Annual Report 2009



Africa Humanitarian Action

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From the President



In 2009, Africa Humanitarian Action (AHA) celebrated its 15th anniversary. It is a habit with us over the years to take a critical look at ourselves on a regular basis. To include wider viewpoints and experiences, we asked INTRAC from Oxford to assist us in revisiting our procedures and resources to bring about best practice. It is resulting in a gradual transformation of our organisation.

Other organisations often seek our advice on humanitarian issues concerning Africa. We therefore decided to offer policy advice on a more formal basis drawing on the vast experiences of our Trustees. Our core business remains as always, a preparedness to make timely humanitarian interventions anywhere in Africa.

Most of our current programmes take place in areas of unrest and violence. Nevertheless, in Darfur alone, we sustained half a million people in 2009. We also signed a memorandum of understanding with the African Development Bank Group to establish a framework for humanitarian interventions and capacity development. The achievements and difficulties we faced are highlighted in this report. We currently have the capacity to meet new hazards and take on additional programmes.

In a hardened economic climate, we thought it prudent to make additional investments in our capacity to mobilise institutional resources, which should add to our overall capacity in the next five years. To this end we secured the services of an external firm to advise us on a business plan for our resource mobilisation in the future.

We have enjoyed an uninterrupted partnership with the UNHCR for 15 years. It has been fuelled by trust, and built on common sense and simplicity. It has functioned - I dare say - to a common satisfaction and to that of the vast number of refugees and communities we have served together. Inevitably, there were a few hiccups along the road, but they were always managed and settled in a rational and respectful way.

We have worked with many partners and benefited from them all as we have moved forward together. I thank them for their contributions to the welfare of those we serve together. And finally, I thank our volunteer trustees, managers and staff for their sound advice and hard work. They have all been a source of inspiration.

May 2010

Dawit Zawde

PORTRAYING AHA

Africa Humanitarian Action was founded in 1994. It is an international non-governmental organization, based on universal humanitarian values, practices, and standards. AHA considers alleviating crisis in Africa is, first and foremost, the responsibility of Africans.

AHA provides humanitarian assistance and development services to populations and communities, notably refugees and displaced persons, which have been affected by instability, disaster, and poverty in Africa. The consistent involvement of local partners in decisions affecting their lives has helped reduce tension and defuse crises, and created equal opportunities.

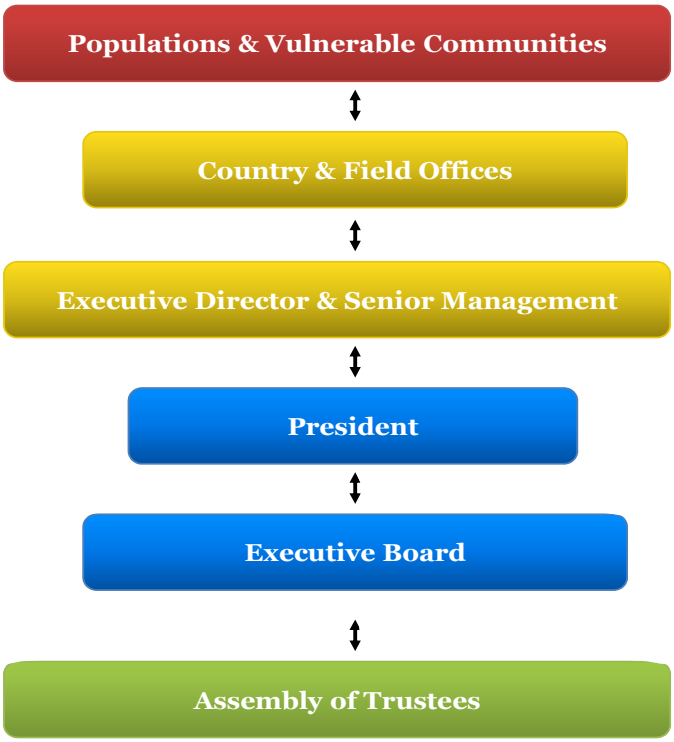
AHA has played a paramount role in tackling policy issues of concern to both refugees and the organisations assisting them. It has consistently advocated the role and responsibility of African organisations in the search for durable solutions. AHA's performance and achievements have demonstrated what can be done by African organisations in resolving both emergency and development issues on the continent.

AHA's interventions are based on contracts with its partners. Most of them have been carried out in a 15-year partnership with the UNHCR. AHA maintains robust links with African governments and institutions, and regional and international humanitarian and advocacy organisations as listed at the end of the report.

AHA has raised and disbursed over USD 68 million, assisting more than 12 million people in Africa. It has gained recognition as a professional organisation that puts funds entrusted to it to sound use with a proven track record of transparency and accountability. It has sustained a focused approach and kept the size and costs of its organisation well-proportionate to the scope and volume of its activities.







AHA is governed by an Assembly of Trustees, whose members serve in a voluntary capacity. The Assembly elects an Executive Board, which sets strategic objectives and operational priorities, and monitors performance, standards and results.

Over the years, AHA was registered in Angola, Burundi, DR Congo, Ethiopia, Guinea (Rep.), Kenya, Liberia, Namibia, Rwanda, Sierra Leone, Sudan, Uganda, and Zambia. It is represented in Benin, Cameroon (where it is scheduled to begin operations in 2010), Nigeria, South Africa and Tanzania. The Head Office is located in Addis Abeba with liaison offices in Geneva and the United States. AHA employees some 1,800 national and international staff.





FIFTH ASSEMBLY



The Fourth Assembly received detailed proposals for changes in its strategic direction together with an institutional capacity development initiative. In response the Fourth Assembly decided to engage an independent consulting firm to review AHA's multi-faceted assistance and services and assess their efficiency and effectiveness. Although AHA regularly conducts internal reviews of its operations, it was the first time that it involved external evaluators. To this end, AHA secured the services of the International NGO Training and Research Centre (INTRAC).

