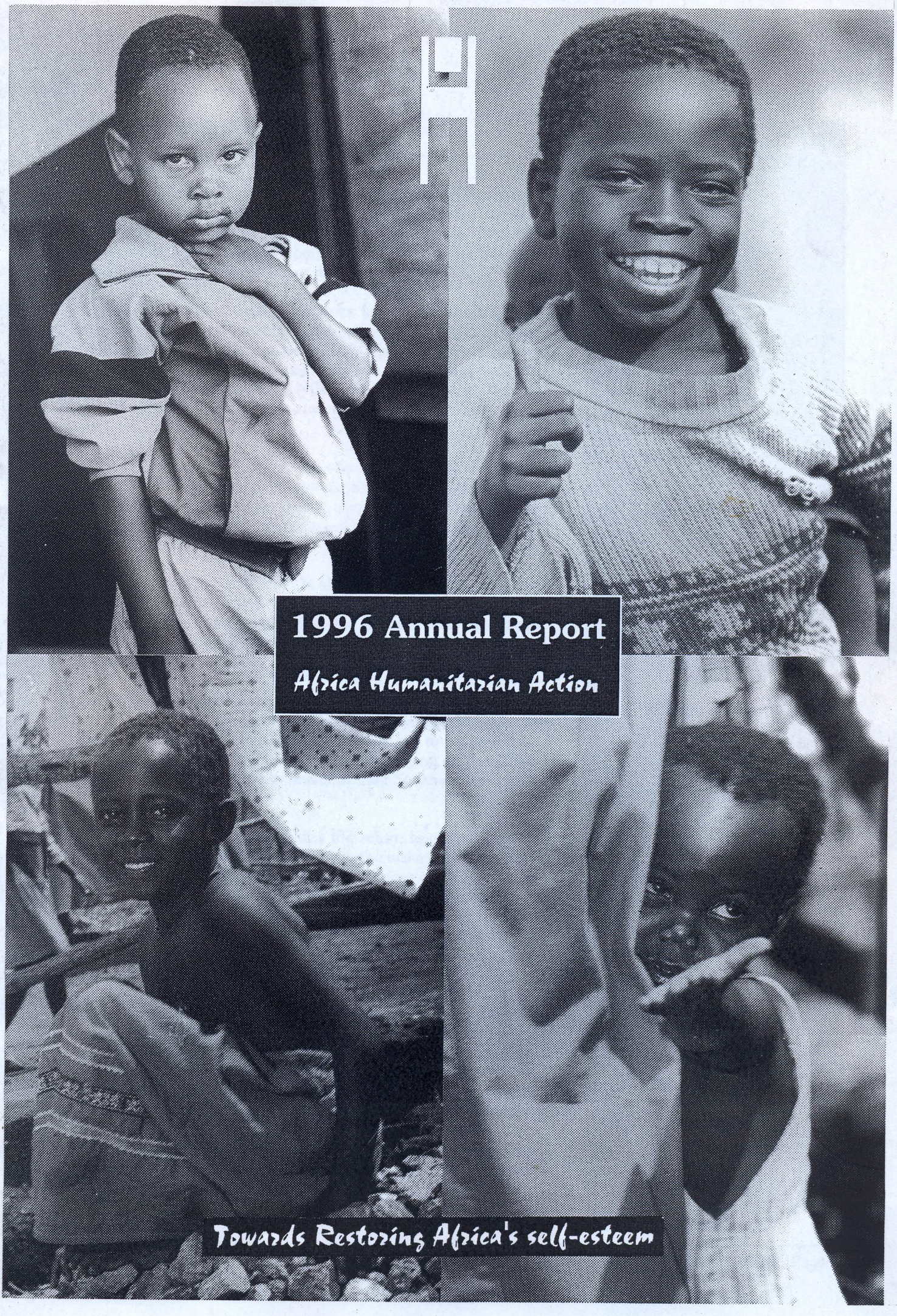


1996 Annual Report

Africa Humanitarian Action

Towards Restoring Africa's self-esteem

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THE YEAR IN REVIEW

The year 1996 has ended and, we can confidently look back to say it was a rewarding one for AHA. Not only did we consolidate our operations in Angola, Ethiopia, Rwanda and Uganda, but we charted new courses in our interventions, moving into areas that we hadn't tackled before.

It was not all smooth sailing however. In Uganda, security concerns remained uppermost throughout the year. Insurgency in the north of the country became particularly bloody between February and April when security precautions were put in place for U.N. agencies and the international NGO community. In July, 108 Sudanese refugees in the Kitgum area near the border of Sudan were shot dead by rebels.

Then in October AHA, along with other aid agencies, was forced to evacuate its international and senior staff from Adjumani in East Moyo to the Ugandan capital, Kampala, some 400 kms to the south. This occurred following a rebel assault on the UNHCR suboffice and on other NGOs.

The direct attack on the UNHCR facilities was the first of its kind in that area and represented a violation of the sanctity of the UN. Several persons were murdered in the incident and 14 vehicles belonging to the UNHCR and its implementing partners were torched by the insurgents.

During the evacuation, which lasted 10 days, AHA's team leader shuttled by air daily between Kampala and Adjumani to supervise the activities of the Ugandan staff. We would like to pay particular tribute to those personnel for courageously staying on and shouldering their responsibilities in favour of their Sudanese wards during those trying times.

