIA	959,989	1,024,966.00	768,303.00	**870,834.63**	3,624,093.00
RWANDA	6,089,692	392,025.00	336,458.00	**540,259.84**	7,358,435.00
SUDAN	-	-	100,000.00	**320,735.24**	420,735.00
UGANDA	3,997,106	432,203.00	413,322.00	**402,695.78**	5,245,327.00
ZAMBIA	2,497,125	915,438,00	983,192.00	**588,842.00**	4,984,597.00
HEAD OFFICE	1,250,682	163,810.00	401,703.00	**405,795.00**	2,221,990.00
TOTAL	**19,995,780**	**4,766,833.00**	**5,733,032.00**	**7,144,331.34**	**37,639,976.34**

Africa Humanitarian Action

Is an independent, non-profit humanitarian organisation which depends on individual and institutional support for its activities.
Tel (251)11 551 -1224/550-4599 - Fax (251)11551-3851

If you would like to support us, please send your contributions to:
Commercial Bank of Ethiopia, Addis Abeba
Swift CBETETAA - Acc. No. 6050092-2
UBS Geneva, Switzerland
Acc. No. 279/D71055620
IBAN: CH57 0027 9279 D710 5562 0

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

We have audited the financial statements of AHA – Head Office on pages 1 to 4 which have been prepared under the historical cost convention and in accordance with the accounting policies referred to on page 3.

RESPECTIVE RESPONSIBILITIES OF DIRECTORS AND AUDITORS

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

BASIS OF OPINION

We conducted our audit in accordance with Generally Accepted Auditing Standards. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements.

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

We have relied on the representations of management that all income received by the Head Office during the year has been correctly reflected in the accounting records of AHA's Head Office as the completeness and accuracy of the income could not be ascertained by us from other independent sources.

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

OPINION

In our opinion the financial statements together with the notes thereon, which have been prepared under the historical cost convention present fairly under that convention the financial position of AHA – Head Office's affairs at 31 December 2005 and its income and expenditure for the year then ended and are in agreement with the financial records maintained at its Head Office in Addis Ababa.

A.A. Bromhead & Co.
Chartered Accountants
and U.K. Registered Auditors
Correspondent firm of *KPMG* International

P.O. Box 709
Addis Ababa
28 April 2006

Compiled by: Julie Dabo & Yonas Kebede
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