After visits to the head office and programme countries, INTRAC delivered its findings and recommendations, including feedback from AHA Trustees and staff, to the Fifth Assembly of Trustees held in Addis Abeba in June 2009. The Assembly reviewed and deliberated on the reports, decided on the way forward as shown in the records of the Assembly; the chief points being:

- *AHA shall operate as a pan-African international NGO based in Ethiopia with subsidiaries elsewhere in Africa, providing assistance and services to vulnerable and disadvantaged populations and communities;*
- *AHA's vision, mission and strategic documents will be amended to reflect a wider range of humanitarian, development and security concerns in and for Africa;*
- *AHA will streamline its constitution to be composed of an Assembly which should meet every two years, and a small Executive Board which should meet every six months;*
- *AHA will reinforce its management structures to include an executive director position and two senior managers for operations and programme support services before the end of 2010.*

The Assembly also considered programme achievements and difficulties faced in some of the countries of operation. It approved the operational, financial and audit reports as shown in its records. The Assembly also appointed a new Executive Board to serve until the end of the next Assembly. It mandated the new Board to set the strategic direction for the next three years based on the deliberations of the Assembly. The Assembly also welcomed one new Trustee.

15th Anniversary

Africa Humanitarian Action was born as a reaction to the Rwanda genocide. Its beginnings were humble; it was a tiny one-country project-handling agent. At its *fifth* anniversary it was able to respond to the crisis in West Africa, but still struggled to raise funds. At its *tenth* anniversary, it was recognised as a resourceful organisation, which permitted it to go into Darfur swiftly. At the *fifteenth* anniversary, it is ready to go anywhere in Africa where there are people affected by instability and disaster. AHA is now a fully fledged international actor with a long-term outlook to link global and national resources with grassroots actions in support of African growth and development.



The *15th Anniversary* celebrations began the day before the Fifth Assembly with a symposium on "*The state of human security in Africa: Humanitarian Crisis and Responses*", held at the UNECA Conference Centre in Addis Abeba. Representatives from the African Union, African and other governments, UN agencies, NGOs and academia made presentations and contributed to a lively debate of the agenda. The records of the symposium are available from AHA's head office.



AHA marked its 15th Anniversary with a reception hosted by Sheraton Addis.

COUNTRY PROGRAMMES

AHA delivers a wide range of lifesaving services to fit complex and varying situations and needs. Our concern about sustainability has repeatedly helped to fill the critical gap between emergency and reintegration.

Capacity development forms an integral part of all our programmes from day one. We emphasise transfer of knowledge and know-how aiming at empowering our partners in order to ensure sustainability. Our assistance is provided in dialogue and collaboration with target populations and communities, and seeks matching inputs from their side. Hence, our activities also carry an impact on local economic and social development.

AHA's services are recognised as both professional and caring by partners and clients alike. Our organisation has been credited for having made HIV/AIDS information and prevention an integral part of our health and social services from the very beginning. All our programmes include an advocacy component working through various information, education tools, and technical assistance. Our work is chiefly divided into the five areas, which are mutually supportive and partially overlapping in order to meet varying conditions and needs. They are:

Relief & recovery
Camp management & Shelter
Food distribution & nutrition
Reconstruction & rehabilitation
Transportation & logistics
Water, sanitation & hygiene
Protection & repatriation

Health Care
Maternal & child health care
Nutrition services
Primary health care, including malaria
Family planning & reproductive health care
Health education & training
Mental health care

HIV/AIDS
Counselling, testing & contraceptives
Treatment, care & support
Information & educational activities
Prevention & community mobilisation

Sexual & Gender-Based Violence
Care, treatment & support for survivors
Public advocacy & prevention
Reducing stigma & discrimination
Safe & ethical data collection

Capacity development
Empowering affected communities & populations
Awareness raising
Supporting community & local structures
Collaborating with African CSOs, locally & globally
Promoting accountability & transparency
Supporting sustainable development
Resource mobilisation at local level



Community training in Sudan

Burundi

PROGRAMME POPULATION:	***50,000 returnees,*** *and* ***17,325 refugees***
PROGRAMME LOCATIONS:	*Camps in* ***Bujumbura, Makamba, Muyinga, Ruyigi, & Rutana***
PROGRAMME EXPENDITURE:	***USD 1,117,449***
PROGRAMME PARTNERS:	***Government of Burundi, UNHCR,*** *and* ***UNICEF***

Introduction

The AHA programmes for 2009 targeted some 17,000 refugees, and 50,000 returnees residing in camps, of which 25,000 arrived back in 1972 and another 25,000 to change have been in the country since 1993. AHA continued to provide health care and other related services to both target groups. The repatriation programmes were scheduled to come to an end in 2009.

Relief and Recovery



The province of Makamba continued to receive returnees through the entry point of Mabanda. Subsequently, 2009 saw the return of old caseloads from 1972 and 1993. Repatriation programmes were supposed to phase out by December. However, by the end of the year, the repatriation movement of the 1972 caseload did not pick up its momentum and only 2.3% of the expected 25,000 people came back. On the contrary, the return of the 1993 caseloads escalated and a total of 21,755 Burundians have returned i.e. 87% of the expected 25,000 returnees. This state of affairs forced the UNHCR to consider the continuation of programmes in 2010 up and until the time when the last leg of returnees come back to Burundi. The repatriation programme will resume in 2010 which will require AHA to mobilise resources to that end.

Preparations are underway to relocate the small number of Rwandese refugees living in Giharo camp in the south east to a new camp currently under construction. Other services included assistance to expelled people from Tanzania who upon arrival benefited from the same services and packages as voluntary returnees. This UNICEF sponsored programme phased out in December 2009.

AHA provided health care and related services to close to 20,000 Congolese refugees, located in the camps of Gasorwe-Kinama and Musasa in the north, and Mwaro in the west. The latter closed down in May 2009, when a new camp was set up in Ruyigi in the eastern part of the country. When the Bwagiriza camp was opened, all refugees waiting

for decisions on their refugee status, including those in Mwaro, were regrouped. This was a sensitive exercise as this latter group, with the Gatumba massacre in mind, refused to be transferred to an area they considered insecure.

