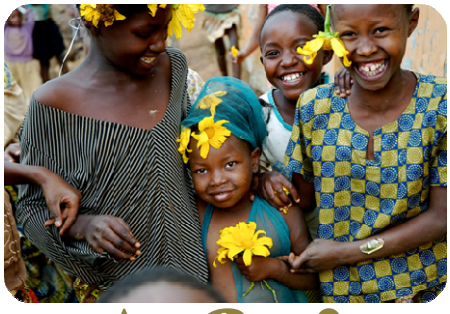
Africa Humanitarian Action

Annual Report 2011









African in

Spirit | Concept | Composition

Who we are

Africa Humanitarian Action (AHA) is an international non-governmental organization that provides emergency, development and advocacy services that target displaced and vulnerable communities across Africa.

This report

The 2011 Annual Report is split into two main sections. The first is a brief summary of the organization and a review of 2011. The second section provides more in-depth information on 2011 activities.

Find out more

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Section One
About AHA 03

Message from the President
Who we are
What we stand for
Structure
What we do
A year in review

Section Two
2011 Activities

Healthcare 12

HIV/AIDS 16

Sexual and Gender Based Violence 18

Capacity Development 20

Relief and Recovery 22

Advocacy 24

Finances 26

Change Makers 28

Front and back cover images from Kiziba Camp, Rwanda

Somalia - in picture



Rehabilitated water tanker in Hodan District, Mogadishu



Newly constructed water distribution points under installation in Hodan District IDP camps, Mogadishu



Rehabilitated incinerator at Banadir Hospital, Mogadishu



Community mobilization and sensitization on sanitation and hygiene in Hodan District



One of 20 block latrines constructed. Each block has 2 female and 2 male private stances



Water purifiers were regularly distributed to internally displaced persons. Detailed discussions on how to use and the benefits of the water purifiers were held with all beneficiaries

Message from the President

In 2011, as we strived to deliver our humanitarian services in various crisis affected regions across Africa, much of the Horn of Africa yet again presented the world a new challenge in the summer. Dubbed as one of the worst droughts in 60 years, this phenomenon hit with a particularly devastating impact in Somalia, where a relentless conflict has depleted the country's resources for decades.

In line with our aspiration to be front-line responders to humanitarian emergencies in the continent, and despite the increasing resource challenges, AHA devised quick intervention plans, and mobilised funds to respond in two destinations of the population movement: the camps for internally displaced persons (IDPs) in Mogadishu and the refugee camps in the Somali region of Ethiopia.

Forging a new frontier of partnership with the African Development Bank Group (AfDB) – and in collaboration with a Somali based NGO, 'Hijra' – we launched water, sanitation and hygiene (WASH) as well as nutrition and health care interventions in IDP camps in Mogadishu. That project has to date succeeded in rehabilitating water systems servicing IDP communities; constructing latrines, waste pits and washing facilities; as well as providing vaccines and food rations and supplements.

In Ethiopia, we scaled up our existing engagements with the United Nations High Commissioner for Refugees (UNHCR) and speedily erected some 3,500 shelters – at a rate of 120 per day during the emergency phase – for newly arriving refugees. As a result of the continuous partnership between the Government of Ethiopia, UNHCR and AHA three of the camps of Dollo Ado: Bokolmayo, Melkadida and Kobe today provide shelter to a total population of some 110,000 refugees.

The year 2011 was predicated with complex and contradictory challenges that lay ahead for humanitarian actors, like AHA, based in the global South. Owing to the recent financial woes of the donor community, operational resources were thinly spread. Southern humanitarian NGOs, in spite of their well-known financial insecurity, were being increasingly impelled to bring in their *monetary contributions* to partnership agreements.

Nonetheless, whenever opportunities had permitted, AHA has brought in additional resources to augment the projects it has implemented with its partners. In 2011 alone, we continued to support a programme addressing the effects of sexual and gender-based violence in Rwanda; provided primary health care services for some 70,000 beneficiaries in Darfur, Sudan; chlorinated water sources for IDP communities in Mogadishu; built staff residences for field staff in Cameroon and supported the salaries of management and health care personnel.

Back in 2007, AHA participated in a vanguard initiative called the Global Humanitarian Platform, which had brought together representatives from NGOs, the Red Cross/Red Crescent movement, UN system agencies and other intergovernmental organisations. The initiative sought to improve humanitarian response through strengthened partnerships at the global and field levels. We adopted five '*Principles of Partnership'* upon which to base our collaborations: *Equality, Transparency, Result-oriented Approach, Responsibility* and *Complementarity*.

Despite the Principles' express recognition that local capacity is a key asset to enhance '*complementarity*', we are observing contradicting practices. At a time when regional humanitarian actors struggle to stand on their own solid institutional footing, compelling them to bring in financial contributions, as collateral for partnership, threatens their very existence. Unable to bear this extra burden, they will simply be forced to wither away.

We could not have achieved the results detailed in this annual report without the generous support of our partners and the dedication of our staff and volunteers, and I thank you all for sharing our commitment.



Dawit Zawde

Understanding AHA

Founded in 1994, AHA is African in

Spirit: Confident that African people have the necessary skills and resources to address the challenges facing the continent, AHA contributes toward and advocates for regional African-driven solutions to conflict and poverty.

Concept: AHA's proximity to affected populations and understanding of local contexts maximize the sustainability and accountability of the multispectral programs it delivers.

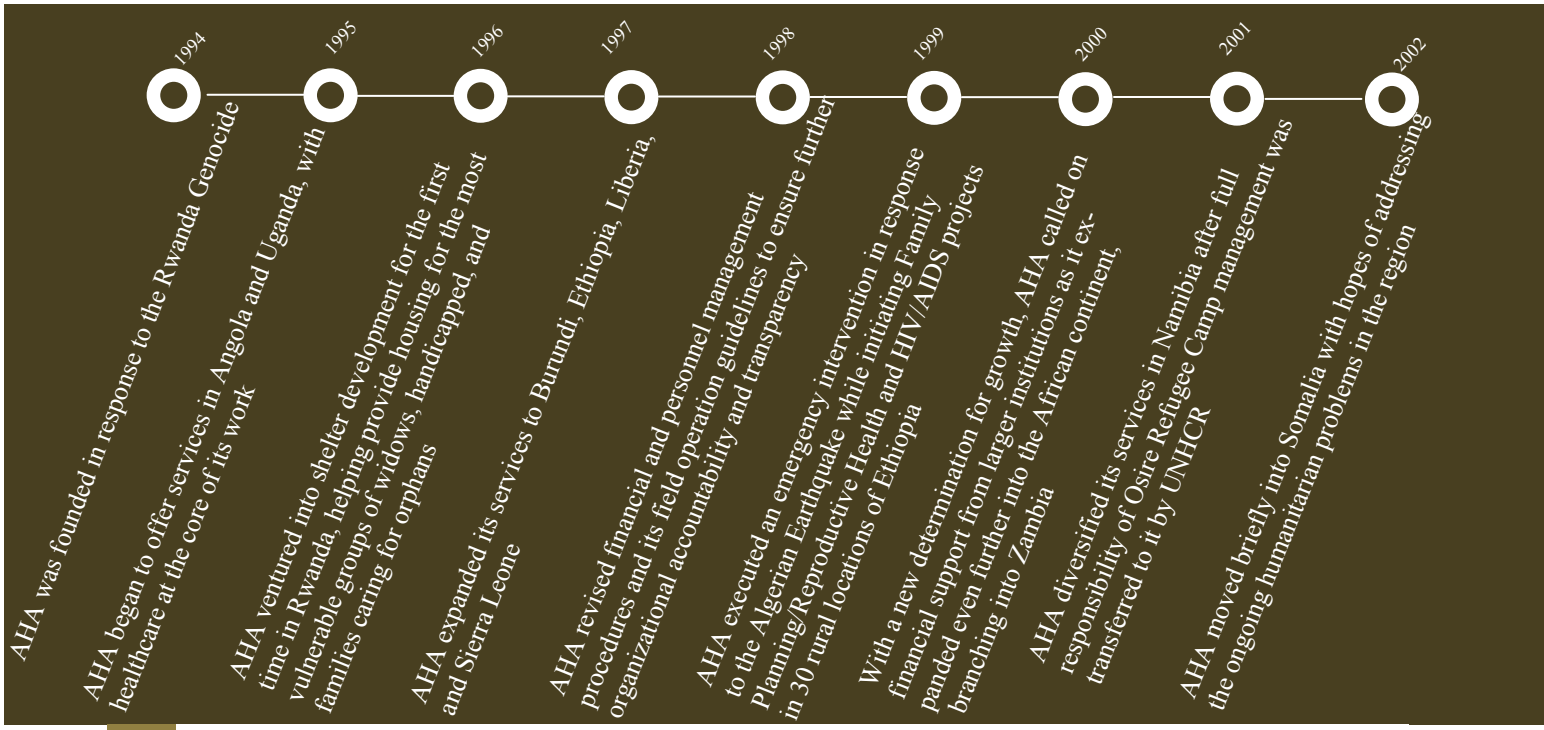
Composition: AHA draws on the commitment and expertise of more than 1,212 staff; 96% of whom are recruited from local communities, to better ensure a continuum between humanitarian assistance and development.

The strength of AHA is in its African roots and reach.

Our ***vision*** is an African continent which can sustain its populations, communities and individuals in human security through its own institutions, working peacefully together.

Our ***mission*** is to respond to crisis, conflicts and disasters in Africa; to enhance communities at risk, so they can solve their concerns themselves; and to advise the international aid community and the private sector on humanitarian issues concerning Africa.

AHA is guided by universal humanitarian ***principles and values***. While upholding our independence, impartiality, and integrity, we advocate and may speak out on humanitarian issues. We take responsibility for our actions, and are accountable for the resources at our disposal to those we work with and to those who support us. We attempt to deliver sound programs and results. We are inclusive and make use of the diversity and resources of the people we work with. We embrace change and innovation, as we seek results that last.