Another major event in 1996 was the return home of a tide of Rwandese who had fled their country in the wake of the infamous genocide two years ago. Most of the returnees came from Zaire and Tanzania. Three-fourths of a million people were estimated to have returned. AHA was among the first international NGOs at Gisenyi, the north Rwandese town on the border of Zaire. To assist this massive influx AHA deployed a mobile team of international doctors and nutritionists.

The refugees had been on the move in Zaire since mid-September when fighting broke out between the government army and Banyamulenge rebels opposed to the Kinshasa regime. Even before the commencement of the refugees' journey home, AHA had been among a group of nine international NGOs invited by the authorities to play a role in responding to the crisis in eastern Zaire.

AHA's staff subsequently pitched tents at appropriate locations on the exiles' 155-km long return route to Kigali, providing curative services, and providing food and water to those in need. The



Africa Humanitarian Action

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Mr. Chefeke Dessalegn

Mr. Jean-Pierre Hocke

Chief Olesegun Olusola, mni,

Mr. Anders Wijkman

Dr. Dawit Zawde

DIRECTORS

Dr. Dawit Zawde
President

Mr. Constantinos Berhe
Senior Vice President

Dr. Getachew Demeke
Second Vice President

AHA international team of doctors drew up a longer-term strategy to address the multi-faceted requirements of the returnees. Over 50% of the repatriates were to live in the districts where AHA has operations.

These events aside, AHA operations experienced healthy expansion overall. The most significant changes occurred in Rwanda and Uganda. In the former, we took over the management of one of the largest district hospitals in the country, Mugonero Hospital in Kibuye Prefecture.



■ *Providing Medical care*

Mugonero Hospital was once a flourishing and reputable institution. After 1965 it fell into disrepute due to neglect and poor management. After the 1994 genocide the institution was in even worse condition as buildings were ransacked and valuable hospital equipment was looted or destroyed.

Upon taking over the hospital, which lies 167 kms west of Kigali, AHA proceeded to renovate, re-equip, re-staff and reorganize. As a result, near normal medical services were resumed for the first time in more than three decades. Upto 60 outpatients are now served daily, sixfold from a year ago. Inpatient service for the 200-bed hospital has also grown.

In 1996 AHA's operations in North Kigali Rural and in the Prefecture of Kibungo were strengthened by the addition of three more health centres. Rutare, Cyarubare and Mulindi health centres were transferred to AHA. Today there are a total of five clinics under AHA management. Given the massive influx of Rwandese refugees into the district last year, the full rehabilitation and restoration of these health centres was of the utmost importance.

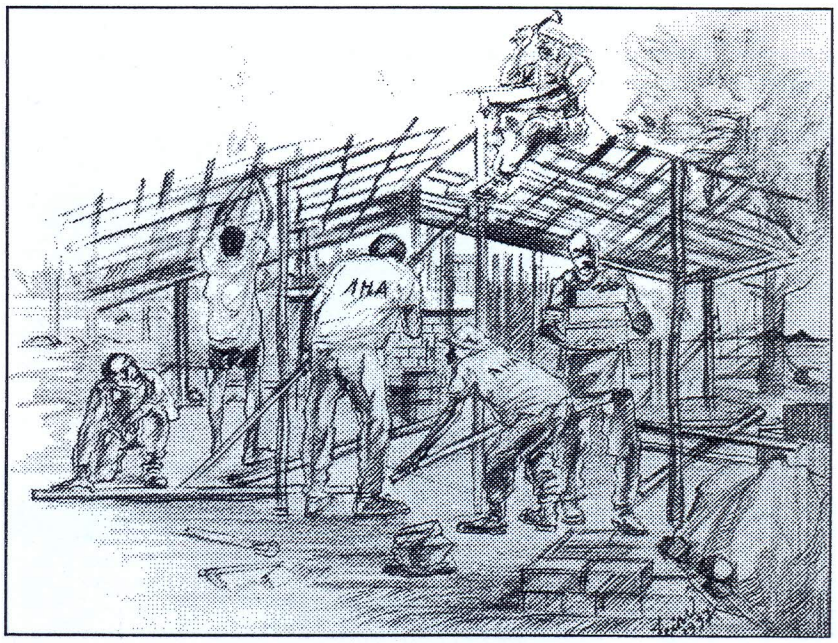
In 1996, AHA made a breakthrough, venturing into shelter development in Rwanda. The provision of food, shelter and clothing are an integral part of the AHA mission. The housing project was initiated to address the needs of displaced people and those repatriated after 1994, especially vulnerable groups such as widows, the handicapped and families caring for orphans.

The goal was to quickly build affordable but durable houses for 360 families in Musasa, Rushashi and Tare communes. To accomplish this, AHA imported appropriate and cost-effective adobe brick technology enabling one family to own a home for the cost of less than US$1,000. This project was so successful that another 700 units are to be built this year. The demand for housing in the country, already weighed down by a huge backlog, increased tremendously after November when the returnee population exploded. In 1997 AHA expects to play a greater role in ameliorating this severe problem in Rwanda and other African countries.

