Africa Humanitarian Action

Annual Report 2012



African in

Spirit | Concept | Composition

Content

Message from the President	03
Understanding AHA	04
Programs	06
2012 in Brief	08
Healthcare	10
HIV/AIDS	12
Sexual and Gender Based Violence	14
Capacity Development	16
Relief and Recovery	18
Finances	20
Partners and Supporters	22

Front-cover photo: *Nutrition screening of a child underway by AHA medical team in Burundi.*
Back-cover photo: *Women in Mogadishu receive 20kgs of rice from AHA's food distribution center.*

Message from the President

A Re-Commitment to Effective and Principled Partnerships

As in the past years, AHA had focused on building more sustainable and effective humanitarian partnerships in 2012. We had done so with various stakeholders at the local, continental and global levels.

Locally, AHA's country programmes have sought to engage more strategically with the populations we serve in order to build resilient communities capable of anticipating and responding to crises. In 2012, in partnership with our supporters such as the United Nations High Commissioner for Refugees (UNHCR), World Food Programme (WFP), a consortium of donors in Liberia, and the African Development Bank Group (AfDB) in Somalia, we have reached over 2.5 million vulnerable persons in our continent. Primary health care programmes in Burundi, Liberia, Rwanda and Uganda; shelter projects in Ethiopia; community development and self-reliance undertakings in Namibia; food distribution and supplementary feeding interventions in Darfuf, Sudan; WASH and nutrition projects in Somalia have reached as many affected and vulnerable populations as resources allowed.

Along with restoring the wellbeing of communities, we envisaged to enhance the skills of local professionals and volunteers. We have worked closely with provincial and national level authorities, often called to step in and fill gaps in providing assistance. Similarly, we have forged and upheld alliances with national civil society actors in order to disseminate unified and coherent advocacy messages on behalf of the affected populations.

At the continental level, AHA continued to explore strategic partnerships that would strengthen a sustained institutional capacity to effectively respond to crises, rather than responding to adversities piecemeal. To this end, we had engaged with longstanding partners as the African Union, as well as building on newer undertakings with the African Development Bank Group. Although the response so far has been lackluster, we continue to seek ways to imbed corporate social responsibility into the thinking of Africa's emerging private sector.

Globally, we have actively engaged with various initiatives. Throughout 2012, AHA has served on the Steering Group of the UNHCR's "*Structured Dialogue on UNHCR-NGO Partnership*". Amongst other important issues, this initiative has put forward recommendations for a strengthened institutional approach to local partner capacity development. AHA also took part in regional and global humanitarian policy dialogues with the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA). All of these initiatives are ongoing as the crucial issues they seek to address are wide and complex. In addition, we continue to duly serve on the governing bodies of the International Council of Voluntary Agencies (ICVA) and the Active Learning Network for Accountability and Performance (ALNAP).

Effective partnerships are time-tested and require trust. They must also be anchored in the widely recognized Principles of Partnership: equality, transparency, result-oriented approach, responsibility and complementarity. In today's world of vast and multi-faceted humanitarian needs, no single group of state or non-state actors, donors, or civil society can address all the issues. AHA keenly recognizes this challenge and thus had re-committed itself in 2012 to enhance its long-standing operational and advocacy partnerships as well as establish new ones.

The challenge in engaging in various dialogues and initiatives is to ascertain a clear path from discussion to action. We are encouraged that most initiatives in 2012 sought to be more frank and inclusive in nature than prior ones. As we are reminded by occasional rubs, there still remains work to be done in bridging the chasm of humanitarian partnerships between global and local – as well as between traditional and "emerging" – actors. We are simultaneously optimistic with the developing trend of honest recognition and dialogue. AHA looks forward to add value and continue its contribution in 2013 and beyond.

Dawit Zawde

Understanding AHA

June 1994, AHA's 1st operation responded to victims of the Rwanda genocide

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 multisectoral 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.

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

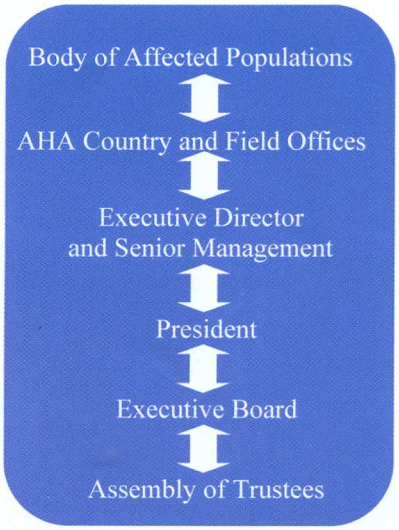
Our ***mission*** is to respond to crises, conflicts and disasters in Africa; to enhance communities at risk, so they can solve their concerns themselves; and to advise the international community and the private sector on humanitarian issues concerning Africa.

AHA is guided by universal humanitarian ***principles and values***. While upholding our independence, impartiality, and integrity, we advocate and 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.



Trustees



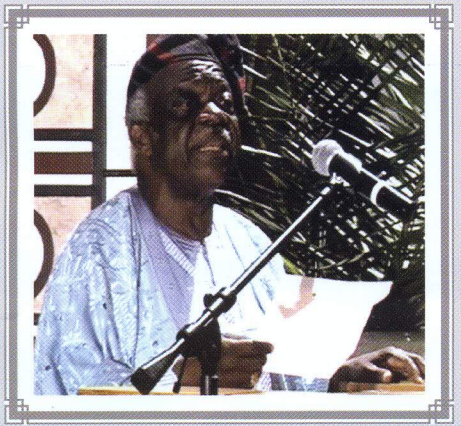
Chair: Dr. Salim Ahmed Salim -Tanzania
Co-Chair: Dr. Sheikh M.H. Al Amoudi - Soudi Arabia
Mr. Paul Adams - UK
Dr. Brigalia Bam - South Africa
Dr. Deo Barakamfitye - South Africa
Dr. Costantinos Berhe-Tesfu - Ethiopia
Mr. Asrat Betru - Ethiopia
Mr. Nicolas Bwakira - Burundi
Mrs. Guenet Guebre-Christos - Ethiopia
Amb. Brownson Dede - Nigeria
Dr. Filomena Delgado - Angola
Dr. Getachew Demeke - Ethiopia
Mr. Chefeke Dessalegn - Ethiopia
Mr. Nils Gussiong - Sweden
Mrs. Patricia Hajabakiga - Rwanda
Amb. Irvin Hicks - USA
Mr. Jean-Piere Hocke - Switzerland
Dr. Mucktarru A.S.Jalloh - Sierra Leone
Dr. Charles K. Kalumiya - Uganda
Ms. Marjon V. Kamara - Liberia
Mr. Yohanees Kifle - Ethiopia
Mr. Getachew Kitaw - Ethiopia
Mr. Mahary Maasho - Ethiopia
Dr. Panuell Maduna - South Africa
Mr. Ibrahim Osman - Sudan
Mr. Albert Alain Peters - Benin
Amb. Teferra Shiawl - Ethiopia
Ms. Clare Short - UK
Mrs. Eularia Syamujaye - Zambia
Mrs. Gillian W. Banda - South Africa
Mr. Anders Wijkman - Sweden
Dr. Dawit Zawde - Ethiopia

Executive Board

Mr. Asrat Betru - Treasury
Mrs. Guenet Guebre-Christos - Programmes
Dr. Charles K. Kalumiya - Legal
Mr. Ibrahim Osman - Programmess
Dr. Dawit Zawde - President

Remembering our late Trustee

Chief Segun Olusola



1935 - 2012

It is with deep sadness that we remember the passing of Chief Segun Olusola, one of Africa's finest humanitarians. Born in 1935, Chief Olusola dedicated his life to bettering the lives of Africans and that of humanity at large. A pronounced diplomat, the Chief wore many hats; most prominently known are his role as a statesman, and patriarch of Nigeria's arts and culture. Chief Olusola received many recognitions throughout his life that attest to his devoted public service, including: the first Nigerian Member of Universal Peace Federation's Global Peace Council; the first Nigerian to receive the Crown of Peace award in Korea in 2004; remains the longest serving Ambassador of Nigeria to Ethiopia; and is recipient of the Nigerian Government National Honor of the Order of the Federal Republic of Nigeria.