Structure

Affected populations are at the forefront of all AHA activities. This ensures that AHA's Field Offices respond appropriately to people's prevalent needs, in a timely and effective manner. Each field Office is supported by a Country Office, which is in turn backed by a team based at the Head Office, in Addis Abeba, Ethiopia.

The AHA Head Office is guided by a Secretariat headed by the President who works with an Executive Board-setting strategic priorities and monitoring and evaluating performance, standards and results. The Board is appointed by AHA's International Assembly of Trustees whose members determine AHA's general policies and ensure quality and accountability to both affected populations and donors.

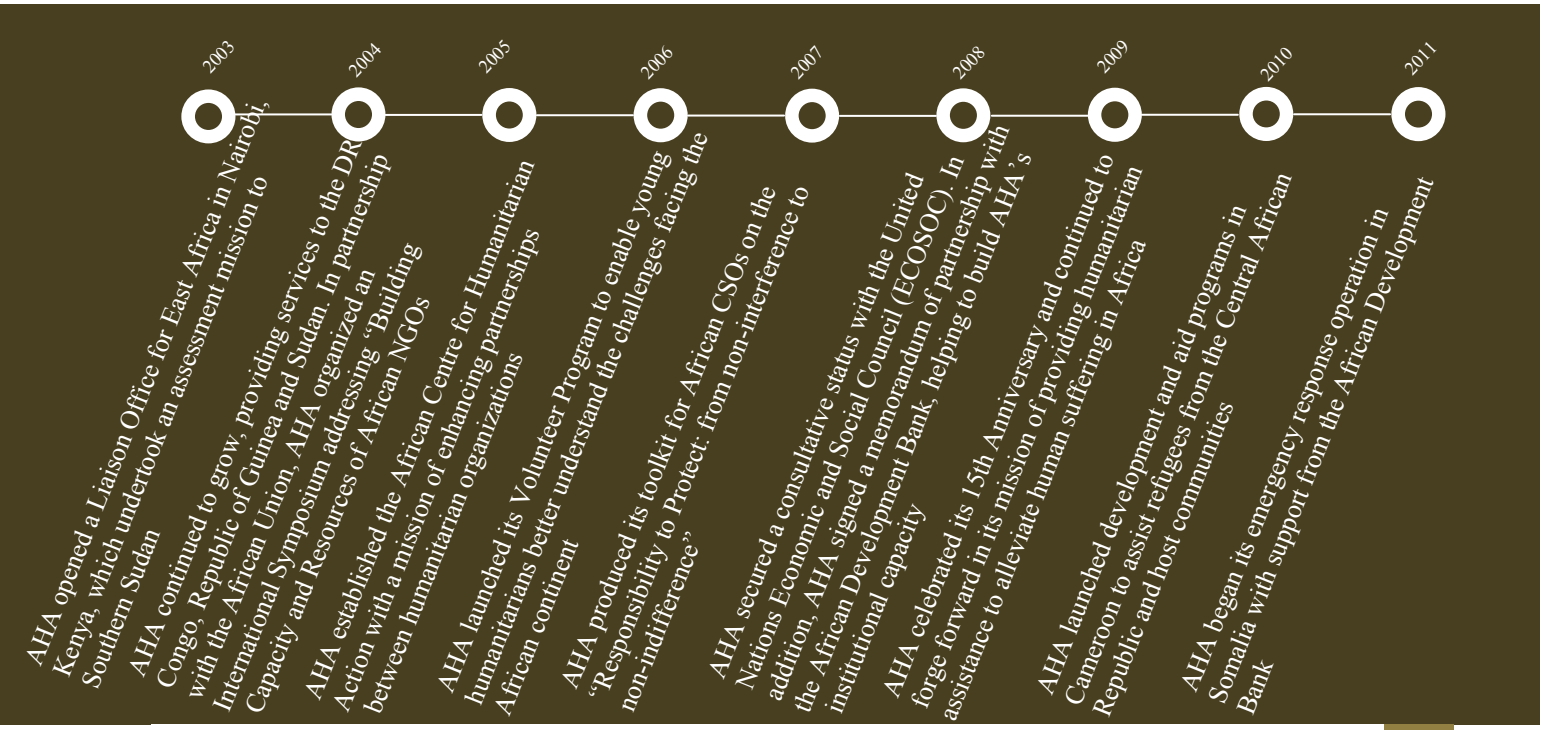


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Programs

Capacity Development

Protracted crisis and chronic poverty have severely devastated African societies leaving them unable to achieve self-reliance. It has been an imperative task of AHA to instigate an African renaissance through developing the capacities of individuals, communities and local organizations, institutions and governments.

- Community empowerment and participation
- Information, education and communication
- Livelihood protection and income generation
- Reconstruction and rehabilitation
- Support of community and government structures and services
- Sustainable development
- Training

Healthcare

The physical, mental and social wellbeing of African communities is essential to the development of the continent. Improved and accessible healthcare delivery is thus given special attention by AHA with emphasis on community based healthcare where assisted populations are both partners and beneficiaries of AHA.

- Health education and training
- Infections and transmitted disease prevention and cure
- Maternal and child healthcare
- Mental healthcare
- Nutrition services
- Primary healthcare
- Reproductive healthcare

Relief and Recovery

Prudent delivery of relief and recovery services is a critical responsibility AHA undertakes across Africa. As displaced beneficiaries are unable to provide food, shelter, transportation and other immediate necessities for themselves, it has been vital that AHA is prepared for unforeseen circumstances in conflict and disaster areas.

- Camp management
- Community development
- Food distribution and nutrition
- Protection
- Rehabilitation and reconstruction
- Shelter provision
- Transport and logistics
- Water and sanitation

Working alongside governments and international partners, AHA takes measures to ensure that aid efforts are not duplicated and that gaps in service delivery are met.

Sexual and Gender-based Violence

Girls and women are most vulnerable to gender based violence during times of crisis, forced displacement and chronic poverty. AHA works to ensure the safety and security of these most vulnerable members of society through gender based violence prevention and response programs in situations where social services are interrupted and may be lacking.

- Care, treatment and support of survivors
- Prevention
- Reducing stigma and discrimination
- Strengthening collaboration and coordination with stakeholders
- Safe and ethical data collection

HIV/AIDS

AHA is dedicated to providing the necessary information and services to enable and empower vulnerable communities mitigate the impact of HIV/AIDS.

- Care, treatment and support for people living with HIV/AIDS
- Information, education and communication
- Prevention and community mobilization

Public Advocacy

AHA builds on the strength of African people to solve African problems. Founded on its experiences and achievements of 17 years, AHA believes that boosting independent African humanitarian and development organizations that have shown determination and ability to help solve the continent's dilemma is essential for alleviating Africa's troubles.

- Support and empowerment of indigenous organizations
- Flexible and timely needs based funding
- Genuine partnerships
- Acknowledgement and integration of African CSOs agenda and strategy
- International recognition of African CSOs value, contribution and expertise
- Enhanced accountability and sustainability
- Increased capacity development for African CSOs and vulnerable populations



A year in review

Year-end reports from AHA's Country Offices across Africa in 2011 showed that, despite the depth of the global financial crisis and decreasing financial support from traditional donors, AHA programs had by and large continued to deliver timely and relevant life saving services and kept the lives of some of Africa's vulnerable communities dignified.

Burundi:

Beneficiaries:28,000 refugees, mainly from the DR Congo

Location: Bujumbura, Gasorwe, Kinama, Musasa and Bwagiriza Camps

Activities: Healthcare, Nutrition, HIV/AIDS, Relief and Recovery

Partners: Government of Burundi, United Nations High Commissioner for Refugees

Cameroon:

Beneficiaries: 20, 136 Central Africa Republic refugees (10,641 female); 49,731 host community members

Location: Kette, Ndelele, and Batouri (Belita II) districts in Eastern Cameroon

Activities: Healthcare, Nutrition, HIV/AIDS

Partners: Government of Cameroon, Ministry of Public Health of Cameroon, United Nations High Commissioner for Refugees, United nations World Food Programme, IFRC, FAIRMAID FRC, IRD and PU

Ethiopia:

Beneficiaries: 2,714,131 local community (1,383,900 female); 140,357 Refugee (55,968 female)

Location: SNNPR Regional State (Wolayita and Gamo Goffa, Hadiya and Kembata Tembaro Zones); Dollo Ado Woreda and Liben Zone of the Afar and Tigray Regional States and Somali Regional State of Ethiopia

Activities: Healthcare, HIV/AIDS, Relief and Recovery, Gender-based Violence, Capacity Development

Partners: Government of Ethiopia, Southern Nations Nationalities and Peoples Regions (SNNPRs) Regional Bureau of Finance Economic Development; SNNPRs Bureau of Health; Wolayita and Gamo Goffa, Kembata Tembaro and Hadiya Zonal Department of Finance and Economic Development (DoFED) and Department of Health (DoH), Agency for Refugee and Returnees Affairs; United Nations High Commissioner for Refugees; USAID through Pathfinder International Ethiopia (PI-E); Jon Snow INC (JSI); Engender Health Inc (EH Inc); and HSBC Bank PLC

Liberia:

Beneficiaries: 283,451 nationals

Location: Bomi, Gbarpolu, and Rivercess Counties

Activities: Healthcare, HIV/AIDS, Gender-based Violence, Capacity Development

Partners: Government of Liberia, Ministry of Health and Social Welfare—Liberia, United Nations Children's Fund, United Nations Population Fund, Citizens Development Association of Rivercess County (CIDAR); Merlin; Child Fund; YAPA

Namibia:

Beneficiaries: 6,936 refugees (3,287 female)