Capacity Development



In 2009, training programmes focused more on building the capacity of the refugee population. Vocational training programmes over a period of six months were held with the aim of imparting skills to interested members of the refugee community. Focus was on young women and men particularly. Having started in 2008, three promotions on sewing and carpentry have graduated in 2009 and received corresponding certificates. At the same time, income generations activities continued with training programmes covering the concept of micro-credit, its management and final outcome to the benefit of the refugee community who will become financially autonomous. By the end of the year, graduates in sewing and carpentry established themselves with the support they were given in terms of material/equipment assistance that enabled them to start their activity.

An evaluation of income-generation activities took place with all concerned and lessons learned were put into practice to redress activities that needed more support and/or to encourage those that were fairing well, while reorganising those having problems.

Training programmes covered various health issues and treatment protocols; information on COP 2010-11, HIV/AIDS and STIs prevention and care; sexual and gender-based violence; prevention against swine flu; skills training for refugees and staff working in local health infrastructures. UNHCR provided training in integration of mental health in the minimum health package; and *Abubef* in reproductive health; and IPPF in SGBV. All topics were taken up by AHA to cover both its staff and refugee workers. Literacy programmes continued for adults and young girls who have left school for various reasons. AHA and *PathFinder International* opened discussions about twinning their programmes on SGBV and reproductive health, chiefly focusing on training of trainers in line with the approach of *Healthier Images of Manhood/HIM*. A memo of understanding is scheduled to be signed in early 2010.



DR Congo

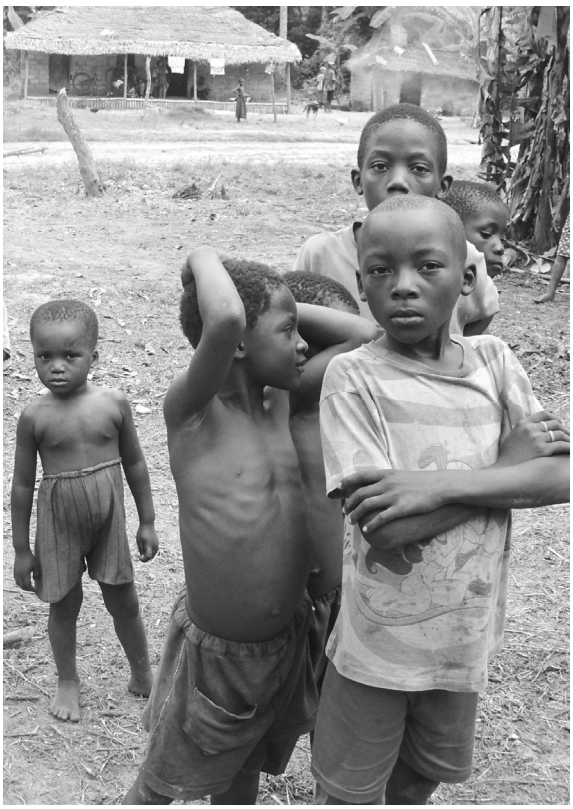
PROGRAMME POPULATION:	***805,257 refugees*** *and* ***displaced persons***
PROGRAMME LOCATIONS:	*Camps in* ***Kinshasa; Equateur & Katanga provinces: Buburu, Imesse, Kalemie, Libenge, Lubumbashi, Mbandaka, Moba, & Pweto***
PROGRAMME EXPENDITURE:	***USD 1,907,625***
PROGRAMME PARTNERS:	***Government of DRC, UNHCR***

Introduction

AHA has several camps in two provinces in DRC , one in the north-eastern region of Equateur and the other in the south-eastern region of Katanga. Both the Tanganyika and Haut Katanga camps are situated in Katanga, and the Bomongo and Bokonzi camps are located in Equateur.

Katanga Province

In Katanga, the main project included repatriation of the Congolese individuals that had come from Zambia and Tanzania. The most common diseases among the returnees were malaria, acute respiratory infections, intestinal parasites, sexually transmitted infections, cholera, and HIV/AIDS. Lake Tanganyika and Lake Moero and the lack of potable water were the predisposing issues.



The Katanga returnees (estimated at 17,000) benefited from medical attention and assistance during their stay in the AHA facilities. Katanga sites have seen rehabilitation and construction works. AHA has built latrines and showers; and furniture replenishments such as closets, chairs; TVs, DVD players and refrigerators.

In the Katanga region there are 20 health centres which are active in the fight against HIV/AIDS by facilitating preventive care. Lack of funds has made it difficult to sustain and continue training programmes. The AIDS outreach was quite successful; out of an estimated 40,000 people to be sensitised through various information tools, over

142,000 people were reached and made aware about the spread and prevention of the pandemic. It represents a 350% success rate, a record in AHA's efforts anywhere over the years!

Equateur Province

AHA, in collaboration with other INGOs, was the UNHCR implementing partner in the Equateur province. It was accountable for improving the health status of the returnees. Some of the activities and programmes that were implemented were:

- *Community awareness of HIV/AIDS, malnutrition, malaria, & hygiene.*
- *Supply of essential drugs & medical equipment to health facilities.*
- *Free medical treatment of returnees for a period of six months.*
- *Construction of health facilities & wells in villages.*
- *Promotion, supply & distribution of condoms to target groups.*
- *Support to & supervision of staff at health facilities.*
- *Monthly analysis & discussion of epidemiological data & patterns.*
- *Management of & support to rape cases.*
- *(JSI) Formation of youth clubs in the fight against HIV/AIDS.*
- *Manufacturing and installation of 14 panels of visibility about HIV/AIDS.*

Although there was success in the Equateur region, it was crippled by the lack of physicians. There are *three doctors to a population nearing 270,000*. AHA will look further into how the partners can improve the situation in 2010.