In Uganda, AHA launched new development ventures in East Moyo district where the refugee population we cater to has risen to well over 15,000. Another 5,000 Ugandan citizens fall under the AHA umbrella. The Ugandan health system allocates one health centre per 5,000 inhabitants. AHA, in theory, has to build three additional clinics to

comply with existing regulations. During the year, the agency began the construction of a second dispensary at Aliwara settlement, located 10 kms away from its first clinic in Mongula. In addition, AHA was given charge of two health posts at Kolididi and Mirieyi in the same sub-county. The completion and/or gradual reinforcement of these facilities will boost disease surveillance and control for the growing Sudanese refugee community.

Today a sound basis for mutual trust and confidence has been established between all the parties - donor, implementing partner and the beneficiaries; this is a significant accomplishment. In fact, negotiations to open up new opportunities for AHA in the same area have been in progress. Presently the prospects for AHA intervention in the new settlement of Magi look good.



■ *Venturing into shelter development*

Now that 1996 is behind us, what of 1997? We have gained sufficient experience to enable us to identify priorities and prevailing needs not only of the African countries we work in but also of the African continent as a whole. The following areas will continue to claim the focus of our attention:

EMERGENCY RESPONSE

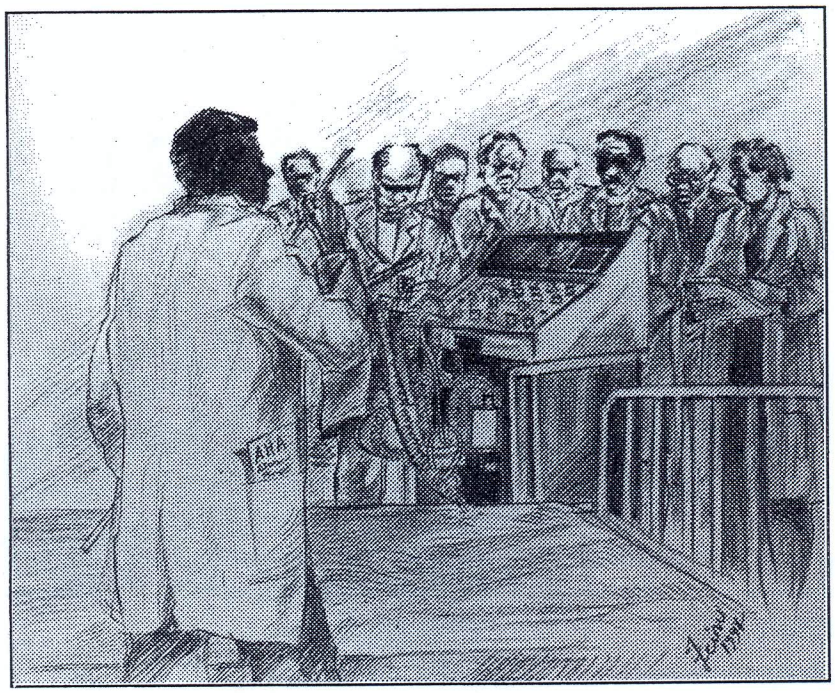
In crisis conditions AHA has intervened to fill the vacuum in the face of scarce manpower resources. AHA has been providing health care and rehabilitating health infrastructure, both of which are essential elements in promoting national reconstruction. To AHA the satisfaction of basic human needs is the cornerstone of human development. This is a lesson drawn from the long tenure of its professionals in the service of famine and disaster victims; refugees and the displaced; returnees and other vulnerable groups, such as women, children, the aged, the handicapped; and the survivors of violence and torture. Enhancing the coping mechanisms of these groups so they can withstand future adversity is a priority for AHA.

CAPACITY DEVELOPMENT

Improving skills is paramount for AHA. Upgrading existing skills, training nationals in new technology as well as strengthening and reinvigorating the national institutions takes precedence wherever the agency intervenes. The reconciliation process in wartorn countries is long; it does not permit a rapid return of the brain drain that saps African nations. New talent must be provided and developed to fill the gap. AHA tries to make its tenure in crisis ridden countries as short as possible. The speedy empowerment of nationals is therefore a top priority.

REHABILITATION, RECONSTRUCTION AND DEVELOPMENT

Rebuilding and rehabilitating infrastructures, destroyed by war or natural calamities, and engaging in new development endeavours have been features of AHA intervention. In Angola, Rwanda and Uganda thus far AHA has focused on the rehabilitation and development of the health infrastructure, improving health centres and hospitals. Lately we have ventured into other sectors such as shelter development and demining operations. These are community-based, enhance self-help potential, and reduce dependence on external assistance. They are helpful to refugees and displaced people who stand to gain from new techniques and skills. Greater AHA involvement in reconstruction and development may be anticipated as we look ahead.



■ *Training towards capacity development*

PSYCHO-SOCIAL TRAUMA MANAGEMENT

Ever since its intervention in Rwanda in 1994, AHA has recognized the need to address the problem of psycho-social trauma afflicting perhaps hundreds of thousands of people. Within a month of entering Rwanda, the agency recruited a specialist in this field to launch a pilot project. The savagery of the genocide in Rwanda and the violence of civil war in Angola and Ethiopia has left so many traumatized. Trauma counselling is part of AHA's ongoing activity. We must set up institutions that can serve isolated regions as well. To that end, we have prepared and circulated projects that seek the establishment of centres for the treatment of violence-induced mental disorders. These projects are to be launched in Rwanda and Ethiopia, but could serve the trouble-prone Horn of Africa and the Great Lakes regions.