Location: Osire Refugee Settlement

Activities: HIV/AIDS, Sexual and Gender-based Violence, Water and Sanitation, Relief and Recovery, Capacity Development

Partners: Government of Namibia, Namibia Ministry of Home Affairs and Immigration, and United Nations High Commissioner for Refugees, United Nations World Food Programme, USA Embassy, Namibia

Rwanda:

Beneficiaries: 37,440 refugees (22,059 female), 3,453 host community members, 6,704 returnees

Location: Kigali and Karongi (Kiziba, Gihembe and Niyabiheke refugee camps), Nyagatare and Nkamira Transit Centers

Activities: Health, HIV/AIDS Relief and Recovery, Gender-based Violence,

Partners: Government of Rwanda, United Nations High Commissioner for Refugees, United Nations World Food Programme, The UBS Optimus Foundation, and District Health Centre

Somalia:

Beneficiaries: Around 200,000 internally displaced persons

Location: Mogadishu

Activities: Healthcare, Water and Sanitation, Relief and Recovery

Partners: Transitional Federal Government of Somalia, African Development Bank, HIJRA Somalia

Sudan:

Beneficiaries: Around 600,000 nationals

Location: Blue Nile State, Darfur

Activities: Healthcare, Relief and Recovery, Capacity Development

Partners: Government of the Sudan, Sudan Humanitarian Aid Commission, Sudan Federal Ministry of Agriculture and Forestry, United Nations High Commissioner for Refugees, United Nations World Food Programme, Food and Agriculture Organisation of the United Nations, and World Health Organization

Uganda:

Beneficiaries: 39,573 refugees, 60,000 nationals

Location: South Western Uganda (Nakivale Refugee Settlement), and Northern Uganda (Rhino Camp, Imvepi, Palorinya, Adjumani and Kiriyandongo Refugee Settlements

Activities: Healthcare, Nutrition, HIV/AIDS, Capacity Development

Partners: Government of Uganda, Uganda Ministry of Health, United Nations High Commissioner for Refugees

AHA partnered with American artist Kresta K.C. Venning, M.A. Photography, to offer a Photography Workshop in basic digital camera skills to refugees ages 19 - 26. The training occurred over two weeks and took place at the Kiziba Refugee Camp Health Center in Kibuye, Rwanda.

In addition to the classroom, field workshops were held at various sites across several quarters and villages throughout Kiziba Camp, including students' homes, churches, football fields, pastures, community gathering places, potable water collection and laundry/washing sites, a secondary school, a grave site, and a hill-top village. The objectives of this visual arts project was three-fold: 1) teach basic camera skills with an emphasis on basic portraiture technique so that students might later be able to earn income making refugees' portraits 2) encourage an artistic outlet and 3) encourage young refugees to depict, dignify, and reflect upon their lives as refugees, for local refugee audience as well as international audience. The training consisted of four days of three hour workshops for each group of five students, supplemented with several hours of optional photography field-trip classes around the camp. Following the camera technique workshops, students participated in an exhibition of their work in Kiziba Camp's Youth Hall attended by 100 friends, family members, AHA and UNHCR staff.

Prior to this Photography Workshop, eight of the students had never held a camera and many did not have a single childhood photograph of themselves. Thus, this workshop was full of firsts. First time touching a camera, first time taking a picture, first time making a portrait of their mother, brother, sister, cousin, friend, local shop owner. Implications of this basic camera training are that students thoroughly enjoyed the training, were challenged and inspired to be creative artistically, felt encouraged to develop a technical and artistic eye, and hoped to receive cameras to share from AHA for regular use.

In this exhibition we learn about food distribution--rations of maize, common beans, and cooking oil delivered in massive World Food Programme lorries and packaged in thick sacks or plastic jugs--and food, goat's meat, processed after a bloody slaughter, the meat man slashing the goat's flesh with a dull knife in a tiny unventilated mud room.

We appreciated a trinity of ripe avocados as abstract art, witness a bride and groom 'I do'. We observe students seated eagerly on long classroom benches the first day back at school, and wide-eyed babies swaddled to their sisters' small backs. We realize that places of hard work might also double as places of play: the cement laundry slab where children both wash clothes and pretend to be gymnasts toddling on thin, soapy balance beams. We are reminded that when we live in a mud home, we must frequently repair it with more mud, slabbing the wet earth to the home's side, an act of necessity and humility.

If these photographs say anything, they say we live in tiny homes with few possessions--a radio, mosquito net, knife, bowl, bed--and we take care of what we own. We make meager meals from wood that we chop, water that we carry, in round smoky huts with singed walls and sloping floors. In other words, we labor to live. This exhibit offers impossible contradictions--how can you smile with something so heavy on your head? To what do you look forward to when you cannot see where you have been? Case in point, you can be 19 and have spent the last 15 years living at a refugee camp, a recognized citizen of neither your native nor your host country. And you might one day have children who can claim the same. This exhibition might also smolder of despair. Despair for what these students, these Congolese refugees depicted in their photographs, inhabitants of a hill-side no man's land, may not also experience in the future, that they may remain in isolation on the camp, with little artistic or intellectual development. With even less true freedom to live in freedom, if by freedom we mean having the choice to live where we want to live, and live how we want to live. This exhibition may speak more about what isn't than about what is.




SUPER STARS















HEALTH CARE

Access to adequate healthcare is a basic necessity of displaced and vulnerable communities. The provision of curative services however needs to be complimented with prevention services to end vicious cycles of diseases and treatments and to obtain a lasting effect. AHA provides both preventive and curative healthcare services and endeavors to empower communities to understand and deal with health related problems. With emphasis on addressing the sources of illnesses. In 2011 AHA managed and assisted hospitals and health centers; conducted home visit campaigns; and held community education and sensitization activities in Burundi, Cameroon, Ethiopia, Liberia, Namibia, Rwanda, Somalia, Sudan and Uganda.

Burundi

Access to healthcare was made available for 28,000 Congolese refugees at Gasorwe, Musasa and Bwagiriza refugee camps and to residents of nearby communities through camp based health posts open 24 hours, seven days a week. Consultation services in adult, paediatric and reproductive health were provided while immunization activities, and nutritional screening of all children under the age of five and vulnerable groups were carried out regularly. Cases requiring specialized care were transferred to regional and national health facilities.

All residents benefited from full support in general health as well as prevention and care for HIV/AIDS, sexually transmitted infections, sexual and gender based violence, and mental and psychosocial disorders. In addition, successful surgical interventions for glaucoma patients from the Gasorwe Kinama, Musasa, and Bwagiriza camps were carried out in partnership with the Rotary Club.

Working in collaboration with other partners in the camps, sensitization activities on general health and good habits were intensified in order to increase refugees' awareness and to empower them mitigate communicable diseases through health education, information, and communication.

Support to healthcare centers was rendered through provision and restocking of selected essential drugs, taking into account the priorities and needs identified on the basis of the epidemiological profile of the target population.

On top of the physical and health strain displacement causes, mental disturbance is also a common occurrence among refugees and internally displaced persons as comprehending their situation becomes overwhelming for some. In light of this, AHA provided treatment and rehabilitation, prevention, care and social reintegration of people with mental disorders and psychosocial problems throughout the year.

Furthermore, efforts were continued to improve the nutritional status of concerned persons through a dietary supplement specific to individual cases and through enrichment of the variety of food used in nutritional supplementation services, in conformity to international and United Nations standards. Subsequently, severely malnourished refugees in the Gasorwe Therapeutic Feeding Centers were classified as 'moderate' and, for follow-up purposes, referred to in-camp supplementary feeding centers.

Overall, a gradual improvement was observed in the nutritional status of refugees, particularly at Bwagiriza Camp. The success of this program was noted by UNHCR's regional epidemiologist who made a recommendation for further strengthening of AHA's capacity for a wider impact.

AHA's systematic and regular monitoring system established at all levels has fostered the establishment of strategies for prevention and treatment of diseases such as diarrhea and anemia which exacerbate and cause malnutrition. With additional staff and increased attention given to this sector of activity, it was possible to focus on community health including prevention of malnutrition with the strengthening of communication, education and awareness activities provided at all levels.

Cameroon

During 2011, AHA provided primary healthcare services in a more coordinated and organized manner for optimal regional healthcare delivery. Along with improving the quality of health services for Central African Republic refugees and host communities, AHA's outreach program provided at home medical visits to refugees settled in remote areas and lack the means to travel to health facilities.

AHA supported three district hospitals, a higher medical centre, and eight health centres in three districts of the Kadey Department. To strengthen the weak public health service in the region, AHA's support ranged from technical to material support. In this context, AHA held capacity building trainings for national health staff, and availed essential drugs and basic medical and laboratory equipment supplies to health centres.

The outreach program utilized two mobile medical teams, each having a medical doctor, two registered nurses, two nutrition supervisors, a laboratory and a pharmacy technician, and a reproductive health and HIV/AIDS focal person to work in collaboration with staff from the Ministry of Public Health.

Regular programs to increase vaccination and malnutrition screening were carried out throughout the year, as a result, 2,910 children under the age of one received vaccinations and all who visited AHA supported health centres had access to anti-malarial treatment. In total, 38,435 persons received community health services and 3,874 persons received comprehensive reproductive health services. Health centres provided 22,002 curative consultations, and 4,825 persons were treated for malaria. In addition, educative sessions on common communicable diseases, reproductive health and HIV/AIDS were held for 76,469 people.



President Ellen Johnson Sirleaf inaugurates a newly constructed Emergency Room in Rivercess, Liberia

With intensive work and close collaboration with districts offices, UNHCR and other partners, essential drug supplies, drug management, and health information systems were successfully put in place, immunization coverage/cold chain systems improved, and capacity building programs implemented. Two health centres in Tocktoyo and Mboumama were constructed and four other health centres were rehabilitated equipping them with latrines and incinerators.