Ethiopia

PROGRAMME POPULATION:	***3,000,101***
PROGRAMME LOCATIONS:	***Afar, SNNR,*** *and* ***Somali*** *regions*
PROGRAMME EXPENDITURE:	***USD 579,593***
PROGRAMME PARTNERS:	***Government of Ethiopia, Engender Health, John Snow Inc. (JSI),Pathfinder International-Ethiopia,*** *and* ***USAID,*** **UNHCR**

Introduction

AHA launched its family planning and reproductive health (FP/RH) activities in Ethiopia in 1997. AHA has gradually extended its community health care provision in the Southern Nations Nationalities and Peoples Region (SNNPR), focusing on FP/RH and new-born child health. It now runs water and sanitation projects in Aysaita and Berhale refugee camps in the Afar Region. It provides the Aysaita camp with HIV/ AIDS prevention and care, and informal education services. AHA provides shelter assembly and management in the Bokolomayo and Aysaita refugee camps in the Somali region.

Health Care

The Integrated Family Health Programme (IFHP) was implemented in partnership with PI-E and JSI and funded by USAID. The programme focuses on FP/RH, and mother and new born child health care. It was implemented in 13 districts and two Zones in SNNPR, and reached 1,295,192 people.



To improve health practices at the household levels, AHA disseminated information, education and behavioural change materials through home-to-home visits, individual and group discussions at work and market places, and at schools. 61,966 community members received education about FP/RH, maternal and child health, HIV/AIDS and STIs, malaria prevention and control, harmful practices, and environmental sanitation. 21,130 people were reached with FP/RH and maternal health messages in four districts through mobile sessions. 3,805 items of IEC/BCC materials were distributed to health facilities and in the communities.

117,722 new and 181,946 repeat clients were provided with contraceptives of their choice after referral to health facilities and by community-based distributions. 40,857 mothers were referred for ANC, DC, PNC and PAC services. 33,898 children were referred for child health care services to various health facilities. An extended family

planning coverage was achieved through four outreach services. 327 Long-Acting Family Planning (LAFP) clients received implants. Six fistula cases received treatment at the regional hospital.

Capacity development

A Training of Trainers programme (ToT) on communication and counselling, including community mobilisation and behavioural change was organised for 31 health extension workers (HEWs) from the Ministry of Health and our own staff. AHA provided woreda and zone health offices with 8,000 vials of injections, 9,600 cycles of pills, and 12,000 condoms to the public sector in 13 *woredas*.

AHA implemented an *Access to Better Reproductive Health Intervention* project in partnership with *EngenderHealth*. It supported the Ministry of Health in expanding comprehensive contraceptive, and abortion care services. The AHA projects cover four zones and 418 kebeles.

720,231 members of the community received sensitisation material on FP/RH, maternal health, post abortion care, HIV/AIDS/STIs, harmful traditional practices, environmental hygiene and malaria prevention and control. With the help of volunteer community health workers AHA distributed contraceptive pills and condoms to 79,225 clients. 41,315 clients were referred to the health facilities for contraceptives, including three new cases of tubal ligation.

75 HEW supervisors received a three-day training on technology update and supervision skills. Training in communication and counselling skills and contraceptive technology was provided to 385 HEWs and 394 VCHWs.

Water and Sanitation

AHA has supplied potable water to the growing number of refugees in Aysaita and Berhale camp since 2008 through a tripartite agreement with UNHCR and the Government of Ethiopia's Administration for Refugee and Returnee Affairs (ARRA). Both camps are now supplied with the standard 20 litter of water per day and newly constructed sanitation facilities.



To improve the water supply system, AHA constructed three concrete water reservoirs at Aysaita and one in Berhale with a borehole; two generator houses; 14 public

fountains; one water trough; four cloth washing; and four community showering blocks. 18 public latrines, 14 waste disposal pits, and two staff toilets and showers were also constructed.

Educational and informative materials on sanitation and health were produced and distributed. To explain the linkage of water, sanitation and health, a workshop was organised with 290 participants, including women, youth, religious and clan leaders, and other community members. Ten CHAs and 50 peer educators were provided basic and refresher trainings on sanitation, hygiene and environmental conditions.

HIV/AIDS Prevention, Care and Support

This programme benefited Eritrean Afar refugees at Aysaita and their host community. It was implemented in partnership with ARRA and UNHCR, and funded by PEPAR. To ensure realistic and efficient planning and supervision, the project has an advisory committee drawn from all stakeholders. Events to celebrate World AIDS Day were organised by AHA's Aysaita field office.

Prevention and Control information was improved through awareness raising and sensitisation workshops for 150 people drawn from the refugee and host communities, ten peer educators, and 30 community leaders. Some 310 people were sensitised on HIV/AIDS transmission and means of prevention, including the negative impact of stigma and discrimination. Informative materials were obtained from UNHCR and distributed to peer-educators, CHAs and youth groups, including entertainment equipment and games.

Shelter Assembly and Management

AHA is responsible for the assembly and management of shelters at the Bokolmayo and Melkadida refugee camps in the Somali region. AHA designed a low-cost and environment friendly prototype, and UNHCR provided local materials and labour. Twenty model shelters were sent to the two camps for testing. The feedback was positive, and 600 shelters were subsequently erected in Bokolmayo and 100 in Aysaita. Shelter assembly and management committees, composed of refugee representatives were established. A project office in Bokolmayo provided technical and support staff.

Non-Formal Education

This activity gives refugee children and adolescents education in various personal hygiene, traditional practices, healthy environmental conditions, language, and basic science. In 2009, two hundred students attended classes. AHA trained and assigned one co-ordinator and three teachers to the programme, and constructed two standard class rooms, and two adjacent offices.

Liberia

PROGRAMME POPULATION:	***450,000 refugees***
PROGRAMME LOCATIONS:	***Bomi, Gbarpolu, Monrovia, Montserrado,*** *and* ***Rivercess***
PROGRAMME EXPENDITURE:	***USD 1,449,055***
PROGRAMME PARTNERS:	***Government of Liberia, UNHCR, WFP,*** *and* ***WHO***

Introduction

The 1989 civil war crippled Liberia's economy, but since then local initiatives and efforts were complemented by support from the international community. AHA in collaboration with UNHCR, WFP and WHO has provided basic health care, HIV/AIDS and sexual and gender-based violence prevention. Its work has been well received and the co-operation with the government and local communities gone smoothly. In 2009, AHA established itself as a reliable and efficient partner, receiving the title of "*best performing NGO*" in Liberia.