PEACE AND CONFLICT RESOLUTION

In Rwanda AHA was instrumental in providing the first forum for an open discussion of the 1994 genocide. Since, AHA has convened a series of conferences and symposia to advance peace and reconciliation. The agency is now set to organize a roundtable meeting for the embattled rivals in Burundi. To consolidate the contributions made to peace and development, AHA will have programmes that will empower conflict-affected communities. These programmes will hopefully promote the concept of dialogue as a force of peace.

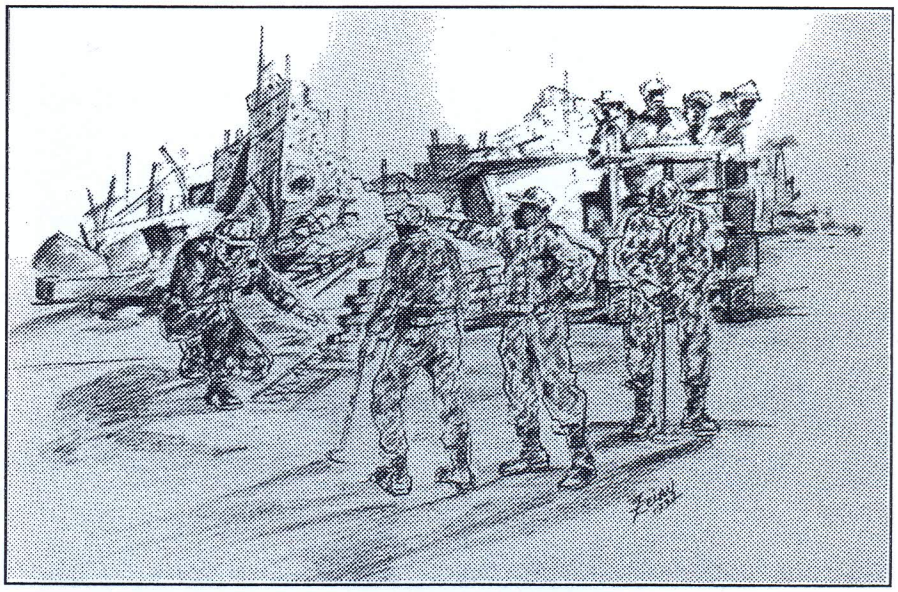
MINE AWARENESS

Since April 1996, mine awareness has become one of AHA's area of activity. We have printed Mine Awareness booklets and posters in several languages. These materials have been widely distributed in Angola and Uganda. The French version is to be distributed in Rwanda and Burundi.

MAJOR OPERATIONS

ANGOLA

In November 1994 the Lusaka Protocol promised a new era of peace for Angola. For nearly twenty years a guerrilla war had devastated the country and its wealth. The civil war had claimed tens of thousands of lives and left in tatters a country with enormous riches and enviable opportunities.



■ *Demining*

With considerable oil reserves, diamonds, copper, uranium, iron ore and manganese, Angola has the potential to develop into the Biblical land of milk and honey. Its sparse population - 9.5 million people in a land area of 1,246,700 sq. km - has created one of the highest per capita incomes on the continent, at 600 U.S dollars in the late eighties. Statistics for the same period give a balance of payments surplus of 600 million U.S. dollars a year.

In October 1995, AHA moved into Angola, once again the first African NGO to enter a stricken African country. AHA was part of the huge international effort mobilized to launch an integrated plan to end the Angolan crisis. The agency was given a role in the health sector following a tripartite agreement with the Angolan government and the U.N. High Commissioner for Refugees. AHA's mission was to support the restoration of the health system through the injection of administrative, medical and technical expertise. The recipients of this aid were an estimated 300,000 refugees expected to return home.

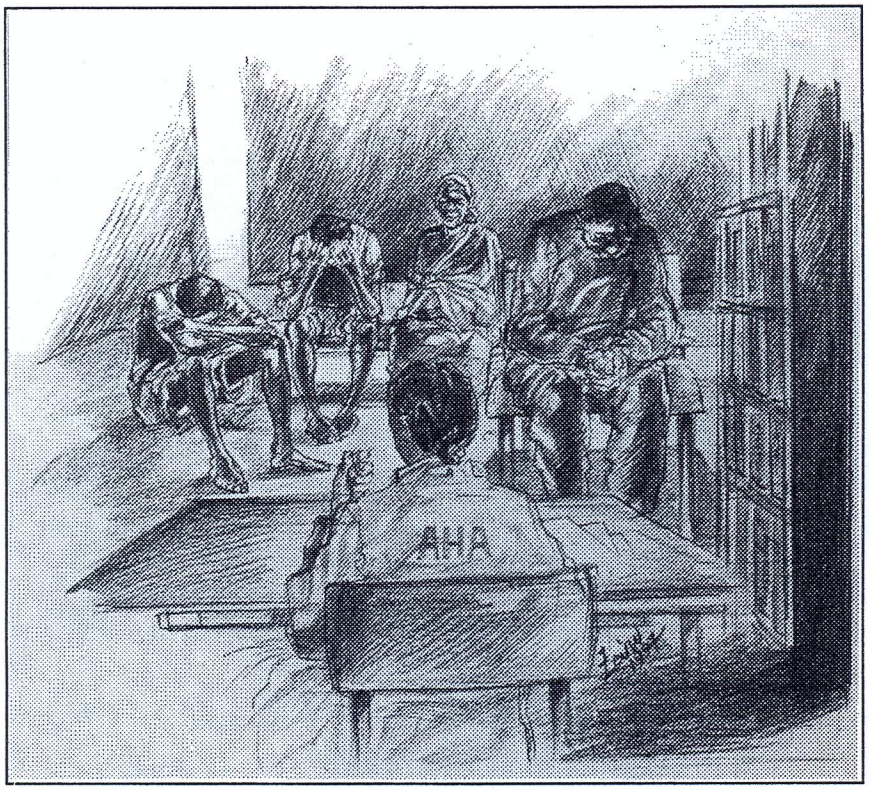
Although intervention was risky, AHA committed resources and personnel immediately. The agency first deployed in Moxico Province bordering Zambia in the east, then took over Cazombo Municipal Hospital and its nine satellite clinics. From mid-1996 the agency assumed management control of yet another municipal hospital and its 19 satellite posts; this time in Lumballa Nguimbo in the southern part of the same province.