Ethiopia

In Ethiopia, AHA worked to eradicate practices that harm the health and overall wellbeing of communities through intense behavioral change and communication campaigns. To this end, over 20,000 informative materials were produced and distributed addressing issues such as gender and adolescent reproductive health. 20,705 home visits and 708 community dialogue sessions were among mediums used to reach people. Furthermore, over 243,028 people were sensitized on family planning, maternal and child health, post abortion care, sexually transmitted infections, environmental hygiene and malaria prevention and control.

Provision of family planning and reproductive health programs to vulnerable communities were among programs continued in 2011. In this regard, various female and male contraceptives were distributed through district health offices and facilities including 188,160 cycles of pills, 579,000 condoms, 360 IUCD, 1,390 sets of Jadelle, 760 sets of Implanon and 54,600 vials of injectables. 5,939 new beneficiaries were added to the family planning program and supported with their choice of contraceptives. Further, AHA's community health workers referred 30 mothers with fistula to hospitals where they were surgically repaired and supported through emotional and physical follow -up assistance.

Liberia

AHA provided healthcare services to a total of 206,559 clients, 33.2% of whom were children under the age of five, in 2011. Major diseases that affected children under five were Malaria (32,707 cases treated), Pneumonia (17,741 cases treated), and watery diarrhea (3,567 cases treated). AHA also emphasized the need to give birth in the presence of a professional health worker to prevent and properly manage birth complications to expecting mothers. To this end, a total of 2,841 babies were delivered at health facilities where as 463 at home births were supervised by AHA health staff.

Working in partnership with the Government of Liberia and local organizations, Liberia's Basic Package of Health and Social Welfare Services (BPHS) was implemented in Rivercess, Gbarpolu and Bomi counties.

In Rivercess, 345 local communities were supported in partnership with the Citizens Development Association of Rivercess County, a community-based organization. Additionally, 17 health facilities, including the St. Francis Government Hospital were assisted by AHA on behalf of the government of Liberia. 107,844 patients, 38% of whom were children under the age of five, visited the 17 healthcare centers during the year.

In Gbarpolu, the BPHS was implemented in 14 health facilities, including the Chief Jallah Lone Hospital, servicing 79,773 patients. 21,997 of the patients were children under 5 years of age. A motorbike ambulance service was utilized for emergency services in the county.

In Bomi, AHA implemented the BPHS in six health clinics while the Bomi County Health Team implemented the community components of BPHS in 77 communities. A total of 38,942 patients, including 12,248 children under five, were assisted in the county.

Rwanda

In Rwanda, priority was given to providing comprehensive primary healthcare services within the camp for refugees at the Kiziba Refugee Camp, and to minimize the number of referrals to different hospitals throughout the country.

In order to achieve the expected outputs and sustain standards of quality health care, AHA utilized competent and qualified health personnel, put in place an efficient and well organized system, had an ambulance ready and available 24 hours a day, and arranged for a dentist and a psychiatrist from the Kibuye hospital to operate at the camp one day a week.

In this manner, AHA delivered high standard preventive and curative health services to 18,962 refugees. 41,106 consultations were held at the camp based health center in 2011, of which 3.2% (1,334) were referred to higher health facilities. 1,022 of these referrals were to the Karongi District Hospital for surgical, ophthalmologic and psychiatric problems.

AHA's surgeon continued to manage most surgical and gynecologic cases for refugee and members of the host community at Karongi District Hospital while undertaking minor operations at the camp's health centre.

AHA's and supported medical staff, community health workers, peer educators, anti-AIDS clubs, and community and church leaders continued their efforts of sensitizations to promote good health and prevention of common diseases.

In 2011, planned parenthood was a focus and strengthened to increase the prevalence rate of contraceptive usage. Extensive work was done to sensitize pregnant mothers to receive antenatal care and delivery services.

Reproductive health services which include safe motherhood, pre and postnatal care, prevention and treatment of sexually transmitted infections and family planning were fully integrated into the comprehensive primary health care. In addition, in collaboration with the district health management, immunization, tuberculosis control, and malaria prevention and control programs were incorporated to the health service delivery program.

Somalia

Through a water and sanitation program, AHA worked to improve the lives of internally displaced Somalis around Mogadishu. The program targeted to facilitate and rehabilitate the water systems of 12 highly vulnerable communities and for Banadir Hospital, one of the major hospitals overwhelmed by the high influx of IDPs into Mogadishu. To this end, 20 water points were constructed in 12 IDP communities to service nearly 26,000 settlers; water sources for 24,235 IDPs were maintained and rehabilitated; a water tanker with daily capacity of 20,000 liters was rehabilitated for six communities; water purifiers were procured and distributed to 7,147 vulnerable households in nine communities; drinking water sources with daily capacity of 72,000 liters were chlorinated regularly for 32 IDP camps; 147 latrine blocks were constructed for 14,541 households of displaced persons and two schools with a population of 1,125; and hand wash facilities for 10 communities and a primary and a secondary school in the Hodan district were constructed.

To eliminate vector-borne diseases in the highly congested camps, 20 waste pits were built across IDP camps; and residents in 37 IDP camps (of whom 70% are women) received wheelbarrows, shovels, rakes, and hoes to maintain a safe living environment.

The project took several measures to facilitate the smooth running of Banadir Hospital and to meet some of its shortcomings. To this end, to improve the overall hygiene and sanitary status of the hospital, hand wash facilities were constructed and rehabilitated; daily laundry services facility for the surgical theater and wards with full capacity were rehabilitated; at the lack of a proper garbage disposal system, including human organs and contaminated instruments, an incinerator was rehabilitated to minimize health and hygiene risks at the hospital; a borehole was revitalized and linked to concrete water tanks, and a generator installed; the laboratory, consultation rooms and maternity ward received medical waste collection bins; and the project supported the hospital to improve its sanitation with proper disposal of medical waste by regularly providing paraffin for medical waste burning.

Sudan

Until the end of June 2011, AHA rendered primary healthcare services for 68,673 residents of the Mellit locality and for internally displaced persons at Abasi in Northern Darfur of the Sudan. This program has been funded and implemented by AHA after the multi-donor pooled Common Humanitarian Fund ended its financial support in 2009.

7,706 consultations; antenatal and post natal care; full and selective immunizations; family planning consultations and provision of contraceptives and pediatric care are among services provided from January to June 2011.

In February of 2011, AHA notified the State Ministry of Health that it can no longer run the health projects in Mellit and Abasi due to funding constraints. AHA handed over the program to the Ministry on June 30, 2011.

Uganda

22,000 Congolese refugees at the Nakivale Refugee Settlement were the population of concern for AHA in Uganda. Through the out-patient department, complete consultations including laboratory services were provided in 2011. Safe motherhood and maternity services including antenatal and postnatal care, and supervised deliveries; health education through static and outreach posts on disease prevention and mitigation; referral services of complicated cases to regional hospitals; Malaria prevention; nutrition programs and Anemia prevention were among programs undertaken in 2011.

Through the delivery of improved primary healthcare services, there has been a stable and improved general health status in the community.



AHA's Mother and Child Healthcare Programs incorporate nutrition and daily supplementary feeding for children while educating mothers on balanced nutrition for the entire family.



AHA encourages expecting mothers to receive pre and postnatal care, as well as to deliver their babies in the presence of a professional healthcare provider regardless of where they choose to give birth.



General health education is provided to all patients who visit AHA supported health facilities as they wait to see a physician.



AHA makes the necessary arrangements to enable parents of hospital admitted children to accompany their children and be consulted through all treatments.

HIV/AIDS

AHA's HIV/AIDS prevention, care and treatment program delivery follows and is complementary to national and global strategic plans. AHA's interventions include: mitigation of the socio-economic impact of HIV/AIDS, voluntary counseling and testing, prevention of mother to child transmission, condom distribution, and counseling services to members of affected families. In 2011 AHA implemented such activities in Burundi, Cameroon, Ethiopia, Liberia, Namibia, Rwanda, and Uganda.

Burundi

AHA continued to provide medical and community support to AIDS patients. Prophylactic drugs that fight opportunistic infections were made available, patients under anti retroviral therapy were closely administered, provided nutritional supplements and psychosocial support.

With psychiatric nurses, psychosocial agents and psychologists specifically assigned to HIV/AIDS activities, confidential access for refugees' to voluntary testing as well as counseling was facilitated.

Furthermore, assessments of already existing activities opened up possibilities with a better focus on the awareness, information, training, and education sessions that have greatly contributed to the behavioral change of the population as a whole. In this context, the target population was reached through committees, organizations and clubs actively engaged on the theme of HIV/AIDS and issues affecting the entire population. Sensitization activities were mostly held within the communities for maximum reach.

Cameroon

AHA worked to bring HIV/AIDS to the forefront of healthcare activities in eastern Cameroon. By working with traditional and community structures, in 2011, AHA provided prevention, care and treatment services to 50,000 persons that had minimal access to such services.

During the project period, over 900 pregnant women received mother-to-child transmission prevention services, 310 patients received STI treatment, and more than 8,000 persons received voluntary counselling.

Sensitization campaigns on HIV prevention were organized. AHA also utilized the local media for a wider reach of its message. Other activities included: 89,000 condoms were procured and distributed; HIV/AIDS related services such as TB/HIV, STI/HIV, PMTCT and VCT were made available; and community programs on stigma and discrimination organized. Preventive and positive behavioral change programs that target risk groups were also specially deigned for the communities and implemented.

Ethiopia

Relentless awareness creation campaign efforts by AHA in collaboration with the Administration for Refugees and Returnees Affairs, the UN High Commissioner for Refugees, and other stakeholders in Aysaita Refugee Camp and its surrounding area was a success in 2011. Following various sensitization activities, more and more people took part in voluntary counseling and testing, the number reaching 320 for the first time in the area.

Additional 103 refugees were referred to the Aysaita Health Centre for consultation and testing.