Chief Olusola supported AHA since our founding in 1994 and continued to serve as a member of Trustees until his death in June 2012.

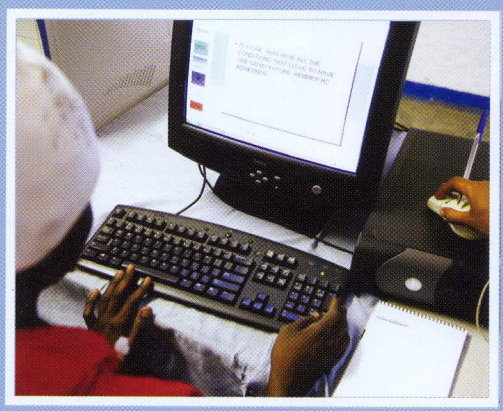
Chief Olusola was buried in his hometown Iperu Remo, Nigeria where prominent Governors and Ministers were in attendance. The Chief is survived by his wife, children and grandchildren.

We will miss his invaluable leadership, advice, and wisdom.

May he rest in peace.

Programmes

Capacity Development



Protracted crisis and chronic poverty have severely devastated African societies leaving them seriously challenged 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, and institutions.

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

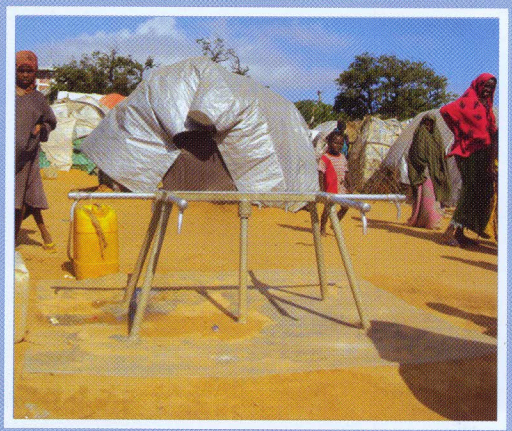
Healthcare



The physical, mental and social wellbeing of African communities is essential to the overall 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

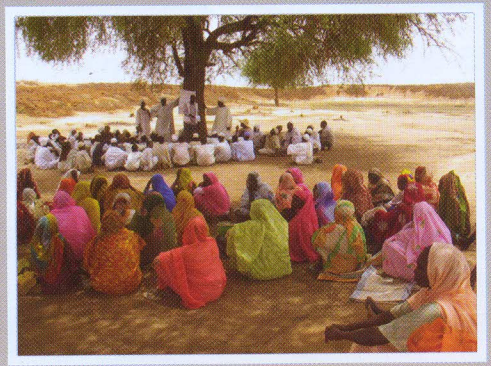
HIV/AIDS



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 19 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.

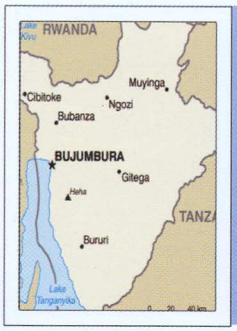
- Support and empowerment of indigenous organizations
- Acknowledgement and integration of African CSOs agenda and strategy
- International recognition of African CSOs value, contribution and expertise
- Enhanced accountability and sustainability
- Increased capacity development for African CSOs

2012 in Brief

An estimated 15.1 million refugees and as many as 27.5 million IDPs were forcibly displaced worldwide in more than 40 countries in 2012. Below is a displacement snapshot of countries of concern to AHA in 2012.

42 MILLION PEOPLE ARE UPROOTED BY WAR WORLDWIDE

Burundi



Refugees (country of origin): 39,713 (Democratic Republic of the Congo)

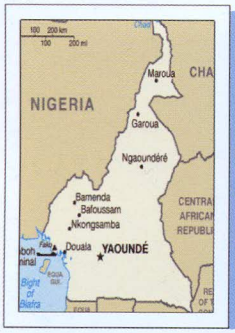
IDPs: 78,800

AHA assisted population: 80,861 displaced persons

AHA program location: Gasorwe, Musasa, Bwagiriza, Butare

AHA programs: Health and nutrition, HIV/AIDS, mental health, protection

Cameroon



Refugees (country of origin): 5,251 (Chad); 87,092 (Central African Republic)

AHA assisted population: 88,800 (21,400 CAR refugees, 67,400 nationals)

AHA program area location: Kadey Department, Eastern Cameroon

AHA programs: Primary healthcare, nutrition, HIV/AIDS, and capacity development

Ethiopia



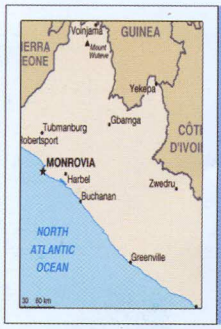
Refugees (country of origin): 238,845 (Somalia); 88,462 (Sudan); 62,996 (Eritrea)

AHA assisted population: 334,000 displaced persons and nationals

AHA program area location: Southern Nations Nationalities and Peoples Regional State; Afar, Tigray and Somali regions

AHA programs : Reproductive health, HIV/AIDS, capacity development, SGBV, education, shelter and water

Liberia



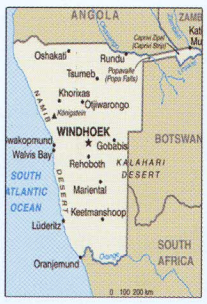
Refugees (country of origin): 175,000

AHA assisted population: 1.5 million displaced persons and vulnerable communities

AHA program area location: Montserrado, Bomi, Gbarpolu, Rivercess, and Nimba counties

AHA programs: Healthcare, gender based violence, HIV/AIDS, capacity development, and public advocacy

Namibia



Refugees: 13,000 estimated

AHA assisted population: 7,389 displaced persons (53% Angolan, 25% Congolese, 5% Burgundies, 3% Rwandese, the remaining come from 18 different African countries)

AHA program area location: Osire settlement

AHA programs: Shelter and logistics, community development, social services, water, sanitation and hygiene, agro forestry, income generating projects, youth and sports

Rwanda



Refugees (country of origin): 57,641 (Democratic Republic of the Congo)
AHA assisted population: 40,000 refugees, returnees, asylum seekers

AHA program area location: Gihembe, Kiziba, Nyabiheke, Kigeme camps, Nkamira and Nyagatare transit centers, and Kigali

AHA programs: Health and nutrition, HIV/AIDS, mental health, protection, sexual and gender based violence