Health service was virtually at a stand still when the AHA team first arrived. Settling down in makeshift, ramshackle housing facilities, the team went to work at Cazombo Hospital. Cazombo is located in Angola's cool central plateau region, which covers two thirds of the country. The target population included returnees and internally-displaced persons, the primary responsibility under AHA's commission. However, it was impossible to exclude the indigenous people who had survived the war under difficult circumstances.

The medical component of AHA's intervention was as comprehensive and qualitative as the circumstances allowed. The more successful operation was implemented in Cazombo. In the area of construction, the hospital was fully renovated, equipped, furnished and

restored to service. All but major surgical operations could be carried out at the end of 1996. The AHA surgeon in charge of the hospital was already conducting operations - swellings, hernia, hydrocele, appendectomy, Caesarian sections, cystostomy and fractures.

The fall in the morbidity pattern at Cazombo speaks for the remarkable success achieved by AHA. The rise in the population figure (not withstanding the number of outpatients treated at the hospital) fell by 50% at the end of 1996. The mortality rate stood at 2.3% at the end of 1996 from a high of nearly 5%.



■ *Pyscho-social trauma counselling*

RWANDA

As the crisis surrounding the 1994 genocide in Rwanda receded slowly and gave way to a period of pacification and reconstruction, there was a sigh of relief - the worst was over. The worst was indeed over. A chapter had been closed on one of the most horrifying carnages in recent times. Yet peace and reconstruction could scarcely succeed without a process of reconciliation. This prospect had seemed elusive when another emergency broke out in late 1996 when hundreds of thousands of Rwandese refugees streamed home from neighbouring countries.

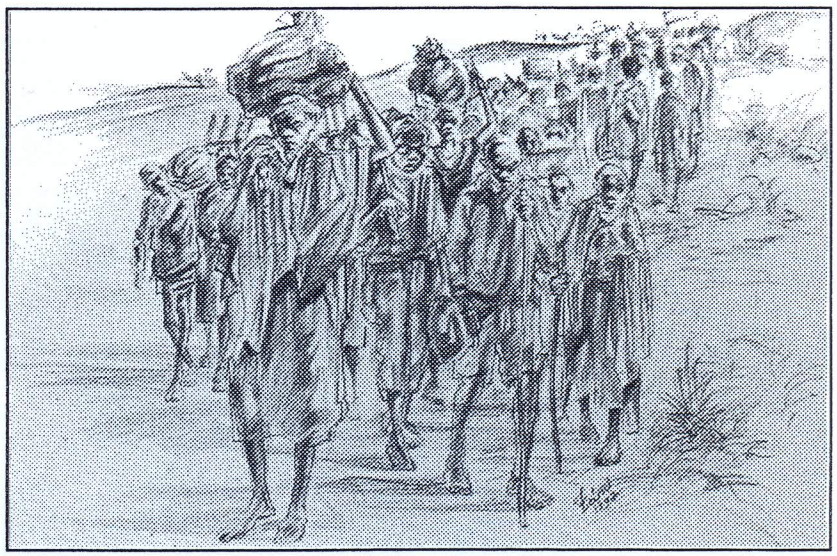
Africa Humanitarian Action (AHA) had responded to the crisis conditions of 1994 by providing a disaster response. In November 1996, when the massive influx of refugees overwhelmed Rwanda again, the agency came back with new initiatives, seeking more durable solutions. The shifting priorities elicited actions that suited the new conditions in a way that adequately demonstrated the agency's capacity for flexible response.

AHA, the only Pan African NGO operating in the country, was a prominent actor throughout. In 1994, it was among the first groups to land in Rwanda to address the critical situation born out of the genocide. Rwanda, at that time, was in physical and spiritual pain due to the legacies of the civil war. The AHA response came in the form of emergency life-saving health care, delivered to the tens of thousands of refugees and internally-displaced.

AHA, in an attempt to restore good governance, organized workshops and seminars for government officials at various levels. This exercise was important considering the vacuum created by the exodus of thousands of qualified Rwandese in virtually all key professions.