HIV/AIDS prevention activities included the distribution of 137,975 condoms through different outlets, including distribution boxes in and around the camp, and community centers, for refugees and host community members.

The active participation of refugees in the production and construction of compressed stabilized earth block houses in Adi Harush, non-formal education, and various events of HIV/AIDS is an indicative of the breakthrough AHA has achieved in the area and enhanced participation is to be expected in the future.

Liberia

With a target to reach 200,000 persons in Liberia, AHA worked to promote safer sexual behavior, eliminate misconceptions, reduce stigma and discrimination, and strengthen the provision of support for infected and affected populations in accordance with Liberia's national Basic Package of Health Services.

HIV services including HIV counseling and testing, antiretroviral therapy, and prevention of mother-to-child transmission were provided at St. Francis Government Hospital of Cestos City and at Chief Jallah Lone Hospital of Bopolu City.

In Gbarpolu County, HIV counseling and testing and prevention of mother-to-child transmission services were extended to all health clinics after the training of clinic staff. Logistics arrangements for the training was facilitated by UNICEF. Similar interventions were also extended to three health clinics in Rivercess County, and to two clinics in Bomi County.

A total of 110 positive clients were enrolled in three mother-to-child prevention programs in the three counties. Community health volunteers in the various catchment areas conducted extensive awareness campaigns, and condom distribution was regularly performed.

Namibia

In Namibia, HIV/AIDS awareness and sensitization activities were linked to gender equality programs. Services were provided for residents at the Osire Refugee Camp and communities around the camp.

World Refugee Day was commemorated under the theme "*Together for a Better World for All*" integrated to a 16 day campaign to end gender based violence in which 367 (193 of them female) attendees took part. Red ribbons were distributed and candles lit to remember HIV/AIDS affected and infected individuals and families. To help people living with HIV sustain their livelihood, 18 vulnerable refugees living with HIV were trained on mushroom production. A refresher training was organized for 10 days to strengthen their skills in mushroom production along with the provision of 200 mushroom seeds, land rented by AHA, and a greenhouse was constructed at Kacyiru valley for the production. Additionally, 12 vulnerable refugees and HIV positive persons were trained in agriculture and received land to rent for 2 years, a small warehouse and seeds.

AHA facilitated treatment services by local health centers. Among 37 refugees registered as HIV positive, 29 were under antiretroviral treatment, received supplementary and fresh foods and basic hygienic materials.

Rwanda

HIV/AIDS activities focused on prevention, voluntary counseling and testing, and care and support for people living with HIV/AIDS. To this end, 76 sensitization campaigns and informative sessions on general HIV/AIDS information, family planning, voluntary testing, and tuberculosis were conducted. Of the 2,183 urban refugees that participated in the sessions, 1,343 were female. An assessment on circumcision was conducted among urban refugees and 95 refugees were registered to undergo the procedure. Among those registered, 72 were circumcised in the month of June at the Kibagabaga hospital.

Over the course of the year, 3,132 condoms were distributed to refugees from hospital consultation rooms, pharmacies, during sensitization sessions, and through selected community facilities. 837 beneficiaries were voluntarily counseled and 453 were tested and appropriate follow-ups and referrals to the local health centers were undertaken. In addition, expecting mothers took part in the prevention of mother-to-child transmission of HIV/AIDS.

Uganda

Comprehensive HIV/AIDS support was provided to refugees in Rwanda incorporating prevention of mother-to-child transmission, provision of antiretroviral treatments, and voluntary counseling and testing services. In addition, general health education sessions for communities on HIV/AIDS were conducted. Education and information on precaution in infection control was also provided for health workers.

During the year, 1,399 refugees accessed the voluntary counseling and testing services; 947 participated in prevention of mother-to-child transmission, 2,480 took part in prevention sensitization events, and 178, 549 condoms were distributed.

SEXUAL AND GENDER BASED VIOLENCE

As abduction and rape continue to be used as weapon of war across the continent, AHA takes great measures to ensure the safety and security of displaced girls and women. In addition, AHA works to eliminate other forms of abuse faced by females such as female genital mutilation and lack of educational opportunities. Working with existing community structures, AHA advocates for the rights of women, empowers women through income generating activities and non-formal education. In 2011, women remained an important factor of all AHA programs and services for their benefit were provided in Ethiopia, Liberia, Namibia, and Rwanda.

Ethiopia

Prevention of gender based violence was incorporated in AHA activities of healthcare, HIV/ AIDS and capacity development for vulnerable communities in the Southern Nations and Nationalities Peoples Regional State of southern Ethiopia, and for refugees in Aysaita. Periodic sensitizations were held on understanding the different forms of sexual and gender based violence, highlighting traditional practices such as early marriage and female genital mutilation that harm girls and women. In addition, parents were encouraged to send their daughters to school. Youth focused activities were also carried out during the year with emphasis on respecting the choices of girls, preventing teenage pregnancy, and staying in school.

Liberia

As result of the civil war in Liberia, sexual crimes increased as sexual violations became weapon of war. In 2011, AHA's Sexual and Gender- based Violence (SGBV) services helped create awareness of SGBV violence and increase the reporting of incidents. Information on punishment for perpetrators and the government's effort to curtail sexual and gender based violence by prescribing severe penalties for rape cases was widely made available to discourage further attacks on women and to empower women to come forward.

During the year, staff from health facilities were trained and refresher trainings provided on proper management of sexual and gender based violence cases. Their trainings included understanding the physical as well as psychosocial impact on victims. Health facilities in Rivercess, Gbarpolu and Bomi Counties managed sexual and gender based violence cases with appropriate medical treatment followed by psychological support. Community Health Volunteers and trained Traditional Midwives also took part in awareness raising and sensitization activities.

Namibia

AHA Namibia remained vigilant of sexual and gender based violence at the Osire Refugee Camp in 2011. Sensitizations to make all residents aware of the types of gender based abuse and how to avoid them was provided to students, teachers, community members and humanitarian workers in the camp. Four hundred and twenty four people were trained on understanding the concept of SGBV, gender stereotyping and human rights, sexual and reproductive health and the promotion of gender equality, defining sexual exploitation, sexual misconduct and sexual abuse of students, sexual harassment and the starting point, forms of sexual harassment of educators, indicators of sexual misconduct of educators, avoiding allegations of sexual misconduct, consequence of sexual abuse on students and learners were also covered.

Further, AHA managed and participated in the reporting and management of various abuses in the camp including child and emotional abuses, sexual exploitations, sexual harassment, attempted and possible rape, domestic violence and extra marital relationships, and economic abuse.

Under the global theme "Equal Access to Education, Training, Science and Technology: Pathway to Descent Work for Women", International Women's Day was observed by 257 participants at Osire camp. The event acknowledged women's contribution to international peace and security, and called for the active participation and equality of women in all camp activities.

Rwanda

AHA concluded its UBS Optimus Foundation supported three year sexual and gender based violence program in 2011. In preparation to handing over the project to the Government of Rwanda, several trainings for national staff including nurses from the district hospital and health centers, and teachers who will resume the work were held. The trainings included trauma counseling and management of sexual and gender based violence.

Staff were trained to implement AHA's Through-Our-Eyes approach that has become successful in the Nyabiheke and Gihembe refugee camps. With this approach, problems that have occurred in the community are acted out as films and shown to the community, which in turn helps in the behavioral change. Seven participants were trained on video production and how to carry out play back sessions.

Nine host community persons and five refugees received refresher trainings to ensure that trained people would, in turn, train others in their respective communities. The training included topics such as the types, causes and consequences of gender based violence, as well as, information on the country's policies, the rights of victims, and on the process to set up anti-gender based violence and child's rights committees.

Other training focused on raising awareness of female camp representatives, case management for the AHA counselor at the Kacyiru Police Hospital, collaboration of 45 religious leaders, information on conflict management, and sensitization of Kiziba camp leaders.

Emphasis on male participation in trainings were made as men often do not receive information on violence against women and the rights of women. To this end, male members of the camp took part in trainings aimed to raise awareness on GBV and human rights issues at Kiziba Camp. Participants made commitments for behavioral change and to disseminate lessons learned to their peers.



AHA makes a special effort to empower women through employment opportunities



CAPACITY DEVELOPMENT

AHA believes that communities are able to lift themselves out of poverty given the relevant all round support. In light of this, AHA conducts several capacity development activities for displaced persons, vulnerable communities and for national health and development staff. Formal and non-formal education, management of community resources and new development and health care skills are among services provided. In 2011, trainings and self improvement schemes continued to be provided in Ethiopia, Liberia, Namibia, Sudan, Somalia and Uganda.

Ethiopia

Capacity development activities focused on enhancing regional infrastructures to address health care; empowering beneficiary communities' abilities to generate income and to mitigate diseases. In these regard, health care professionals received trainings on Long–Acting Family Planning service provision (for 47 health workers); clinical skill training on Implanon insertion (47 health workers); gender mainstreaming training in the health sector (30 health workers); family planning and HIV integration training (28 health workers); and basic youth friendly service training was provided to 23 health service providers.

To enhance capacities of the general community on family planning and reproductive health issues, sensitization events were held through six town administrations and seven market places in 48 *Kebeles* reaching a total of 47,105 persons.

Youth groups and high school students were also a focus in this program. 212 coffee ceremonies to discuss adolescent issues such as teenage pregnancy and staying in school were organized for high school students in which 9,249 participated. In addition, 26 anti-AIDS clubs were supported with equipment for their outreach and sensitization programs, and 30 students were trained on peer counseling and communication skills.

Additional 60 youth from Kucha Woreda and Sawla town were provided with basic peer educators and counselors' training, and a refresher training was held for 66 youth.

Liberia

Capacity building in 2011 focused on enhancing management of the decentralized health system by county health teams. In this direction, training sessions were conducted for Rivercess, Gbarpolu and Bomi Counties' Health Teams in Health System Management, Supportive Supervision, and Health Management Information System.