Somalia



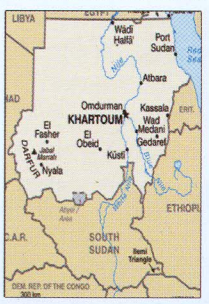
IDPs: 1.1 million

AHA assisted population: 224,108 internally displaced persons

AHA program area location: Mogadishu

AHA programs: Health/nutrition, water, sanitation and hygiene, and community mobilization

Sudan



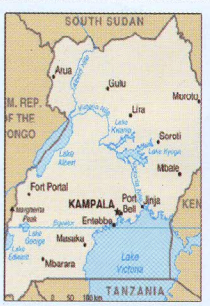
Refugees (country of origin): 100,464 (Eritrea); 31,871 (Chad); 4,421 (Ethiopia)
IDPs: more than 2.4 million

AHA assisted population: 615,290 internally displaced and vulnerable persons

AHA program area location: North Darfur (Dar-Al Salam, Kelmando, Shangel-Tobay, Shadad camps; localities of Kuma, Korma, Umkadada, ElFasher and Kafot)

AHA programs: General food distribution, blanket supplementary feeding programs, income generating activities

Uganda



Refugees (country of origin): 134,357 (Democratic Republic of Congo); 27,143 (Somalia); 17,928 (Rwanda); 12,527 (South Sudan); Other 33,996 (East Africa)

IDPs: 30,000

AHA assisted population: 45,000 Congolese refugees from DRC

AHA program area location: Kyaka II, Rwamwanja

AHA programs: Primary health care, reproductive health, HIV/AIDS, nutrition, capacity development

Health Care

AHA began its humanitarian intervention by assisting victims of conflict through emergency health care services. After 19 years since the launch of its first operation in Rwanda, health care remains at the forefront of AHA's humanitarian and development programs.

Health operations in 2012 provided assistance to some 756,266 refugees, internally displaced and vulnerable persons in eight African countries with support that ranged from primary, preventive and curative health care, to assisting national health institutions with public health facilities management.

The challenges faced by AHA in its endeavors to provide quality, timely and sustainable health services remained similar to that of previous years. The lack of adequate health facilities, insufficient funding allocations, and delayed reactions to emergencies by the donor community continued to dictate the types of support provided.

This section of the 2012 Annual Report highlights some of the activities undertaken by AHA in the health sector.

Burundi

Over 27,000 refugees and returnees were supported in the Bwagiriza, Butare, Gasorwe, and Musasa camps with an onsite health center and laboratory in each of the camps.

Camp	Female	Male	Total
Gasorwe	5,196	4,797	9,993
Musasa	3,454	3,333	6,787
Bwagiriza	5,143	4,915	10,058
Butare	134	121	255

Voluntarily repatriating refugees and Burundian returnees received general health screens prior to their journey home and re-integration with the general public. Repatriates were accompanied by health staff to ensure their wellbeing during their journey. AHA monitored the nutrition and general health of all repatriates while paying special attention to the chronically ill, children under the age of five, and pregnant and lactating women.

In addition, camp residents were provided with primary health care; mental health support, vaccinations for children and expecting mothers; referral services; and essential medicines in accordance to the World Health Organization standards were regularly provided.

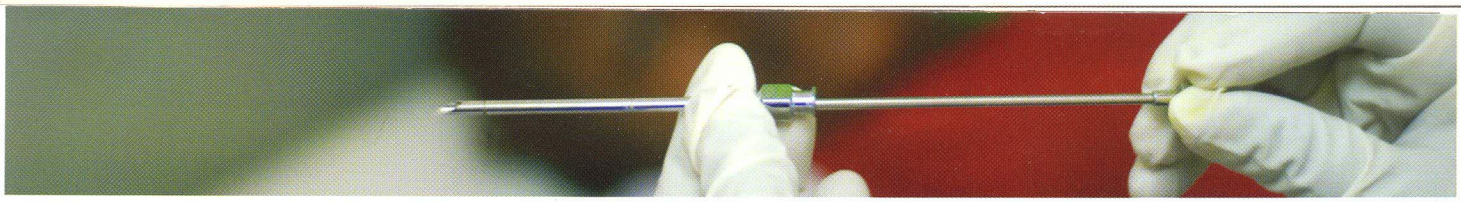
New and refresher trainings were carried out for doctors, nurses, midwives, paramedics, laboratory technicians, pharmacists and community health workers.

Cameroon

The Kadey Depatment, East Region of Cameroon is one of the country's most vulnerable areas. In addition to the Department's destitute residents, over 20,000 refugees have settled in the area, living integrated with the national population. To ensure xenophobia towards refugees do not prevail in the midst of scarce resources, AHA's operations in Cameroon focused on supporting public health facilities that render services to refugees and nationals alike. In 2012, three district hospitals, two higher medical centers, and ten health centers assisting over 20,000 refugees were enhanced through improved primary healthcare provision and infrastructure development.

Age Group	Female	Male	Total
0-4	1,285	1,369	**2,654**
5-11	2,677	2,712	**5,389**
12-17	1,824	1,672	**3,496**
18-59	4,807	3,519	**8,326**
60 and >	193	363	**556**
Total:	**10,786**	**9,635**	**20,421**

Access to health care and nutrition services by persons living in the most rural areas were increased by 100%; service utilization rate in health facilities improved as health centers became better equipped and their staffs better trained, instigating trust in the quality of care among service recipient; nutrition and vaccination coverage increased, and the health information and referral systems put in place the previous year were further strengthened, improving the areas overall healthcare delivery. Over 2,800 persons utilized the Nutrition Stabilization Center managed in collaboration with the Ministry of Public health.



Ethiopia

Reproductive health remained to be a major challenge in Ethiopia in 2012 triggered through an unticipated pregnancies and continued reliance on traditional midwives for handling deliveries. With a focus in 32 districts of the Southern Nations Nationalities and Peoples Region, AHA worked to empower women to take control of their and their families' lives through integrated family health programs and access to better reproductive health interventions. Some 203,000 community members directly benefited from the various health programs undertaken in 2012, while an estimated 1.2 million were indirectly impacted through outreach and sensitization activities.

In 2012 community members participated in education sessions; were provided with various contraceptives, and benefited from referral services and at home consultations. Enhancing regional health capacity was also AHA's target in the year. To this end, health staff and community based voluntary health workers received new skills and refresher trainings.

Liberia

Preventable illness continued to prevail in AHA concerned areas of Montserrado, Rivercess, Gbarpolu and Bomi Counties of Liberia in 2012. Supported by a multi-donor pool fund, AHA, through national health infrastructures treated 409,932 individuals, 33% of whom were children under the age of five, with essential curative healthcare. Working alongside national humanitarian organization, AHA insured that nationals took ownership of the healthcare programs ensuring the sustainability of good health practices. Refugees at the Bahn Refugee Camp were also recipients of wholesome healthcare services through facility based and at home consultations. Malaria, Acuter Respiratory Diseases and Watery Diarrhea remained the foremost seen health problems in the year.

Rwanda

Returnees, camp-based and urban refugees, and asylum seekers were supported through quality healthcare services in 2012.With operations in Kiziba and Kigeme refugee camps, and the Nyagatare and Nkamira Transit Centers safe and effective preventive and curative health services were provided. In 2012, significant reduction in morbidity and mortality from common diseases, integration of comprehensive reproductive health care and advocacy against infectious and preventable diseases brought substantial positive impact towards maintaining standard well being of the population of concern. Over 57,000 displaced persons were supported through AHA's health scheme in the year while host community members also benefited from AHA's presence in regional public health facilities several times a week.