Health Services

The Ministry of Health in Liberia has envisioned much improved health and social welfare services and care, and equity in health. To support this vision, AHA worked closely with the Ministry to make these services attractive, and help train and retain health staff. To combat the high level of communicable diseases such as malaria, STI, respiratory tract infections and diarrhoea, AHA has launched numerous promotional activities that has helped sensitise communities and engaged them in various forms of similar activities. 274,340 people were received for consultations; 9,532 cases of STI were treated; and 31 victims of sexual gender-based violence received help and support.

35 health facilities were expanded to include operational space, and were renovated with modern medical equipment, and stocked with medical and non medical supplies. A constant supply of electricity, clean running water and ambulance services for referral of patients have been set up. Furthermore, these facilities are now adequately staffed with certified and skilled workers. AHA also provided logistic and financial support towards immunisation and surveillance projects.



Perspectives

There were also obstacles to overcome though. Lack of funding towards staff incentives in combination with high costs of living led to a frequent turnover of staff. Moreover, poor transportation links made it difficult to deliver drugs, medical and non-medical supplies. Thus a solution might be to collaborate more closely with the Ministry of Public Works to find more effective and efficient transport methods to guarantee that the needs of health facilities are met on a priority basis.

Namibia

PROGRAMME POPULATION: ***7,270 refugees***
PROGRAMME LOCATIONS: ***Osire,*** *and* ***Windhoek***
PROGRAMME EXPENDITURE: ***USD 1,050,349***
PROGRAMME PARTNERS: ***Government of Namibia, UNHCR, USAID***

Introduction

In 2009, AHA assisted 7,271 refugees in the Osire refugee camp. Our intervention continued the services we have provided since 2001: curative and preventive health care, water and sanitation, logistics, HIV/AIDS, hygiene education, shelter, food distribution, income-generating activities, and other community services.

Osire Camp



In 2009, the Osire camp received 351 new arrivals who were rapidly accommodated. Members of the shelter team assisted families with building supplies, roofing material, plastic sheeting for the rainy season, and the construction of homes. Despite some overcrowding from January to April, AHA was able to accommodate everyone adequately. Additional larger sized tents will be mobilised for any future overcrowding.

64 million litres of safe water were served in the camp, and the newly installed 10,000 litre water tanks fitted with solar pumps. AHA's aim is to provide adequate water amongst the refugee community, and to meet domestic and individual needs. A monthly assessment meeting was conducted to ensure that the water equipment is looked after responsibly.

Osire Youth Group is a forum created for the youth to provide a place to discuss with their peers about challenges facing them in their daily lives. A number of sessions were held on sexual and gender-based violence, sexually transmitted diseases, teenage pregnancy and other issues of interest and concern. A group of young people are called



Life Style Ambassadors (LSAs). Their mission is to promote behavioural change. These potential youth leaders are recruited to act as role models in the community through dialogue and examples. Through workshops and recreational activities, AHA intends to provide the youth with life-skills and a positive attitude. In addition AHA continues to empower survivors of SGBV.

Awareness

As with most AHA operations, the health of refugees is the centre of our focus in Namibia. Various health promotion and awareness campaigns on hygiene, water and sanitation, HIV/AIDS and gender-based violence prevention were conducted throughout the year. A wide range of assistance and care was provided to all who sought counselling and testing or medical and psychological support.

Through organised activities and projects, yearly events are held to celebrate and raise awareness on different concerns such as, Women's Day, Human Rights Day, Environmental Day, and World AIDS Day. Educational campaigns on cleaning and '*Mobilisation on Sexual Reproductive Health*', along with events for condom promotion and HIV/AIDS awareness, were held in the settlement through focus groups. There was also a community-based rehabilitation committee (CBRC) which conducted home visits to those who are physically challenged and assisted them with physiotherapy.

Resource Mobilisation

AHA and CBRC came together to devise and promote self-reliance through income-generating projects for those with disabilities. Members of the community were making notable progress with projects like *Rent a Bike* and *WRADP Ice Cream*.

Rwanda

PROGRAMME POPULATION:	***43,385 refugees***
PROGRAMME LOCATIONS:	***Kibuye, Kigali,*** *and* ***Kiziba***
PROGRAMME EXPENDITURE:	***USD 1,108,479***
PROGRAMME PARTNERS:	***Government of Rwanda, GLIA, PEPFAR, UNHCR, UBS Optimus Foundation***

Introduction

AHA considers providing protection for refugees an important aspect of the entire programme and strives to give women, children, elderly people and other vulnerable better access to services in accordance to UNHCR strategy and priorities addressing mainstreaming age and gender issues in protection and assistance.

Elderly people and children get priority at the in out-patient department, and community health workers make house-to-house visits to give them special support. In order to encourage school attendance, school children get consultation at the health center during recess time. AHA also works towards ensuring women participation in decision-making and promotes their empowerment. Much effort was made to incorporate basic reproductive health into the primary health care services and ensure safe motherhood, and prevent sexual and gender-based violence with provision of medical and psychological support to victims. AHA endeavors to sensitise on SGBV prevention and give the necessary assistance to SGBV survivors both in Kiziba and in the urban refugee projects.

There was a positive co-operation with other actors in the province and the district, and with implementing partners of UNHCR who are engaged in other sectors. AHA also had an excellent co-operation with public local hospitals.

KIZIBA REFUGEE CAMP

Health Services

AHA delivers a high standard of preventive and curative health and nutrition services to more than 18,000 refugees and surrounding population. AHA only employs qualified health personnel. There is a 24-hour ambulance service dealing with emergency referrals to the district and tertiary hospitals in Kigali. AHA's surgeon at Karongi District Hospital manages most cases of surgical and gynaecologic nature and performs minor operations in the camp health centre. Hence the number of referrals is low from the total 32,661 consultations made at the camp health centre in 2009.