County Health Teams were provided with financial and technical support to hold coordination meetings, Health Board meetings, and conduct county planning sessions.

Facility-based health workers were trained in Integrated Management of Childhood Illnesses (IMNCI), Basic Life Saving Skills, SGBV, HIV/AIDS Case Management, and Family Planning Service Provision.

Additionally, General Community Health Volunteers were trained in Community Case Management of simple Malaria, Diarrhea, and Pneumonia, three communities were able to gain hands on experience in construction by engaging in the construction of new clinics in Gozohn and Dorbor of Rivercess County, and in Gbangay of Gbarpolu County.

Namibia

In 2011, refugees at the Osire Refugee Camp were encouraged to grow their own foods in order to minimize their dependency of food subsidies and to increase their household income. To this end, 100kg of sorghum, crop and mushroom seeds were distributed to persons of concern involved in crop production. Technical trainings on crop production in a climate such as Osire, and on the Namibian soil, and pest control were provided to seed recipients and persons with gardens.

In addition, local markets were identified and arrangements made for the refugees to sell their vegetables to the host community. Refugees took advantage of the in-camp green house and planted summer crops such as tomatoes that were in high demand by both the refugee and host community in winter.

Other capacity enhancing activities included, behavioral change events organized in collaboration with the Osire Youth Group; athletic workshops for the youth who compete in national sporting events; material support for youth clubs and sports groups; and management and bookkeeping trainings for refugees in business.

Through Agro Forestry projects, green areas of the camp were expanded and rehabilitated throughout the year.

Somalia

Through AHA's on the ground partner, HIJRA Somalia, AHA supported various trainings of community members. Complementing AHA's Water and Sanitation program in Mogadishu, water, environment and sanitation committee members from 37 internally displaced person's camps were trained on preserving camp sanitation and good hygiene practices and eighteen water point attendants from 37 camps were trained on servicing water outlets and on maintaining a clean environment. In preparation for the health and nutrition phase of the project, mothers were trained to lead and participate in the mother-to–mother support groups.

Education programs on sanitation, proper use of latrines, and drinking chlorinated water were periodically provided to displaced persons. Communities were also provided with cleaning materials and regularly sensitized to clean their communities. Most communities have adopted the practice of good hygiene and regular cleaning.

Further, representatives of internally displaced persons' communities as well as the displaced persons' community at large were constantly consulted on projects, initiatives and implementation to enhance their involvement in programs geared to benefit them. Towards this end, community expectations were recorded and complaints registered to work towards addressing raised issues. Based on these consultations, some projects were altered to meet demand. Extra efforts were made to include as many women as possible in all dialogues.

Sudan

In an effort to improve food security in Daralsalam, Kalimando and Korma localities of Darfur, 38 MTs of cereal, ground nut, sesame and watermelon seeds were distributed to 8,333 vulnerable households in 2011. Households, both headed by female and male, were selected in collaboration with community farmers' groups.

In addition, farmers were trained on good farming techniques to maximize their productivity. The implementation of the provided trainings was monitored through follow up assessments conducted during and after the implementation of the program.

Uganda

Local capacity building has been a cross cutting intervention in Uganda whereby AHA projects had a component of upgrading the knowledge and skills of community based health workers through basic and refresher training sessions.

Support to district health departments through effective coordination, participation in AHA organized workshops, and collaboration was an integral part of delivery of services.

Among trainings provided in 2011 are: Basic Emergency obstetric and Neonatal Care; infection control/ universal precautions; training for vaccinators and cold chain attendants; and training for community health workers on community based outreach services.

These capacity building programs supported the effective delivery of services at all levels.



RELIEF AND RECOVERY

Early warning systems and preparedness are vital tools for prevention in times of disasters. Through its partnership with the African Union, its subsidiary organs, and regional institutions, AHA is constantly updated on regions of concerns to enable it to deliver timely services, coordinating its efforts with national and international partners. AHA is also working to put in place appropriately equipped rapid response teams for immediate deployment in the five working regions of Africa. In 2011, AHA's relief and recovery programs included provision of shelter, water and sanitation facilities, food and non-food items and transportation for displaced persons in Burundi, Ethiopia, Namibia, Rwanda, Sudan and Uganda.

Burundi

Working closely with the United Nations High Commissioner for Refugees, AHA's activities in Burundi ranges from provision of healthcare and transportation to refugees to receiving, accompanying, and arranging the resettlement of returnees. In 2011, 28,000 refugees and asylum seekers including 9,000 in urban settings were provided with support in Burundi.

The 2011 project planned and all efforts focused to organize the repatriation of 35,000 refugees from camps in: 23,000 from Tanzania; 10,000 from the DR Congo; 2,000 from Zambia and from within Burundi. However, only 155 persons were willing to return to their homes. AHA maintained all provisions in place in preparation for a mass-movement across the borders.

Ethiopia

Since 2009, AHA has been providing shelter, water and sanitation facilities, non-formal education, and HIV/AIDS programs to Eritrean Afar and Somali refugees in the north and south eastern part of the country. In 2011, these efforts were continued at a larger scale as the influx of refugees into Ethiopia increased throughout the year.

Accordingly, 12,489 dome shaped shelters were erected in the Dolo camps of Bokolmayo, Melkadida and Kobe refugee settlements. AHA also designed and introduced improvements to the dome shaped shelters by using concrete hollow blocks and corrugated iron-sheet roofs to reduce the high temperature in the shelters.

Improvement of water structures in refugee camps were carried out during the year. In Aysaita, the Hitherto water supply was improved to and supply increased to 10 lt per second to meet the United Nations Commissioner for Refugees' minimum standard of 20 liters per day per person.

In the Berhale camp, a borehole constructed in 2008 by AHA was revitalized with a new hydro-electric power to increase water supply for refugees and host communities.

Namibia

AHA's responsibilities in Namibia are ensuring the smooth running of services in logistics; water, sanitation, and hygiene; shelter and community development; social services; agro forestry; youth and sport; and income generating activities.

Supply of food rations was unreliable throughout the year, with reduction of portions by half in some months.

The supply and quality of water for refugees was constantly monitored and insured. Water samples were periodically tested; an average of 7,138,175 liters of water was supplied each month; and a water tank with 1000L capacity was installed in the camp to reduce the distance traveled to collect water. In addition, water points were regularly maintained and there were no complaints recorded on water provision to public area schools and the health center.

To maintain sanitation of the camp, 257 latrines were constructed and renovated; 110 domed slabs and soak pits at water taps were maintained; 304 pit latrine cleaning products distributed; and five pit latrines for people with specific needs were constructed.

The shelter aspect of AHA's program focused on maintenance of existing shelters and support for new arrivals. Towards this end, of the registered 317 new arrivals, 148 were rendered accommodation at the new arrival centre while the rest joined family members in the settlement immediately upon arrival. Two tents were pitched when the influx of new arrivals to the camp was high and construction of houses was delayed due to rain. During the reporting period, 29 houses were constructed with mud bricks for new arrivals; molded 4,402 cement bricks and 18 houses were constructed with cement bricks foundation; 53 houses were renovated by the shelter team for women with specific needs; three houses were retrieved from families who left the camp for repatriation and resettlement; 23 doors and 29

windows were made and fixed; and 13,232 bricks were molded for new arrivals.

In addition, non food items such as stoves, mattresses, pots, cutleries and other essential household items were provided to existing and newly arriving residents.

Sudan

In 2011, services were provided to nearly 600,000 internally displaced Sudanese in Northern Darfur with general food distribution, blanket supplementary feeding, and milling and food voucher programs to meet the basic food needs of severely affected persons. Displaced persons in rural El Fasher, Daralsalam, Shangel Tubaya, Shedad, Korma, Umkedada, Kalimando and Kuma were supported through the said programs. In addition to the planned distributions, emergency food aid was conducted in localities that encountered low harvest during the year to prevent further displacement of people in the region.

A total of 11,931.5 MTs of food was distributed utilizing AHA organized Food Aid Management Committee, tribal leaders and existing village council committee, who also took part in the supervision of proper distribution. Four distribution posts were randomly selected and monitored for efficiency in Daralsalam Rural, Shangel Tubaya, Shedad and Korma localities.

The blanket supplementary feeding program for 67,289 vulnerable households was provided to reduce the number of morbidity and mortality rate among children under the age of five in North Darfur. To this end, 56,333 households with children under five were provided with premix and vegetable oil from May to October 2011. In addition, cooking demonstration and sensitization trainings for 112 women in Kafot, Kuma, and Umkedada were performed. Refresher trainings for trainers in Shangel Tobaya and Shedad camps were also provided.

With an objective to save lives and to reduce chronic hunger and malnutrition, AHA conducted a milling voucher program for 53,779 internally displaced persons in the Shangel Tubaya and Shedad camps. In addition, to increase the variety of food for displaced persons, AHA provided food vouchers worth 22 SDG each to purchase locally available and preferred food items. 35,523 vouchers were used from June to September 2011.

These programs were instrumental in reducing household expenditures on foods, preventing further degradation of the nutritional status among vulnerable populations, and in reducing the number of food aid rations distributed in the kilo-caloric value.

Rwanda

In Rwanda, AHA was responsible for food, non-food items (soap, mosquito nets, saucepans, and plastic sheeting) and firewood distribution in the Kiziba, Gihembe and Nyabiheke camps. These items were distributed with minor hiccups in 2011. A refugee committee selected by the refugee population participated in the distribution. The food ration regularly given to refugees contained maize grains, beans, cooking oil and salt. The standard measurement set by the World Food Program (WFP) was respected during the distribution and a system was developed for firewood distribution in each camp.

The provision of these services were, at times, interrupted for reasons ranging from delay in delivery of items to replacement of food items due to low quality.