Somalia

Emergency interventions for drought and war affected populations of Mogadishu continued in 2012. A component of this wholesome intervention, some of the health needs of internally displaced persons and community members identified as highly vulnerable were addressed. Some 12,000 orphans; pregnant and lactating women; and anemic patents; received vaccinations, food and vitamin supplements. In addition, the nutritional status of female headed households were evaluated. 2,500 Households identified as the most vulnerable received rice, beans, skimmed dried milk, and 880 bags of dry corn soya blend to supplement their dietary needs. In addition the households were trained on the nutritional value of some locally available food products to minimize their risk of malnutrition.

AHA also continued to assist Banadir Hospital, one of Mogadishu's largest health facilities AHA had partially helped reconstruct. In total some 22,000 internally displaced persons and vulnerable Somalis were direct beneficiaries of AHA activities in 2012.

Uganda

Through essential primary health care, reproductive health, nutrition, and sanitation and hygiene promotion services, AHA in Uganda worked to contribute towards the improvement of the health status of refugees and the host population. Quality, accessible and sustainable health care services were provided via Rwamwanja and Kyaka II health centres. The number of beneficiaries exceeded AHA's planning group of 17,334 as renewed conflict in the Democratic Republic of the Congo instigated influx of new refugees in to the area. In addition, 40% of the host community visited AHA run health facilities for consultations, which further strained allocation of medicine and supplies for the refugee population.

In 2012 an Ebola outbreak crippled Uganda for several months, although none were reported in AHA affiliated health centres. Emergency prevention, awareness and sensitization were implemented in refugee settlements in response to the outbreak.

HIV/AIDS

With nearly one in every 20 Africans living with HIV/AIDS, Sub-Sahara Africa remains severely affected by the HIV epidemic. AHA has thus made it its priority to mitigate the effects of HIV/AIDS by minimizing the risk of transmission and new infections through awareness campaigns, and by ensuring wider access to antiretroviral therapy for people living with the virus.

By and large, the numbers of people dying from AIDS-related causes in AHA countries of concern have declined by 25 to 50% in 2012. Along with the health aspect of HIV/AIDS, AHA provides support and assistance to HIV impacted families through income generating activities warranting them a sound future.

In 2012, AHA supported persons impacted by HIV/AIDS in seven African countries.

This section of the 2012 Annual Report highlights some of the activities undertaken by AHA in the HIV/AIDS sector.

Burundi

AHA continued to assist medical and social support to AIDS patients in 2012. Voluntary testing and counseling; psychological support; drugs for persons living with the disease were among services provided in the year. As component of AHA's other services to displaced persons in Burundi, behavioral change sensitization and awareness campaigns, particularly targeted to youth, were periodically conducted to eliminate new infections.

69% of HIV-positive people worldwide live in sub-Saharan Africa

Health workers periodically conducted home visits to ensure that patients are properly following their prescription, that they are aware of their diet intake, and to also ensure that the community is not discriminating HIV/AIDS patients.

Cameroon

To encourage the predominantly Muslim communities of AHA focus areas in Cameroon, HIV/AIDS programs were incorporated with reproductive health care services in 2012. Through highly visible campaigns, refugee and host community members were sensitized to get tested. Special emphasis was placed on expecting mothers and young refugees who are most vulnerable for HIV infection and transmission.

Because AHA affiliated health centers were not stocked with ART medications, persons with AIDS were referred to hospitals with adequate treatment capabilities. This initiative also encompassed the screening and treatment of TB/HIV and other sexually transmitted diseases.

Ethiopia

HIV/AIDS prevention, care and support services were conducted in the Aysaita refugee camps, home to Eritrean Afar refugees in Ethiopia. Through dissemination of informative materials, promotional effort was made on the prevention of new infections of HIV. This initiative utilized school and community based youth clubs who regularly held events and activities, and engaged the refugee and host communities.

In 2012, some 6,438 persons were sensitized, supported with voluntary counseling and testing, and capacity building programs. In addition, community health workers received refreshment trainings to enhance their counseling and education methods; condoms were distributed via distribution centers and local facilities; and patients were referred to regional hospitals for further support. The very low new infection in the camp was encouraging to all humanitarian workers in the camp.

91% of HIV-positive children live in Africa



Liberia

HIV services including HIV counseling and testing (HCT), Antiretroviral treatment, and prevention of mother -to-child transmission (PMTCT) services were provided at two hospitals: the St. Francis Government Hospital in Cestos City, and Chief Jallah Lone Hospital of Bopolu City. In Gbarpolu County, HCT and PMTCT services were extended to all who visited the health clinics. HCT and PMTCT were also extended to three clinics in Rivercess County, and to two clinics in Bomi County. PMTCT programs were widely implemented in Mantserado based health facilities.

476 HIV positive patients were enrolled in PMTCT programs across four counties. In addition to support for patients, extensive awareness campaigns were conducted by in various catchment areas; condoms distribution was widely performed; and clinic staff were provided with refresher trainings.

Namibia

HIV/AIDS advocacy services were provided at the Osire Refugee Camp and to host communities near the camp. Building on AHA's 2011 sensitization programs, 2012 activates were linked to gender issues. Under the global theme "Getting to Zero: Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths", World AIDS Day 2012 was commemorated in Osire camp, bringing together various camp actors for a successful sensitization event.

71% of HIV-/AIDS related deaths in 2012 were people living in Africa

Other sensitization activities included the involvement of the Osire Boys and Girls Club. Informative leaflets were produced and distributed to youth and camp residents, and information sessions to not discriminate against people living with the disease were carried out. In addition to prevention activities, support for persons living with HIV was rendered through capacity building initiatives.

Rwanda

It was evident in 2012 that HIV/AIDS sensitization carried out by AHA in the Kiziba camp and among urban refugees, had been effective as AHA began implementing similar operations in newly established camps. Kigeme camp was amongst those where its residents had little or no basic knowledge of HIV/AIDS. Intensive sensitization, education and testing sessions were carried out to empower most vulnerable members of the refugee committee while access to treatment and support was rendered to persons living with the disease.

Unfortunately, urban refugees did not enjoy the same level of HIV/AIDS care and services as funding to carry on urban HIV project were not available. Thus, urban refugees were referred to public health facilities to access the necessary treatments.

Along with HIV/AIDS information, family planning, voluntary testing, and tuberculosis testing were conducted. Over the course of the year, condoms were distributed to refugees from hospital consultation rooms, pharmacies, during sensitization sessions, and through selected community facilities.

Uganda

AHA implemented a comprehensive HIV care program in 2012 through AHA managed heath centers in Kyaka II and Rwamwanja serving both refugees and nationals. ARVs, which are freely provided from National Medical Stores were scarce in 2012 due to funding shortages from donors. Funding constraints further hindered regional health providers from conducting assessment of HIV prevalence rate in the region. As new influx of refugees continued, however, extended HIV/AIDS sensitization campaigns to benefit the host community and newly arriving residents were carried out.