AHA continued its community sensitisation campaigns, focusing on promotion of good health and prevention of HIV, SGBV and other common diseases. Focus is given to

increase awareness and prevalence of contraceptive usage. Reproductive health services which include safe motherhood, Ante- and Post-natal care, prevention and treatment of STIs, and family planning are fully integrated into the comprehensive primary health care.

Both moderate and severe malnourished children were enrolled in the supplementary and therapeutic feeding centres. They were chiefly identified through Under-5 programme, which screened 4,551 children.

HIV/AIDS



Comprehensive HIV/AIDS prevention, care and support were continued to refugees in the camp and the local population. Awareness campaigns and community mobilisation were conducted by peer-educators, community health workers, anti-AIDS clubs, women and religious leaders throughout the year. 3,703 volunteers tested for HIV in VCT , of which 36 cases were positive and referred to the ARV programme. 13 pregnant women in PMTCT programme were also found positive.

The refugee communities benefited from an ARV programme provided at the camp health centre. Nutritional supplement food comprising 200g of *CSB* + 15g of *sugar* + 20g of *oil* per person/day was distributed to ART 70 patients on a weekly basis. Regular home-based care was given by community health workers, and psychosocial, and PMTCT nurses.

Sexual & Gender-based violence (SGBV)

AHA launched a SGBV prevention and response project for Kiziba, urban refugees, and the surrounding community with financial assistance from the UBS Optimus Foundation. The health staff together with animators, peer-educators and other stake-holders sensitised the community to an increased awareness and response to survivors of SGBV. Several training sessions were held to increase the capacity of both the staff and the community with Information, Education and Communication (IEC) reaching 41,090 refugees. Since the beginning of the SGBV project, the number of reported cases was rising as a result of the community becoming cognisant of SGBV issues. An

additional effect was that couples legalised their marriages.

Capacity Development

Various training and refresher sessions were conducted on health, HIV/AIDS, PMTCT, ART, SGBV for AHA medical staff, animators, peer-educators, anti-Aids club members, home-based care providers, community and religious leaders, police officers, teachers and youth both in the Kiziba Camp and the nearby urban settings. Skill-building training was provided to vulnerable groups and OVCs covering subjects such as tailoring, cotton colouring, soap production, computers, driving, cooking, and hair dressing. AHA also constructed a six-room, fully equipped maternity ward at the Kiziba Health Centre, and the PMTCT-services were improved.



The PLWHA association benefited from micro-garden, handicrafts, soap production, cotton colouring and other skills they learned. An arrangement was made with a micro -finance organisation where vulnerable groups could get loans with which to start small businesses.

URBAN REFUGEES IN KIGALI

AHA continued its health and community services and the management of medical referral cases, receiving patients for treatment and follow up in specialised health facilities. Patients and their attendants were assisted with accommodation, food and transport as required. Routine consultations were made in 97 sessions for 4,703 urban refugees and asylum seekers. Supplementary food is provided to patients suffering from tuberculosis, diabetes, malnutrition; children with HIV; adults on ARV treatment; and children whose parents are living with HIV.

HIV/AIDS

Sensitisation campaigns on HIV prevention continued among urban refugees. 81 IEC sessions were conducted for a total of 1,887 participants (1,317 females and 570 males) at the clinic. With the help of additional funds from UNHCR, expanded HIV activities were carried out in urban areas since June.

Using Anti-AIDS clubs, awareness sessions took place through exhibitions, songs, poems and dances with a message on HIV and SGBV. In addition, two youth forums

were organised for students on reproductive health, HIV, STI, condom use, and sexual gender- based violence. HIV prevention messages were also broadcasted on the national radio on a regular basis. An artistic competition was organised among different groups to promote community participation.

VCT and PMTCT

VCT services at the clinic were started up. A laboratory room was installed and equipped with equipment and supplies ready to provide VCT service in 2010. A counseling room will be equipped at the beginning of next year.

CARE/SUPPORT AND TREATMENT

Local health centres provide treatment to PLWAs with assistance from AHA. PLWAs received vocational training in tailoring and driving. To provide psychological support to PLWAs and their families, home visits were done to follow up on living status, ART adherence, and the identification of particular needs.

Training and refresher training were held on health, HIV/AIDS, PMTCT, ART, SGBV for AHA medical staff, animators, peer-educators, anti-Aids club members, home based-care providers, community and religious leaders, police officers, teachers and youth in both the Kiziba Camp and urban areas.



Awareness on SGBV was conducted by animators and peer educators in collaboration with the SGBV staff. A 16-day intervention against SGBV on the global theme of "Commit ▪ Act ▪ Demand: We CAN End Violence against Women" was conducted by AHA in collaboration with UNHCR. AHA disseminated a message on "Behaviour Change Communication" through radio spots, billboards, pamphlets, and t-shirts. It also carried out artistic competition emphasising the "*role of men in improving the quality of family life*".

Sudan

PROGRAMME POPULATION: ***191,500 refugees***
PROGRAMME LOCATIONS: ***Balila, Challi, Gindi, Kumruk, Samari,*** *and* ***Wodaga***
PROGRAMME EXPENDITURE: ***USD 1,812,816***
PROGRAMME PARTNERS: ***Government of Sudan, UNHCR, UNOCHA, FAO, WFP***

Introduction

Twenty years later, after all the wars, hardships and turmoil Sudan is left bare, without any fertile land, animals, without any means of sustenance. Hundreds of thousands of refugees and IDPs now return home, or more specifically what they thought was their home. As they had been in exile or internally displaced for so long that a sustainable social integration cannot be seen in the near future. AHA in collaboration with UNHCR, WFP and FAO has helped facilitate their return home with safety and dignity, ensuring they have basic essentials such as health and nutrition. AHA also provided food, non-food items, seeds and agricultural tools, water, schools, livestock and medical care.

Reception areas were set up fully renovated equipped with first aid posts, small offices and health education sites. Efforts to make the repatriation as smooth as possible were done through community mobilisation, training the Kumruk locality and the food aid management committee. The major activities carried out where distribution of food and non-food items. AHA also engaged in water transport and primary health care everywhere.