During the course of the reporting year, components of the general ration (except CSB) were distributed to all refugees except on the occasions when bad quality maize was received and later replaced by the WFP. In September, the maize and beans rations at the Gihembe and Kiziba camps were halved but the quantity was later rectified in October. Refugees in the Nyabiheke only received a quantity of 13,175 CSB in the month of May.

Soap and sanitary pads were distributed to refugee adolescent schoolgirls in the camps. Except for the months of August and September, soap was distributed to all adolescent refugees in the Kiziba camp. There were delays in the Gihembe soap and sanitary pad distribution in the months of September and October. Apart from the August and September quotas, the quotas of soap for the Nyabiheke camp have been distributed. Sanitary pads were not distributed to the adolescent refugees of the Nyabiheke camp in the reporting period.

There was a delay in the distribution of firewood to refugees in the Kiziba camp. However, at the end of the reporting period, all refugees received their quota of firewood. Firewood was distributed at the Gihembe camp for the months of January to August but there were no distributions for the months of September to December. This gap was due to the delay in firewood supply by the contractor. The firewood supply in the Nyabiheke camp, which was initially expected in February, began in April as a result of change of supplier.

Uganda

AHA Uganda held several trainings relevant to its services in health care in 2011. AHA and national health staff benefited from trainings addressing basic emergency obstetric and neonatal care; infection control and universal precautions; continued medical education; vaccination and cold chain management; and community based outreach services.

ADVOCACY

Humanitarian advocacy is at the heart of AHA's work, focusing not only the immediate needs of the communities we serve, but also the root causes of displacement and strengthened partnerships amongst global humanitarian actors. By advocating at the local, continental and global levels, AHA seeks to multiply the scope of its impact beyond program implementation to influence humanitarian policies that affect the lives of vulnerable communities we serve and the disparities within the system that supports them. Essentially, we aim to promote a more inclusive, transparent, and accountable decision-making process from the field level up to executive boards.

The AHA Head Office performs its policy and advocacy work through its various outreach engagements and in coordination with its country offices, thereby promoting coherent and mutually supportive messages across the board. In 2011, we continued to work with host and donor governments, United Nations agencies, the African Union and other like-minded organizations from across the globe to actively promote positive change and share experiences. The messages we carry remain extensively anchored in the realities of our field work and, thus, resonate in policy debates.

At the local and national level, we continued to work with the relevant government agencies in charge of displacement issues as well as the country representation of our partner organizations and seek strategic collaborations to serve affected communities. At the regional level, AHA carried the views of African humanitarian civil society actors in various engagements with the African Union, the Intergovernmental Authority on Development (IGAD), the African Development Bank and other continental bodies.

Globally, AHA continues to serve on the Executive Committee of the global policy and advocacy network of humanitarian NGOs, the International Council of Voluntary Agencies (ICVA). We especially utilized the opportunities presented through our engagement in ICVA during the Horn of Africa drought in the summer of 2011 by actively taking part in high-level coordination meetings of the U.N.'s Inter-Agency Standing Committee (IASC).

We actively promote South-South cooperation in our advocacy messages. To this end, we attended humanitarian policy dialogues and shared our field experiences with our sister NGOs in Africa and Asia. Specifically, AHA and the Refugee Consortium of Kenya (RCK) collaborated to convene a meeting of ICVA Members in the Eastern Africa region to contribute in the development of the network's Strategic Plan for 2012-2014.

Expanding our advocacy network to Asia, we shared our experiences of community mobilization at the annual International Humanitarian Conference hosted by Mercy Malaysia. In addition, AHA's Head of Programmes undertook a mission to the Philippines to visit the operations of another partner NGO, Community and Family Services International (CFSI), where he exchanged experiences with CFSI's field personnel in conflict-affected provinces of Mindanao.

With AHA's re-election on the governing board of ICVA, and our new election on the board of the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP), we look forward to continuing our engagement in humanitarian policy and accountability dialogues. We maintain our Special Consultative Status with the United Nations Economic and Social Council (ECOSOC) in New York and continue to partner with the African Union.

INTERNATIONAL PRESENCE

AHA is a registered Charity in Switzerland;

AHA is a registered Public Charity in the US and a tax exempt non-profit organization under the US Internal Revenue Code 501 (c)(3);

AHA is a working partner of the African Union (AU) and the African Development Bank (AfDB);

AHA is an NGO with Special Consultative Status with the UN Economic and Social Council (ECOSOC);

AHA is on the Executive Boards of the Geneva based International Council of Voluntary Organizations (ICVA) and the London based Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP).

HOW TO SUPPORT AHA….

Support to a particular project or contributions to AHA's Program Pool-fund can be made online through a secure payment system on our website: www.africahumanitaria.org or through the following bank accounts:

Dashen Bank Bole Area, Addis Abeba, Ethiopia

Account No. 0012008248001

SWIFT Code: Dashetaa

UBS Geneva, Switzerland

Account No. 279/D71055620

IBAN: CH57 0027 9279 D710 5562 0

SWIFT Code: UBSWCHZH12A

Bank of America

Account No. 446009494857

Routing Number: 052001633

SWIFT Code: BOFAUS3N

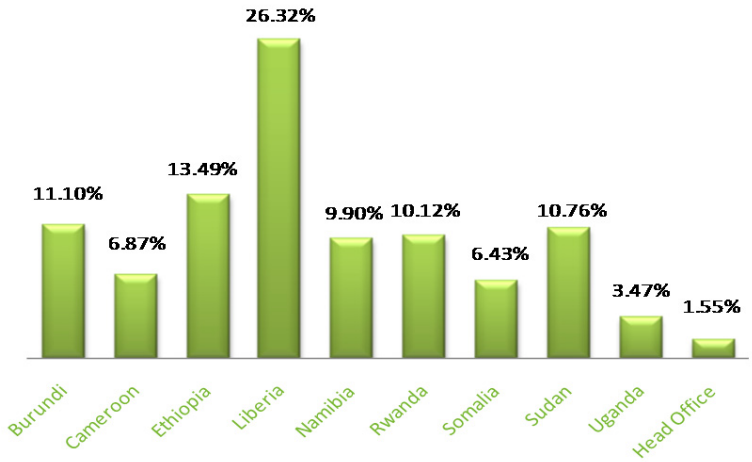
FINANCES

2011 Income and Expenditure in USD

	Income	Expenditure
Burundi	1,129,992	1,129,980
Cameroon	699,207	691,033
Ethiopia	1,373,640	1,331,640
Liberia	2,680,808	2,680,808
Namibia	1,007,869	1,014,705
Rwanda	1,030,558	1,030,457
***Somalia**	655,000	304,683
Sudan	1,095,772	1,095,772
Uganda	353,451	353,184
Head Office	158,194	156,046
Total	**10,184,491**	**9,788,308**

*Somalia income indicates funds for the entirety of the program from July 2011 to March 2012. Expenditure figure shown here is for the year 2011.

2011 Income Percentage by Country



1995 – 2011 Budget in USD

Angola	8,240,277
Burundi	8,175,568
Cameroon	1,600,728
Chad	1,014,845
DR Congo	7,106,045
Ethiopia	5,928,425
Guinea	215,467
Liberia	10,788,727
Namibia	9,873,679
Rwanda	13,083,841
Somalia	655,000
Sudan	7,476,923
Uganda	8,793,238
West Africa	233,118
Zambia	6,490,207
Head Office	3,725,719
Total	**93,401,806**

Note:

1995 – 2011 audited figures

2004 2004 Head Office figures include 150,000 from the International Symposium on "Building the Capacity and Resources of African NGOs"

2007 Sudan figure include 204,960 from GI-Net

2011 Auditors

Auditeurs Cabinet CECOS (*AHA Burundi*)

MOHY & Co. Le Counseil au service des organizations (*AHA Cameroon*)

Getachew Kassaye & Co. Chartered Certified Accountants (*AHA Ethiopia*)

A.A Bromhead & Co. Chartered Accountants and UK registered Auditors (*AHA Head Office*)

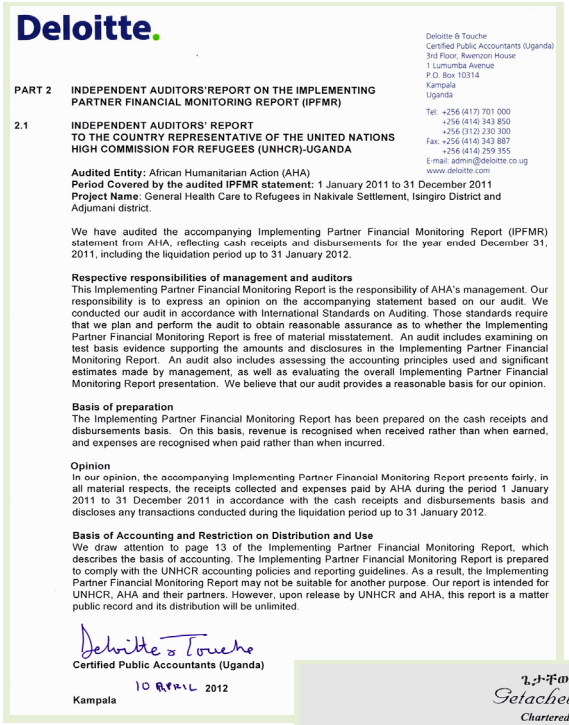
PKF Accountants & Business Advisors (*AHA Liberia*)

STIER VENTE ASSOCIATES Chartered Accountants (*AHA Namibia*)

Price Waterhouse Coopers (*AHA Rwanda*)

H.A.S.M Certified Accountant & Financial Consultant (*AHA Sudan*)

Deloitte & Touche Certified Public Accountants (*AHA Uganda*)



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PART 2 INDEPENDENT AUDITORS'REPORT ON THE IMPLEMENTING PARTNER FINANCIAL MONITORING REPORT (IPFMR)

2.1 INDEPENDENT AUDITORS' REPORT
TO THE COUNTRY REPRESENTATIVE OF THE UNITED NATIONS HIGH COMMISSION FOR REFUGEES (UNHCR)-UGANDA

Audited Entity: African Humanitarian Action (AHA)
Period Covered by the audited IPFMR statement: 1 January 2011 to 31 December 2011
Project Name: General Health Care to Refugees in Nakivale Settlement, Isingiro District and Adjumani district.