59% of HIV-positive people in Africa are women

Sexual and Gender Based Violence

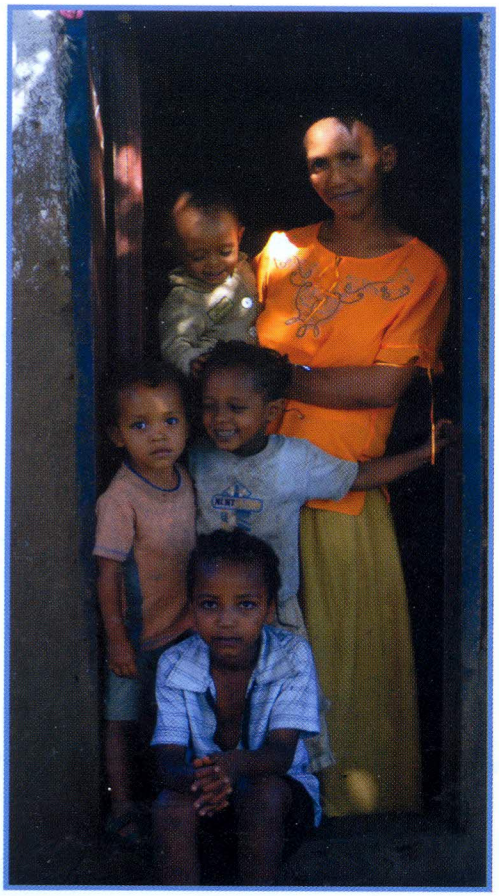
Gender based violence, particularly against women, continues to thrive in conflict and disaster affected AHA operating areas. Addressing the issue has thus been AHA's priority. As the nature of violence against vulnerable groups varies with the diverse population demographic, AHA Gender and Sexual Based Violence (SGBV) programs are tailored to fit each program area and target group, and are integrated into the different AHA programs to ensure the maximum number of girls and women are empowered.

One of the major crosscutting challenges AHA faced in 2012 was that girls and women were unaware of what constitutes as abuse. Many went on without reporting domestic abuse as, in many cases, it is the accepted social mores. The stigma associated with being raped and molested, in particular by authority figures within communities, also hindered many from reporting exploitations across many of the AHA operating regions.

With this in mind, AHA conducts intensified campaigns so all members of society are aware of the impact of sexual and gender based violence, its consequences and, most importantly, information on access to legal services are regularly disseminated. AHA also works with local authorities and facilities to provide first response kits, counseling and trainings for national professionals on gender based violence incidence management.

In 2012, AHA supported girls, women and communities at large impacted by gender based violence. The youngest child to be cared for was a three year old girl raped by a 14 year old minor in a refugee camp.

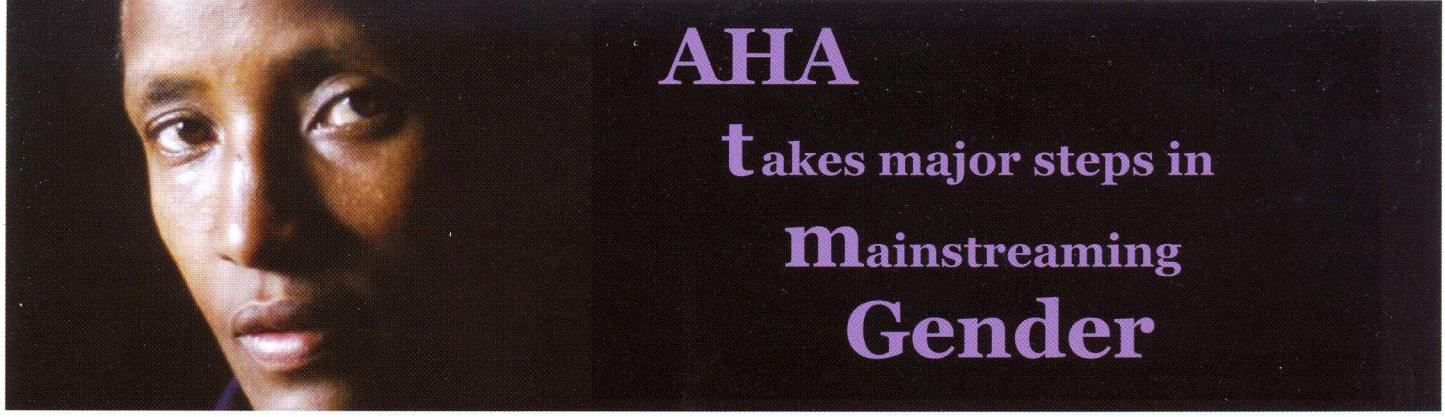
This section of the 2012 Annual Report highlights some of the activities AHA undertook in the gender based violence prevention and response sector.



Ethiopia

The SGBV program was undertaken with an objective of training and sensitizing the refugees and host community on the negative impacts of SGBV and contributing to the reduction of occurrence and risk of SGBV. Awareness creation against gender based violence was incorporated in AHA activities of healthcare, HIV/AIDS and capacity development for vulnerable communities in the Southern Nations Nationalities and Peoples Regional State of Ethiopia, and for refugees in Aysaita and Berhale.

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 encouraging staying in school. Refugee host communities were also highly sensitized on SGBV and its effects where female and male participants took part. Polygamy and marriage between close family members were also addressed during the year.



Liberia

AHA's Sexual and Gender Based Violence services helped create awareness of SGBV violence and to 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.

In 2012 activities focused on providing awareness and treatment services to local communities and refugees. AHA, as health implementing partner, worked in coordination with other partners in minimizing the trauma of SGBV survivors in Bahn Refugee Camp. AHA's main role in Bahn concerning SGBV program was providing medical care for the survivors. This includes management of any physical injuries, screening for HIV, provision of post exposure prophylaxis for HIV/AIDS, STI treatment, provision of emergency contraceptives and treatment of any related conditions and complications. Patients were referred by humanitarian counterparts responsible for the protection services in the camp to the clinic who are managed by AHA.

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

In 2012 AHA took measures to ensure that incidents of sexual and gender based violence are minimized at the Osire Refugee Camp. Sensitizations, trainings, and measures to make the camp more secure were among activities undertaken. Emphasis were made on security of all camp residents from violence and exploitation, protection of children, reducing SGBV risks, improvement of response, and bringing perpetrators to account for their actions were some of the major initiatives of 2012.

Residents were made aware of the types of gender based abuse and how to avoid them. Stereotyping and human rights, sexual and reproductive health and the promotion of gender equality, defining sexual exploitation, sexual misconduct and sexual abuse of students, forms of sexual harassment and indicators of sexual misconduct of educators, avoiding allegations of sexual misconduct, consequence of sexual abuse on students and learners were among topics discussed during the year.

Rwanda

In 2012, SGBV services were extended to refugees in urban settings and at the Kiziba refugee camp. Most of the reported SGBV incidents in 2012 were domestic violence, thus AHA focused its efforts on sensitizing men and women on the issue. AHA's activities included: dialogues with community members that highlighted women's perspectives, events that celebrated women – including a commemoration of International Women's Day-, events committed to the rights of children and youth.

Through distribution of informative materials, trainings and sensitization activities, issues such as: domestic violence, emotional abuse, physical assault and related laws, economic violence, and GBV cases reported by men were addressed.

In additions various trainings that integrated SGBV and HIV/AIDS were carried out through HIV clubs.

Capacity Development

AHA is founded on the belief that Africa can prosper if and when its people are empowered to do so. Thus, it has been a critical and a core component of all AHA activities to involve the utmost number of local residents, nationals and beneficiaries in AHA's program designs and implementations across the continent.