The restoration of political, economic and social activity - as part of the policy of re-integration and reconciliation - could not take place without the conscious development of the nation's manpower capacity.

Another concern for AHA was the presence of large numbers of people traumatized by the savagery of the Rwandan carnage. Many thousands of women and children had become sleepwalkers after their experiences in 1994. AHA, in response, offered professional counselling and treatment for torture, rape and victims of violence.



■ *Refugees returning home*

Once the initial emergency period was over, the Rwandan Health Ministry, and the U.N. High Commissioner for Refugees (AHA's funding partner) invited the agency to play a bigger role in the health sector. This was just after a new national policy began requiring health sector NGOs to manage health districts in the country. Accordingly, AHA was given management responsibility for the health district of Rwinkwavu in Kibungo Prefecture, in the east of the country, and of Mugonero health district, in Kibuye Prefecture, in the west. The hospitals, health centres and posts within the districts automatically reverted to the operational control of the NGOs invited by the authorities.

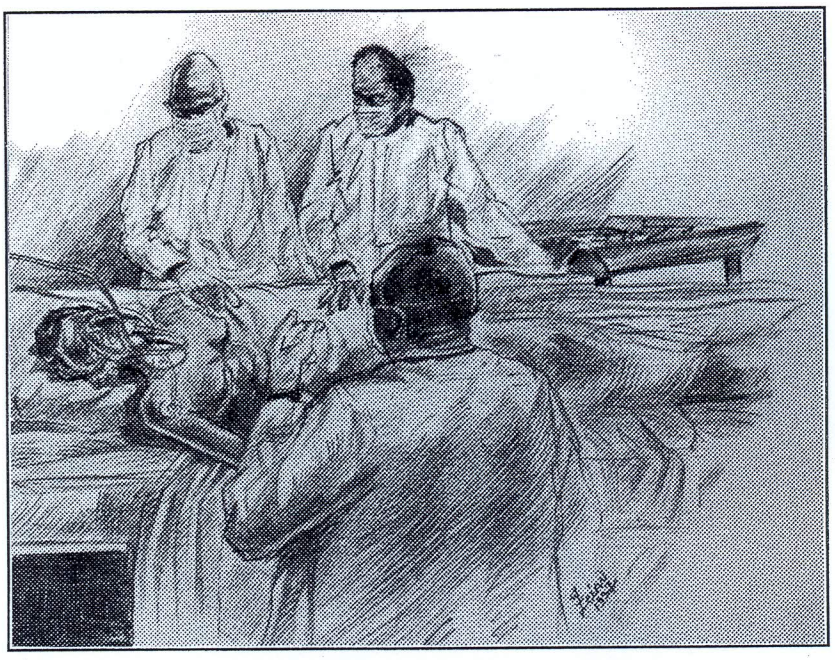
UGANDA

Northern Uganda is an area with many Sudanese refugees. As a result, the UNHCR is often present in the region. In Northern Uganda, in 1991 there were 80,000 Sudanese refugees; in 1992 92,459; in 1993 180,366; and in 1994, 234,134. Concerned by the growing influx, the Uganda government , in 1995, became the first African country to offer refugees land for permanent settlement.

The UNHCR invited a number of international NGOs to work with the authorities. The aim was to make the exiles self-reliant. In July 1995, AHA was one of the NGOs stepping in to support the initiative. The agency set up a coordination office in the Ugandan capital, Kampala, and operational bases in Adjumani and Mongula, in the district of East Moyo (about 25 kms south of the Sudanese border). AHA has remained there since.

AHA's 1996 operation was in essence a continuation of the 1995 programme. In 1996 AHA played a bigger role in such fields as infrastructural development. The Agency took control of two health posts previously under the management of *Medecin sans Frontiers* - Swiss (MSF) at Kolididi and Mirieyi. This brought an additional 5,307 refugees into AHA's health care coverage.

While the agency may not take the credit alone, the relatively low crude death rate at 3.13/1000 for the dispensary and its satellites - shows that the morbidity and mortality levels in the settlements have been brought under control. The average crude death rate for developing countries is 20 per thousand.



■ *At a health post*

AHA participated in four major immunization campaigns in 1996. The first was in response to epidemic-size outbreaks of measles in non-refugee villages in April, June and September. Nearly 8,000 children were immunized, with a 100% coverage achieved in the last drive in September. Then, in December, AHA joined forces with the government in a battle against polio

In 1996 cooperation between AHA and its partners in Uganda - the government, the UNHCR and other NGOs - was exemplary .We hope the same spirit of mutual support and collaboration will prevail in 1997.

PROSPECTS FOR 1997
BURUNDI, GUINEA, LIBERIA AND SIERRA LEONE

AHA is poised to take up new challenges in 1997. The year will see AHA's intervention in Burundi, Guinea, Liberia and Sierra Leone.

In Burundi, in 1996, AHA carried out needs assessment missions to help establish a framework for assistance in the health sector. Contacts have already been established with the concerned authorities, who have expressed their approval of AHA's intervention in the districts of Ngozi and Kayanza . In the two districts, the disruption of the health services has increased the health related problems in the surrounding communes.

AHA is to set up a Country Office in Bujumbura. This will be followed by a convention that will enable Burundi's civic and government leaders to address the various problems the country faces.