We have audited the accompanying Implementing Partner Financial Monitoring Report (IPFMR) statement from AHA, reflecting cash receipts and disbursements for the year ended December 31, 2011, including the liquidation period up to 31 January 2012.

Respective responsibilities of management and auditors
This Implementing Partner Financial Monitoring Report is the responsibility of AHA's management. Our responsibility is to express an opinion on the accompanying statement based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we plan and perform the audit to obtain reasonable assurance as to whether the Implementing Partner Financial Monitoring Report is free of material misstatement. An audit includes examining on test basis evidence supporting the amounts and disclosures in the Implementing Partner Financial Monitoring Report. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall Implementing Partner Financial Monitoring Report presentation. We believe that our audit provides a reasonable basis for our opinion.

Basis of preparation
The Implementing Partner Financial Monitoring Report has been prepared on the cash receipts and disbursements basis. On this basis, revenue is recognised when received rather than when earned, and expenses are recognised when paid rather than when incurred.

Opinion
In our opinion, the accompanying Implementing Partner Financial Monitoring Report presents fairly, in all material respects, the receipts collected and expenses paid by AHA during the period 1 January 2011 to 31 December 2011 in accordance with the cash receipts and disbursements basis and discloses any transactions conducted during the liquidation period up to 31 January 2012.

Basis of Accounting and Restriction on Distribution and Use
We draw attention to page 13 of the Implementing Partner Financial Monitoring Report, which describes the basis of accounting. The Implementing Partner Financial Monitoring Report is prepared to comply with the UNHCR accounting policies and reporting guidelines. As a result, the Implementing Partner Financial Monitoring Report may not be suitable for another purpose. Our report is intended for UNHCR, AHA and their partners. However, upon release by UNHCR and AHA, this report is a matter public record and its distribution will be unlimited.

Deloitte & Touche
Certified Public Accountants (Uganda)
10 APRIL 2012
Kampala



STIER VENTE ASSOCIATES
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AUDIT REPORT TO THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES ON THE FINAL SUB-PROJECT MONITORING REPORT IMPLEMENTED BY THE AFRICA HUMANITARIAN ACTION NAMIBIA FOR THE OPERATIONAL YEAR ENDED 31 DECEMBER 2011

We have audited the final Sub-Project Monitoring Reports for Sub-Project Africa Humanitarian Action Namibia dated 31 December 2011, which has been prepared under the historical cost convention and in accordance with the accounting requirements set out in the Sub-Project Agreement. The Sub-Project is primarily responsible for humanitarian assistance to distressed communities in Africa, the pursuit of development in peace in the continent and to provide financial and technical assistance to the Namibia refugee camps.

Respective responsibilities of the Country Representative and the Auditors

As stated in the Sub-Project Agreement, the Country Representative is responsible for the maintenance of proper financial and project records and the preparation of the Sub-Project Monitoring Reports. It is our obligation to form an independent opinion, based on our audit, on those statements and reports the opinion to you.

Basis of opinion

We conducted our audit in accordance with International Auditing Standards. An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. An audit includes an assessment of whether the accounting policies used are appropriate, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we consider necessary in order to provide us with sufficient evidence to give reasonable assurance that the Sub-Project Monitoring Reports are free from material misstatements, whether caused by fraud or other irregularity or error. In forming our opinion, we have also evaluated the overall adequacy of the presentation of information in the final Sub-Project Monitoring Report.

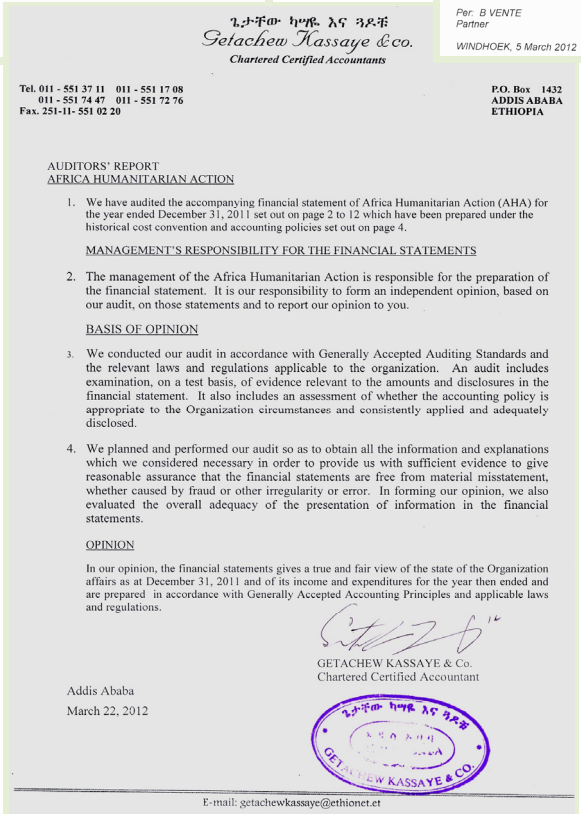
Audit opinion

In our opinion the Sub-Project Monitoring Reports dated 31 December 2011, showing donations received totaling N$ 6 776 593 fairly presents the state of affairs of the Sub-Project for the year under review.

Stier Vente Associates
STIER VENTE ASSOCIATES
REGISTERED ACCOUNTANTS AND AUDITORS
CHARTERED ACCOUNTANTS (NAMIBIA)

Per: B VENTE
Partner

WINDHOEK, 5 March 2012



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AUDITORS' REPORT
AFRICA HUMANITARIAN ACTION

1. We have audited the accompanying financial statement of Africa Humanitarian Action (AHA) for the year ended December 31, 2011 set out on page 2 to 12 which have been prepared under the historical cost convention and accounting policies set out on page 4.

MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS

2. The management of the Africa Humanitarian Action is responsible for the preparation of the financial statement. 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

3. We conducted our audit in accordance with Generally Accepted Auditing Standards and the relevant laws and regulations applicable to the organization. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statement. It also includes an assessment of whether the accounting policy is appropriate to the Organization circumstances and consistently applied and adequately disclosed.

4. 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 that 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.

OPINION

In our opinion, the financial statements gives a true and fair view of the state of the Organization affairs as at December 31, 2011 and of its income and expenditures for the year then ended and are prepared in accordance with Generally Accepted Accounting Principles and applicable laws and regulations.

GETACHEW KASSAYE & Co.
Chartered Certified Accountant

Addis Ababa
March 22, 2012

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GETACHEW KASSAYE & CO.

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Partners and Supporters

Active Learning Network for Accountability and Performance (ALNAP)
African Centre for Humanitarian Action (ACHA)
African Concern
African Development Bank Group
African Development and Emergency Organisation
African Refugees Foundation (AREF)
Afrique Secours et Assistance
African Union Commission
Alliance for Direct Action Against Rape in Conflicts and Crises, Switzerland
American Joint Distribution Committee, USA
Danish Red Cross Society
Danish Refugee Council
Gesellschaft für Internationale Zusammenarbeit (GIZ)
Environment and Development Society of Ethiopia
European Commission Humanitarian Office (ECHO)
Family Health International
Genocide Intervention Network
Government of Burundi
Government of Cameroon
Government of DR Congo
Government of Ethiopia
Government of Liberia
Government of Kenya
Government of Namibia
Government of Rwanda
Government of Sudan
Government of Switzerland
Government of Uganda
Government of the United States of America
Government of Zambia
Great Lakes Initiative for AIDS
Herrod Foundation
HSBC Bank PLC
International Council of Voluntary Agencies (ICVA)
International Medical Corps (IMC)
International Office for Migration (IOM)
International Planned Parenthood Federation (IPPF)
Japan International Cooperation Agency (JICA)
Lawyers for Human Rights
Namibian Red Cross Society
Norwegian Refugee Council
Office Africain pour le Developpment et al Cooperation (OFADEC)
Oxfam, United Kingdom
Pathfinder International
Program National Multisectoriel de Lutte Contre le Sida
Sudan Health Association
Swedish International Development Agency (SIDA)
Swedish Refugee Aid (SWERA)
UBS Optimus Foundation
UK Department for International Development (DfID)
UN Children's Fund (UNICEF)
UN Women
UN Economic Commission for Africa (UNECA)
UN Food and Agricultural Organisation (FAO)
UN High Commissioner for Refugees (UNHCR)
UN Office for the Coordination of Humanitarian Affairs (UNOCHA)
UN Population Fund (UNFPA)
UN World Food Programme (WFP)
UN World Health Organisation (WHO)
United Support of Artists for Africa (USAforAfrica)
U.S. Agency for International Development (USAID)
The World Bank

AHA works with many individuals, organizations, institutions and governments at local, national, regional and international level. Whilst it is difficult to mention everyone in this succinct report, AHA offers its sincere gratitude to all who have supported its efforts to assist affected populations; not least the communities with whom AHA works, whose strength and dignity remain our inspiration.

A Big Thank You

To our **staff** who execute AHA's mission in harsh and challenging environments across Africa,
To our **donors** who believe in AHA's vision and integrity,
To our **partners** who continue to collaborate with us for a better Africa,
To our 2011 **Volunteers**,



From Left: Betselot Teklu (*Stanford University, USA*), Adam Terefe (*Addis Ababa University, Ethiopia*), Abebe Kebede (*University of Virginia, USA*), Yonathan Eyob (*Syracuse University, USA*), Nejat Abdella (*Trent University, Canada*)

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Africa Humanitarian Action