Adequate food rationing was provided for targeted registered refugees. During the rainy season the poor infrastructure made transport very difficult however the food aid

management committee was trained well to distribute food in case the AHA staff could not be reached. The heavy rains also posed as a problem for cultivating the distributed seeds such as maize, okra, tomato and sorghum. Distribution of other non-food items such as construction tools, agricultural tools were nonetheless successful.



The majority of the locals depended largely on livestock. As such livestock was distributed to the most vulnerable households. However this activity was faced with lack of veterinary services and shortage of drugs and fodder for animals. Another major challenge the returning refugees and IDPs faced was poor quality and quantity of water. Recognizing this misfortune AHA transported potable water and drilled 3 boreholes. Aside from efficient running water, the reception centre provided medical care, schools, and clean toilets. Furthermore, the refugees and IDPs were sensitised on issues regarding hygiene, STI, SGBV and HIV/AIDS.

Handouts were a very good way of relieving short term problems however in the long run communities should sustain themselves. Thus AHA and UNHCR have envisaged a plan to assist needy communities with income generating activities such as animal restocking, fishery, horticulture, and provision of sewing machine. Proper orientation and skill training sessions preceded the start of these initiatives.



Uganda

PROGRAMME POPULATION: ***30,000 refugees***
PROGRAMME LOCATIONS: ***Adjumani, Juru, Kampala,*** *and* ***Nakivale***
PROGRAMME EXPENDITURE: ***USD 630,193***
PROGRAMME PARTNERS: ***Government of Uganda, UNAIDS, UN Foundation,*** *and* ***UNHCR***

Introduction

AHA has provided comprehensive primary health care and nutrition services to Sudanese refugees and the host communities in Adjumani District since 1995. There are 17 health clinics and a comprehensive outreach programme in partnership with UNHCR's larger Uganda programme.

In 2009, AHA began a new project in south western Uganda for Congolese refugees in the Nakivale refugee settlement providing similar PHC services to those in Adjumani for some 20,000 new arrivals from DRC. AHA implemented malaria projects (funded by *Nothing But Nets*), and a HIV/AIDS awareness programme (funded by UNAIDS). AHA doctors have also been assisting the district referral hospital in managing emergencies.

The health services provided by AHA's clinics include:

- *Essential clinical care services;*
- *Comprehensive Maternal & Child health care services; and*
- *Outreach PHC services.*

Adjumani Operations

In 2009, AHA targeted a population of 21,161 refugees and 60,000 nationals. However with the repatriation of refugees, this figure was reduced to 8,497 refugees at the end of the year. By December 2009, a total of 233 births, 105 male and 128 female and 46 deaths, nine male and 37 female had been registered.

Indicators	*Progress*
Refugees have access to 100% clinical care in two health centre IIIs, eight health centre II, and eight health posts (22,080 refugees)	More than 99% of the refugees have access to essential health care services
Maternal mortality ratio below 1/1000 new births	0/1000/new births
Under-five's mortality ratio maintained below half of 5/1000/pop/year	0.6/1000/year
Consultation rate of target population	1.4/person/year (includes nationals)
Consultation rate of refugees	1.05/refugee/year
Contraceptive rate	9.1 percent.
Global malnutrition rates kept below 7% and acute severe malnutrition below 1%	Global Acute Malnutrition rate is at 6.9%; and acute severe malnutrition is averaging 0.8%
More than 80% of the expected new pregnancies enrolled for ANC	79.2 % enrolled
More than 50% of the deliveries assisted	79% deliveries assisted in our health units
DPT-3/OPV-3 coverage of 85%	89.6% covered
Measles coverage rate of >95%	89.44% target not achieved

Nakivale Operations

In January 2009, the population in the Nakivale camp stood at 48,212, and the population of the Juru camp, where AHA worked had a population of 20,000. In the first quarter, there were 155 deliveries, 70 male and 85 female. 255 deliveries were registered in the second quarter, and 173 live births were recorded, 92 male and 69 female, in the third quarter. There were 256 deliveries in the fourth quarter. The crude birth rate for Nakivale settlement was 3.1 for 2009.

Sector Objectives	*Indicators*	*Progress*
Improved access to basic health care services	Immunisation coverage	
	BCG - 95% ; DPT3 - 95% ; Measles - 95% ;TT - 95%	BCG - 82.3%;DPT3 - 52%; Measles - 40.3% - TT - 52%
	At least 70% of the pregnant women will have at least four antenatal checks by trained staff	Coverage of complete antenatal care is 50%
	100% of the pregnant women will have supervised deliveries by trained health workers	Proportion of births attended by skilled health worker excluding TBA is at 76%
	ITN coverage in ANC raised to at least 75%	Coverage ITN is 97% for pregnant mothers
	IPT raised to at least 100%	Currently stands at 52%
	Health facility utilization rate at least 2	Health facility utilisation rate is currently at 1.2
	Provision of laboratory supplies and reagents to health centres'	Laboratory reagents & supplies were provided. 4,248 malaria tests; 793 syphilis; & 72 for TB with 9 positive & referred for treatment.

Prospects

The programme continues to face long-term funding uncertainties with regard to the basic needs of refugees and host communities. While the refugee caseload in northern Uganda has come down significantly as a result of the repatriation, the services required by the host communities still exist. The district health departments face critical inadequacies in terms of qualified human resources, medical supplies and equipment, and the required resources and reliability for logistical support and supervision services.

It is envisaged that the health and nutrition services in northern Uganda (the AHA Adjumani project) will be integrated into the district health delivery system. This will lead to a gradual phasing out of the AHA project. A memo of understanding has been signed by all stakeholders to assist in speeding up the integration process. The integration process is foreseen to be completed at the end of June 2010. AHA will then, together with the UNHCR close down the project. Since the refugee caseload form DRC is expected to remain the same, the AHA project in south western Uganda is expected to continue throughout 2010.