In West Africa, AHA is establishing itself in Sierra Leone, where it will soon deploy a team of professionals. The agency is to promote sound health care practices among refugees, returnees, the internally displaced and the community of Kambia District in Sierra Leone. AHA's office in Sierra Leone will serve as a base for its operations in Liberia and Guinea.

AFRICA HUMANITARIAN ACTION STATEMENT OF INCOME AND EXPENDITURE FOR THE YEAR ENDED 31 DECEMBER, 1996

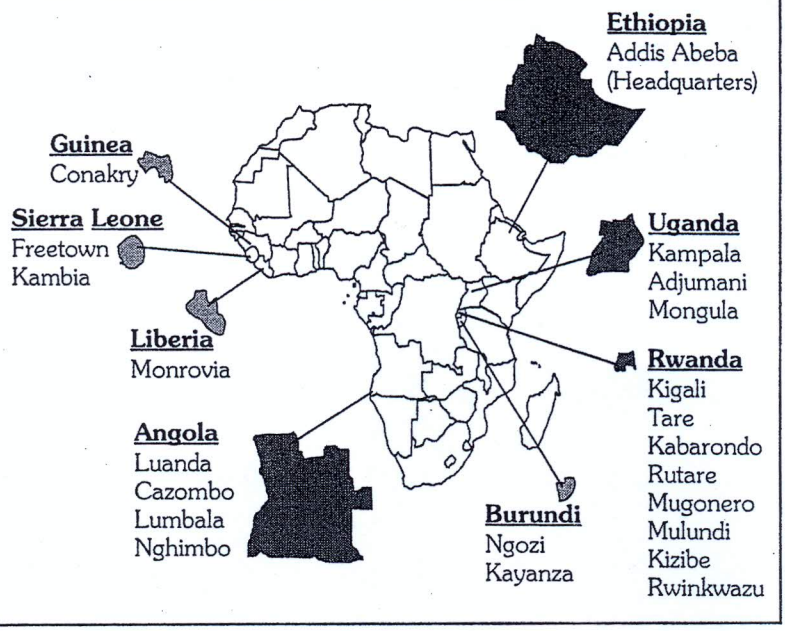
INCOME

Head Quarter			
Contributions			
Excess cash from 1995	USD	3,826.00	
Organizations		71,428.57	
Rwanda			
Contributions		740,416.00	
Organizations			
Uganda			
Contributions			
Organizations		526,149.76	
Angola			
Contributions			
Organizations		777,350.00	
			2,119,170.33

EXPENDITURE

Head Quarter			
Office furniture & equipment		7,815.57	
Office running cost		82,956.20	
Rwanda			
Administrative		24,000.00	
Health & nutrition, housing & rehabilitation		710,708.22	
Uganda			
Administrative		15,300.00	
Health/nutrition & construction		510,406.73	
Angola			
Administrative		66,803.00	
Health/nutrition & rehabilitation		710,018.00	
			2,128,007.72
Excess of Income over Expenditure			1,162.61

AHA OPERATIONS



MAJOR DONORS

American Joint Distribution Committee/**AJDC**

Operation USA

Organization of African Unity/**OAU**

United Nations Development Program/**UNDP**

United Nations Economic Commission for Africa/**ECA**

United Nations Fund for Women/Africa Women in Crisis umbrella programme/**UNIFEM/AFWIC**

United Nations High Commissioner of refugees/**UNHCR**

Numerous individuals

PARTNERS

Africa Refugee Foundation/**AREF**

Ajibulu Moniya Gallery
Plot 49
Babs Animashaun Extension
S/Lere
Lagos, Nigeria

AHA - THE ORGANISATION AND ITS MISSION

Africa Humanitarian Action (AHA) is a private, non-profit, non-sectarian and non-governmental humanitarian organisation based in Addis Abeba, Ethiopia. Its corporate mission is to provide emergency relief and sustained development assistance to distressed communities affected by disasters and conflict. AHA approaches this task directly; it also tries to empower communities to cope with adversity.

AHA was established, in the aftermath of the cold war, by African professionals with a proven track record in disaster relief, recovery, and management. It is one of the first regional voluntary agencies which is African in conception, in spirit and in composition. It is dedicated to serving the continent as a whole.

Its main objectives are the following:

- To provide humanitarian relief and sustained development support to distressed communities in Africa
- To equip displaced people and refugees with the basic skills necessary to deal with disaster situations
- To develop indigenous capabilities in disaster prevention, preparedness, relief management and recovery
- To create and assist independent, non-profit, non-sectarian and non- governmental organisations in the countries of Africa that embrace its own ideals and objectives
- To research, develop, and disseminate information and policies - involving governments, institutions, and local communities - that are aimed at reducing the scope and scale of conflict, and the prevention and resolution of conflict
- To set up a database of readily available African professional resources for relief and sustainable development initiatives

AHA came into existence in the post-cold war years, at a time when the priorities of its traditional partners in the west seemed suddenly to shift in favour of central and eastern Europe. Africa appeared poised to enter the 21st century overwhelmed by donor fatigue, deeply marginalised and even more vulnerable than it already was.

AHA's founders are convinced that the fundamental responsibility of alleviating the worsening crisis in Africa belongs to Africans. They need to grapple more with the effects of calamities. Africans should not only be seen working alongside their international partners in humanitarian work; they should also take the lead in coming to the assistance of their fellow Africans.