The active participation of local communities has had dual achievements over the past 19 years. The first is that the strong involvement of persons of concerns helps AHA address the core problems beneficiary communities face because with involvement, beneficiaries develop a level of confidence and become frank about the needs of their communities. The second aspect of this method ensures that communities acquire the necessary skills to handle and deal with atrocities and disasters that may occur in the future, building their capacity for resilience.

In 2012, AHA supported various vulnerable groups through capacity development initiatives in seven countries. This section of the 2012 Annual Report highlights some of the activities undertaken by AHA in this sector.

Cameroon

Review of 2011 annual performance indicated that the main cause of low achievements of some health indicators or identified gaps were the lack of adequate knowledge and skill among Ministry of Public Health (MOPH) staff and community health agents, community volunteers and traditional birth attendants. Hence, the refugees and host communities were affected from either receiving inadequate or lack comprehensive health care services. Recognizing these facts, AHA in partnership with the East Regional Health Bureau and Health Districts, organized four different capacity building trainings for MOPH staff, AHA staff, community volunteers and traditional birth attendants. By the end of 2012, 45 MOPH and AHA staff were trained on HIV counseling and testing, PMTCT and STI/HIV; 55 community volunteers trained on community mobilization, 52 birth attendants and community volunteers received training on reproductive health, and 198 MOPH and AHA staff were trained on acute malnutrition management. In addition, regular on the-job- training and mentoring enhanced the capacity of MPOH staff and community health agents. This capacity building trainings motivated MOPH staff to improve the quality of the services they provide. The capacity building trainings of community volunteers and birth attendants helped to bring awareness and promote disease prevention and hygiene in the community. This diversified capacity building program has significant implication for long term development of health care services in the region in addition to improving the quality and comprehensiveness of health service.

Similarly, the program also increased the capacity of health districts and the regional health bureau to supervise, monitor and evaluate the activities in health facilities. In general, during the reporting year, AHA provided significant technical, material and logistic supports to health districts and regional health bureau to improve the health care service.

Ethiopia

Refugees and vulnerable communities were empowered through all AHA activities in Ethiopia. In areas where intensive interventions were needed, specific programs were carried out to enhance local capacity. To this end, trainings and refresher trainings were provided to community based health workers, members of youth groups, and AHA staff. In addition, non-formal and preschool education programs were implemented in the Aysaita refugee camp providing education opportunities for children and adolescents. This platform was also used to discuss community issues such as traditional practices, personal hygiene, environmental conditions in classrooms built by AHA in the previous year.

In 2012, an additional two classrooms and a feeding center were constructed for the preschool program. The project was staffed with teachers and caregivers from the refugee community and a project coordinator from the host community. AHA also supported the program with teaching aid materials .



Liberia

Capacity building initiatives in 2012 aimed at enhancing health teams' capacities to respond to malaria, HIV/AIDS, and nutrition. To this end, trainings were provided for refugee camp medical staff on management of Malaria, first level comprehensive HIV/AIDS care, nutritional screening and case management of acute malnutrition in children.

In additions patients who visited AHA managed health care facilities benefited from weekly seminars at out-patient departments. Themes for discussion reflected challenges faced in the communities.

Namibia

In 2012, refugees at the Osire Refugee Camp were supported to gain financial independence through income generating activities. Through agro forestry programs, refugees were encouraged to grow some of their worn foodsIn previous years some refugees were provided with seed-money in the form of a loan to begin business ventures. As many of them began paying back their loans, the money, in 2012, was recycled and given to a new group of refugees for the same purpose.

Through self reliance and livelihood programs, AHA also provided basic business skills and proposal writing trainings. Other non-formal trainings such as carpentry, hairdressing and tailoring were also provided. Once trainings are completed, beneficiaries receive technical support to run their businesses.

Rwanda

In Rwanda, capacity building initiatives targeted refugees and AHA health staff. These various groups were supported through trainings, informative sensitization activities, and income generating activities. Topics ranging from health, to hygiene and education were covered in this program. Nurses, teachers, youth groups, vulnerable women, community and religious leaders, and national non-governmental institutions took part in the training sessions provided.

Displaced persons were also assisted in income generating activities such as rabbit breeding, poultry farming and vegetable garden management. Urban refugees and residents of Kiziba and Kigeme camp all benefited from this initiative.

Sudan

To reduce the dependency of vulnerable groups on food aid, AHA in 2012 worked with the Ministry of Agriculture and FAO in Northern Darfur in crop production. Seeds and farming tools were distributed in areas identified as having good potential for fruitful crop production for the year. To this end, farmers in the Dar Al Salam, Kalimando and Korma areas of North Darfur were supported through provision of millet, sorghum, ground nut, sesame, cow pea, and rake seeds. In addition, the farmers were provided with locally produced iron ploughs.

Animal health management was also an important component of AHA's 2012 capacity building activities. As cattle are an important component of livelihood in North Darfur, AHA's initiative focused on maintaining the health of livestock in the area. To this end, 195,000 animals were vaccinated and 9,162 treated for various diseases.

Uganda

Capacity building programs in 2012 supported the effective delivery of health care services at health facility and community levels. At the clinical level, health workers were trained on the management of HIV,TB and syndromic management of sexually transmitted infections. Because some communities continue to utilize the services of traditional care givers, AHA conducted training for traditional circumcisers on universal precautions. National health staff also took part in this training as part of AHA's circumcision to reduce HIV/AIDS campaign.

In addition to these supports, peer educators were assisted on information dissemination while out of school youth received vocational trainings.

Relief and Recovery

For persons displaced by atrocities, the difference between life and death could depend on how fast aid organizations reach them. To this end, AHA works in collaboration with its counterparts to make sure that aid agencies are better aware of looming disasters through its community rooted field offices. AHA also collaborates with national and international actors to eliminate duplication of efforts during emergency responses.

Keeping in mind the advantageous proximity of African organizations, AHA has several initiatives that are geared to empower indigenous organization become first responders to emergencies on the African continent. In this regard, various schemes are underway to stockpile emergency goods that could be used by African humanitarian agencies when disasters strike. Working with African institutions and global actors, AHA also ensures that currently displaced persons across Africa receive the essential services they need in dignity.

In 2012, AHA supported displaced persons through relief and recovery services in five countries. This section of the 2012 Annual Report highlights some of the activities undertaken by AHA in the sector.

Ethiopia

Working in harsh environments on the Somali and Eritrean boarders, AHA's relief and recovery services provided shelter and water to refugees in 2012. Shelter construction and management work were continued in the Aysaita, Adi Harush, Berhale, Bokolomayo, and Melkadida refugee camps. AHA also undertook operations in Kobe camp, a temporary home to asylum seekers.

In addition to constructing new shelters, shelters constructed in previous years were maintained and modified to suit the severe weather of the Somali, Afar and Tigray regions. In consultation with partners in the camps and the beneficiary community, materials and the designs of shelters have been improved throughout the year to suit the culture and living conditions of the displaced persons. In addition to living space for refugees, areas for communal use such as schools and warehouses were also constructed.