Zambia

PROGRAMME POPULATION: ***4,782 urban refugees***
PROGRAMME LOCATIONS: ***Chilenje*** *and* ***Makeni*** *transit centres in* ***Lusaka***
PROGRAMME EXPENDITURE: ***USD 476,581***
PROGRAMME PARTNERS: ***Government of Zambia,*** *and* ***UNHCR***

Introduction

AHA began its operations in the Republic of Zambia in 1998 and has since provided assistance to refugees from surrounding countries. After the successful repatriation of thousands of Angolan refugees from the Nangweshi Refugee Camp in 2007, AHA has focused its assistance on urban refugees in Lusaka.



In 2009 AHA delivered health care services, community services, basic education support and the management of two transit centres in Lusaka. Health care services varied between primary and specialised care to urban refugees and refugees referred from various camps.

There was an increase of referred cases with HIV infections in 2009. Eight workshops were conducted to counsel members of the community about HIV/AIDS, other sexually transmitted diseases and TB. The workshops focused on prevention methods and fighting the stigma that is often associated with HIV/AIDS.



The Chilenje transit centre received 257 refugees/asylum seekers. All transiting refugees were provided with food, toiletries, beds, mosquito nets, mattresses and blankets. Second-hand clothes were supplied in vulnerable cases. In addition, over 700 chronically ill refugees were given access to basic medical care, food supplements and received home based care by outreach teams and qualified medical staff.

AHA supports the promotion of basic education for all refugee children. Our objective is to assist the children in acquiring the necessary knowledge and survival skills to cope

with life in their host country. To this end, in collaboration with UNHCR, AHA supported 386 refugee pupils with tuition fees, examination fees, books, uniforms, and transport allowances. Along with the counselling and career guidance services offered by AHA, these students will benefit from educational and cultural integration into their host community.



Scholarships for colleges and universities were awarded to 54 refugees. They have been placed into seven colleges and two state universities. Female students made up 53.6% of all scholarship recipients, while 46.4% were male students. Each student was monitored at least once per term. In 2009, ten students graduated from colleges of higher learning. Prospects for these graduates to integrate into their host communities have improved, and all graduates are gainfully employed.

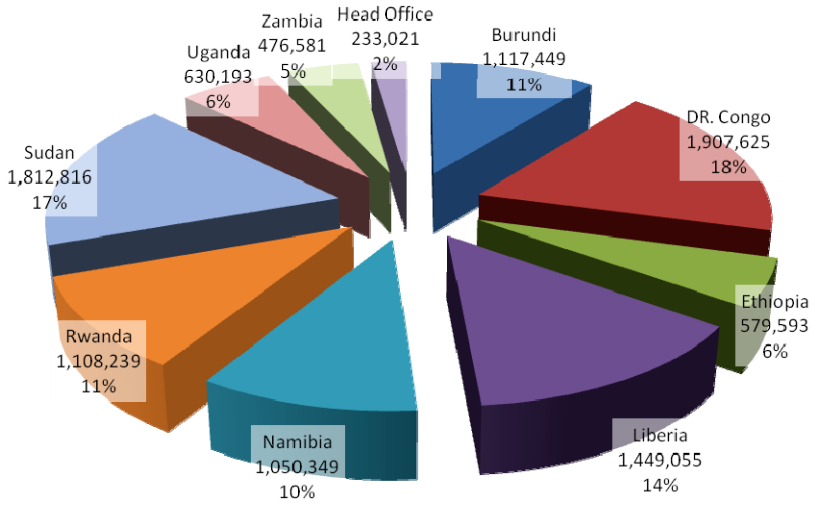
AHA's 2009 operating budget did not permit the provision of income generating activities. Fortunately, a good number of urban refugees are self-sufficient and only require supplementary assistance to acquire legal documents (work and study permits) and to supplement their children's education. AHA plans to continue providing reliable and efficient assistance to the refugee community in Lusaka in the coming years.

The year saw its fair share of challenges. The lack of adequate project vehicles made it difficult for volunteers to get to distant outreach posts. Bicycles would allow for easy access to distant areas, but a limited budget did not allow such procurements. Also, the rise of HIV/AIDS prevalence in the refugee camps called for a scaled up HIV/AIDS programme. In sum, due to limited resources, the project was unable to cater to all identified gaps in outreach areas.

FINANCES

	Income			Expenditure		
	2008	2009	Total	2008	2009	Total
Burundi	1,476,958	1,117,449	2,594,407	1,476,958	1,117,449	2,594,407
DR. Congo	2,073,066	1,907,625	3,980,691	2,073,066	1,907,625	3,980,691
Ethiopia	817,087	579,593	1,396,680	817,087	579,593	1,396,680
Liberia	939,867	1,449,055	2,388,922	939,867	1,449,055	2,388,922
Namibia	1,059,124	1,050,349	2,109,473	1,059,109	1,050,349	2,109,458
Rwanda	768,819	1,108,239	1,877,058	768,818	1,028,479	1,797,297
Sudan	1,203,446	1,812,816	3,016,262	1,203,446	1,812,816	3,016,262
Uganda	466,619	630,193	1,096,812	466,619	630,193	1,096,812
Zambia	_	476,581	476,581	_	476,581	476,581
Head Office	201,995	233,021	435,016	201,995	230,248	432,243
Totals	**9,006,981**	**10,364,921**	**19,371,902**	**9,006,965**	**10,282,388**	**19,289,353**

Income By Country



AHA Programmes 1995-2009	
	Total
Angola	8,240,277
Burundi	5,796,884
Chad	1,014,845
DR. Congo	6,106,064
Ethiopia	3,744,798
Guinea	215,467
Liberia	4,872,779
Namibia	7,795,416
Rwanda	10,152,750
Sudan	4,512,944
Uganda	6,883,774
Zambia	5,910,902
Head Office	3,342,728
Totals	**68,589,628**

Note: *All figures audited in USD*

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UN Development Fund for Women (UNIFEM)
UN Food and Agricultural Organisation (FAO)
UN High Commissioner for Refugees (UNHCR)
UN Mission in Liberia
UN Mission in Sudan (UNMIS)
UN Office for the Coordination of Humanitarian Affairs (OCHA)
UN Population Fund (UNFPA)
UN World Food Programme (WFP)
UN World Health Organisation (WHO)
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AHA thanks all those who have contributed to its work and achievements.

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