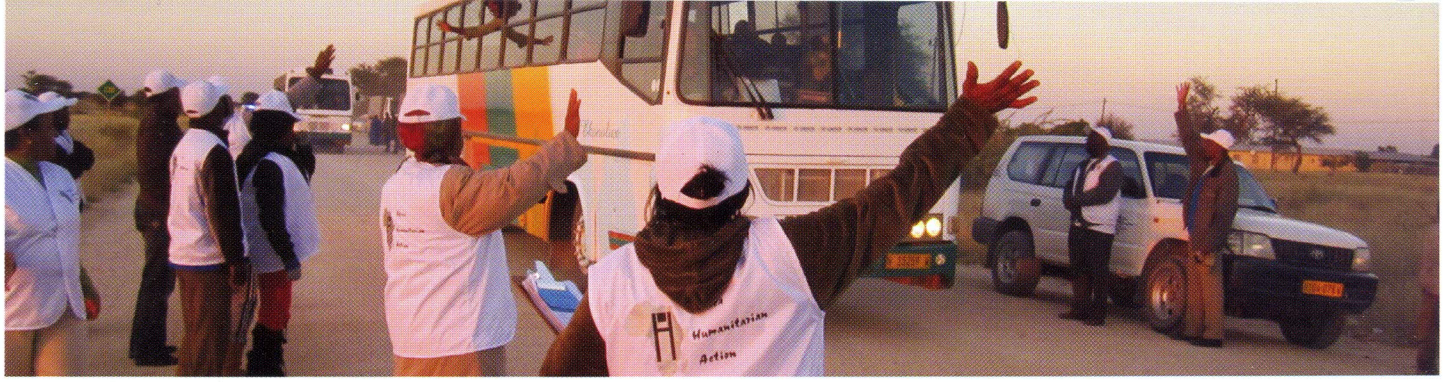
In the water sector, the Aysaita and Berhale refugee camps continued to be provided with essential potable water in accordance to the international 20 liters per person per day quota. In Aysaita, construction of an independent water resource secured in 2011 was completed. With a capacity of 10 liters discharge rate per second, the refugee population and host community now have a reliable and sustainable water supply.

Other services in the water sector included construction of community water taps, maintenance of existing facilities. Orientations and trainings were also provided to water point attendants and the community at large to maintain these facilities.

Namibia

In 2012 AHA continued to handle the distribution of food and non-food items, to supply water, sanitation and hygiene, and to manage refugee housing at the Osire camp. Through a warehouse and logistic unit, food and non-food items were distributed. Over 800 women were assisted with sanitary pads, soaps, and other hygiene goods in 2012. 7,604,000 liters of water was provided to camp residents in 2012. In addition to ensuring the adequate supply of water to the camp, AHA was responsible for chlorinating and treating the water supplied and maintaining water infrastructures. In addition, sanitation facilities were constructed and maintained in the camp. 50 pit latrines were maintained in 2012, and 31 new once constructed bringing the total of pit latrines in the camp to over 800.

The shelter unit was responsible for providing constructing materials and managing camp housings. Houses were made available to refugees as they arrived. From the 219 new arrivals, 180 were provided housing while the rest joined family members. 632 Neem tree seedlings and 385 Leucena trees were distributed to the community to plant in order to combat desertification and maintain a green living environment.



AHA conducted voluntary repatriation project of Angolan refugees in Namibia in partnership with all stakeholders in April 2012. Following meetings between the governments of the Republics of Namibia and Angola, and the UNHCR, refugees were informed of the opportunity to register for organized voluntary repatriation. AHA conducted sensitization campaigns on voluntary repatriation and arranged for the transportation of refugees and their belongings.

In coordination with organizations such as the World Food Programme, AHA also provides food, water, sanitation, and counseling services in order to make the transition manageable. The first convoy of 108 Angolan refugees left Osire Camp in Namibia on 15th of May 2012. They crossed the border two days later accompanied by Namibian government officials, UNHCR and AHA staff. The Angolan government, along with UNHCR, received them 15 km from the border. A total of 2,858 Angolan refugees returned home in 2012.

Rwanda

AHA remained responsible for food and non-food item distribution in Gihembe, Kiziba, Nyabiheke refugee camps, and Nyagatare and Nkamira transit centers in 2012. Food items such as maize grains, beans, cooking oil, sugar and salt were monthly distributed. The influx of newly displaced persons from the Democratic Republic of the Congo strained the already minimal resources for some of the camps, however with the support of humanitarian counterparts and volunteers, all displaced persons were assisted with timely interventions. Demands for some non-food items, such as wood for fire were higher than what was available throughout the year.

To maintain the quality of goods distributed, the World Food Program took measures to renovate and improve storage units. In 2012, in-kind support from national and regional institutions was received that complemented this relief and recovery effort.

Somalia

AHA continued its relief and recovery services in Mogadishu supporting internally displaced persons and vulnerable communities in 2012. Through a water and sanitation program, several water points were constricted, bringing the total number of water point constructed through the AHA short term emergency intervention to 20 and with the capacity to assist 26,000 displaced persons. In addition, households in 9 communities were provided with water purifiers, and a water source with daily capacity of 72, 000 liters was chlorinated regularly to service 4,847 households in 32 displaced persons camps. 224 water and sanitation facilities were also constructed and renovated for communal use, at schools and a hospital.

In addition in 2012, AHA through its national partner HIJRA Somalia, provided vaccinations, vitamins, food supplements, and selective feeding inputs for some 11,000 infants and 2,500 mothers. In addition, Community mobilization efforts and awareness building activities were incorporated throughout the project in order to enhance existing capacity and foster community ownership.

Sudan

In 2012 displaced persons and vulnerable communities in rural El Fasher, Daralsalam, Shangel Tubaya, Shedad, Korma, Umkedada, Kalimando and Kuma were supported through general food distribution, blanket supplementary feeding, and milling and food voucher programs to meet the basic food needs of severely affected persons in North Darfur. To this end, 568,766 beneficiaries received a total of 9150.49Metric Tons of food utilizing AHA organized Food Aid Management Committee, tribal leaders and existing village council committee, who also took part in the supervision of proper distribution.

AHA conducted a milling voucher program for internally displaced persons in the Shangel Tubaya and Shedad camps. *99, 481* milling vouchers worth 22 SDG each for purchasing locally available and preferred food items. This program was 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.

Finances

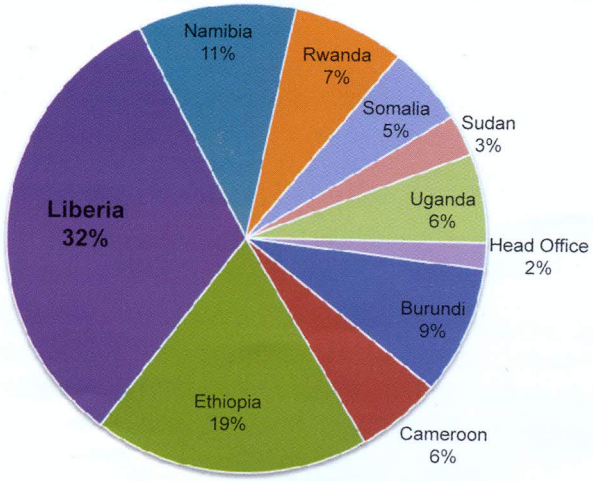
2012 Income and Expenditure in USD

Location	Income	Expenditure
Burundi	1,126,730	1,112,018
Cameroon	738,894	738,628
Ethiopia	2,381,170	2,377,392
Liberia	4,117,322	3,977,628
Namibia	1,368,486	1,362,740
Rwanda	972,467	972,467
Somalia	689,874	689,874
Sudan	364,633	364,633
Uganda	787,158	776,533
Head Office	228,083	218,083
Total	**12,774,818**	**12,589,996**

1995 - 2012 Budget in USD

Location	Income
Angola	8,240,277
Burundi	9,302,298
Cameroon	2,339,622
Chad	1,014,845
DR Congo	7,106,045
Ethiopia	8,309,595
Guinea	215,467
Liberia	14,906,049
Namibia	11,242,165
Rwanda	14,056,308
Somalia	1,344,874
Sudan	7,841,556
Uganda	9,580,396
West Africa	233,118
Zambia	6,490,207
Head Office	3,953,802
Total	**106,176,624**

2012 Income Percentage by Country



D. K. WAMBUA & ASSOCIATES

*Audit * Risk Assurance * Accountancy * Taxation * Consultancy

Certified Public Accountants

February 28, 2013

The Directors
Africa Humanitarian Action
Addis Ababa
Ethiopia

Dear Sir/s,

We are pleased to report the completion of the audit of the Somalia Humanitarian Assistance Project – for the year ended 31st December 2012. Nothing worth reporting has come to our attention.

The excess spending by AHA towards the project has amounted to US Dollars 34,874. The cash-closing balance is US Dollars 323.

We would like to take this opportunity to thank your staff for the co-operation and courtesy extended during the course of audit.

Please do not hesitate to contact us, should you have any queries.

Thank you.

Yours truly,
D K Wambua & Associates
Certified Public Accountants

Dennis Wambua
Managing Partner

Encl: Three (3) originals and three (3) copies

5th Flr Suite 1, Tembo Co-oporative House, Moi Avenue.
P. O. Box 5957 - 00100 Nairobi Kenya. Tel: +254-20-2514799 Cell:+254 722 771 411, +254 736 801 64
Email: info@dkwambua.co.ke, dkwambua.associates@gmail.com
Kisii Branch 2nd Flr, Magson Plaza,Room 8, P. o. Box 3086-40200 Kisii

STIER VENTE ASSOCIATES
CHARTERED ACCOUNTANTS

50 Olof Palme Street
P.O.Box 90001, Klein Windhoek
Tel: 061-264440/60/80
Fax: 061-264490
e-mail: admin@svcaam.com

INDEPENDENT AUDITOR'S REPORT

TO THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

ON THE FINAL SUB-PROJECT MONITORING REPORT IMPLEMENTED BY THE AFRICA HUMANITARIAN ACTION NAMIBIA, 0000000020/14101/1073021, FOR THE OPERATIONAL YEAR ENDED 31 DECEMBER 2012

We have audited the final Sub-Project Monitoring Reports for Sub-Project Africa Humanitarian Action Namibia dated 31 December 2012, 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 Standards of Auditing. 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 2012, showing donations received totaling N$ 9 795 000 fairly presents the state of affairs of the Sub-Project for the year under review in accordance with the accounting requirements set out in the Sub-Project Agreement.

Stier Vente Associates

STIER VENTE ASSOCIATES
REGISTERED ACCOUNTANTS AND AUDITORS
CHARTERED ACCOUNTANTS (NAMIBIA)

Per: B VENTE
Partner

WINDHOEK, 15 February 2013

Partners: Hilma Gunther Vente, Bernhard Vente, Johan Lourens, Arno Stier

PKF Liberia

PKF
Accountants & business advisers

INDEPENDENT AUDITOR'S REPORT

TO THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

AFRICAN HUMANITARIAN ACTION
January 1, 2012 to December 31, 2012
Health Care to Refugees, Sub-Project Symbol: 2012/11221/1LBRD/1073021

Report on the Implementing Partner Financial Monitoring Report

We have audited the accompanying Implementing Partner Financial Monitoring Report (IPFMR) of African Humanitarian Action, which comprises the statement of revenue and expenditures and supporting schedules for the year ended December 31, 2012.

Management responsibility for the Financial Monitoring Report

Management is responsible for the preparation and fair presentation of the Implementing Partner Financial Monitoring Report in accordance with US Generally Accepted Accounting Principles (US GAAP) and for such internal control as management determines is necessary to enable the preparation of financial statements that is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on the financial monitoring report 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 about whether the financial statement is free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statement. The procedures selected depend on the auditor's judgment, including the assessment of the risk of material misstatement of the financial statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of the accounting estimates made by management, as well as evaluating the overall presentation of the financial statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Tel +231-886-510 562 · 231-886-510 603 · 231-886 835-784 · Email: pkfliberia@pkf.com.lr · pkfliberia@yahoo.com
PKF Liberia · Randall Street · Lara Building · Fourth Floor · Suite 41 · P.O. Box 10-3635 · 1000 Monrovia 10 · Liberia
contact Person: Nim'ne E. Mombo Sr., Managing Partner & Prof. D. Ansu Sonii Sr., Partner

PKF-Liberia is a member firm of the PKF International Limited network of legally independent firms and does not accept any responsibility or liability for the actions or inactions on the part of any other individual member firm or firms

Opinion

In our opinion, the accompanying Implementing Partner Financial Report referred above, presents fairly, in all material respects, the amounts of revenue received and expenditures made by African Humanitarian Action during the year ended December 31, 2012.

PKF-Liberia
Accountants & business advisers

Monrovia

April 9, 2013

2012 Auditors

AHA Burundi: AD Experts–Conseil

AHA Cameroon: MOHY & Co. Le Counseil au service des organizations

AHA Ethiopia: Getachew Kassaye & Co. Chartered Certified Accountants

AHA Head Office: A.A Bromhead & Co. Chartered Accountants and UK registered Auditors

AHA Liberia: PKF Accountants & Business Advisors

AHA Namibia: Stier Vente Associates Chartered Accountants

AHA Rwanda: Price Waterhouse Coopers

AHA Somalia: D.K. Wambua & Associates, CPA

AHA Sudan: H.A.S.M Certified Accountant & Financial Consultant

AHA Uganda: Deloitte & Touche Certified Public Accountants

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 Somalia
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 several 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.

How to Support AHA

Financial 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

AHA also accepts in-kind assistance from its supporters. To find out how you can get involved, contact us: info@africahumanitarian.org

Twitter.com/@ahaction
Facebook.com/AfricaHumanitarianAction

Credits:
Cover photo: AHA Burundi Country Office
Back-cover photo: AHA Somalia Country Office
James Seigel: www.jamesseigel.com
Michael Tsegaye: www.michaeltsegaye.com
Data and facts: United Nations High Commission for Refugees; UNAIDS; US Government
Printed by Central Printing Press



Burundi
burundi@africahumanitarian.org

Cameroon
cameroon@africahumanitarian.org

DR Congo
drcongo@africahumanitarian.org

Ethiopia
ethiopia@africahumanitarian.org

Kenya
kenya@africahumanitarian.org

Liberia
liberia@africahumanitarian.org

Namibia
namibia@africahumanitarian.org

Rwanda
rwanda@africahumanitarian.org

Somalia
somalia@africahumanitarian.org

South Sudan
ssudan@africahumanitarian.org

Sudan
sudan@africahumanitarian.org

Switzerland
geneva@africahumanitarian.org

Uganda
uganda@africahumanitarian.org

USA
us@africahumanitarian.org

Zambia
zambia@africahumanitarian.org

AHA Head Office
PO Box 110, Code 1250
Addis Abeba, Ethiopia
T: +251 (0)11 551 -1224/ -3541
F: +251 (0)11 551 38 51
info@africahumanitarian.org

www.africahumanitarian.org