The debate about Africa's failures and who is to blame has gone on for far too long. That debate has bred a sense of dread, despair and inferiority in the minds of Africans. In every facet of human endeavour, in science and technology, in economics and finance, and in the humanities, the African psyche is burdened by a sense of defeat. AHA intends to show that Africans on their own are capable of achievement. Success here will in some small measure restore to Africans their self-esteem. The opportunity provided by AHA to Africans from diverse countries and cultures to work together in crisis situations will doubtless contribute to the peace, harmony, and unity we all crave for our continent.

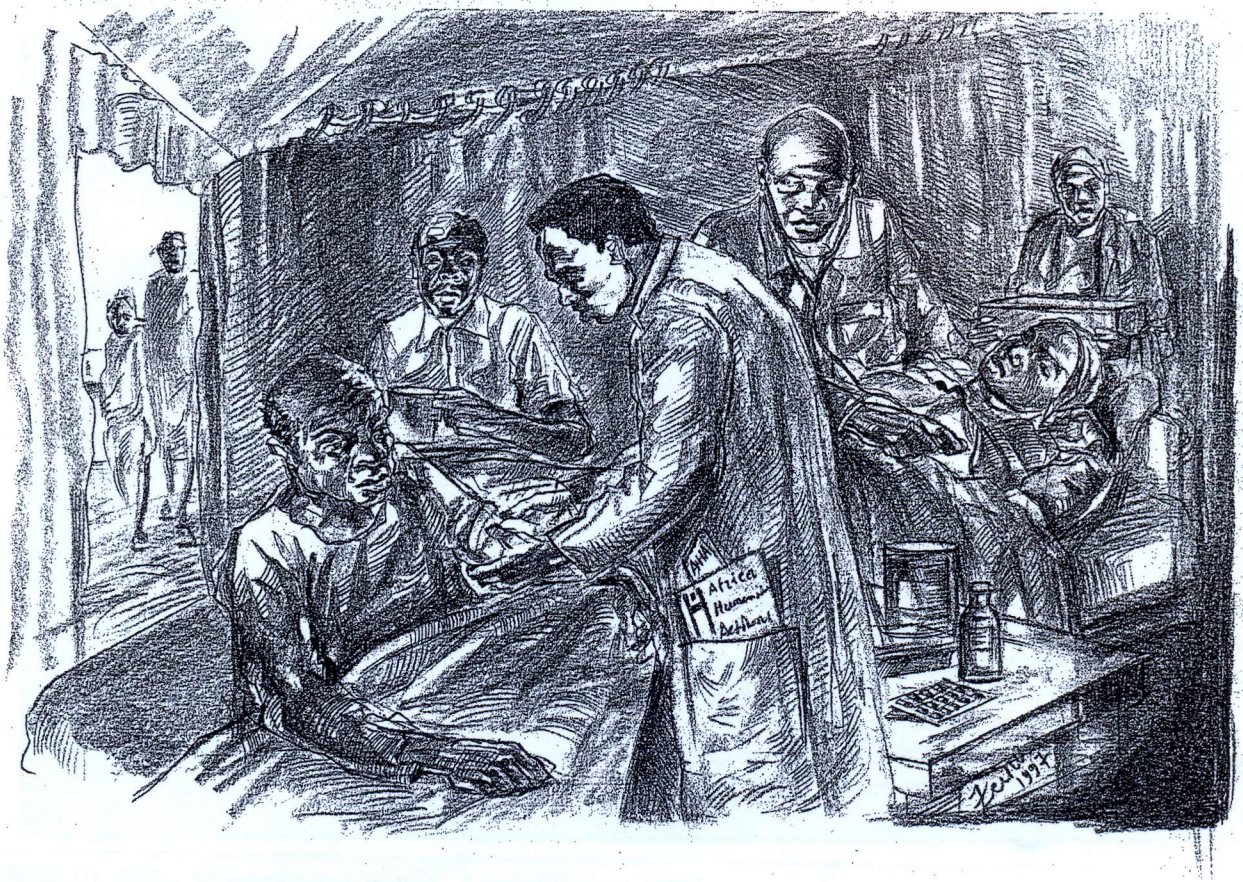
AHA has, within one year of operation, been able to attract the support of the United Nations system, the Organisation of African Unity, and a number of bilateral and multilateral funding sources for its varied humanitarian activities.

The agency operates out of its headquarters in Addis Abeba, Ethiopia. Its core group of professionals in refugee and health care, disaster control, long-term development management as well as conflict prevention and resolution is ready for deployment at a moments notice.

AHA is headed by a Board of Directors that maps out policy. The President, whom the Board appoints, conceptualises, articulates, plans and executes that policy. The President is assisted by two Vice-Presidents who co-ordinate the implementation of programme activities and supervise projects.

An International Assembly of Trustees advises and supports AHA's Board of Directors.




Africa
Human
Action

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The future could be bright!
We have to work hard at it.

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If you would like to support AHA's activities, donations can be sent to P.O. Box 6398, Addis Abeba, Ethiopia or funds can be transferred directly to the following bank accounts:

c/o The Commercial Bank of Ethiopia
Addis Abeba
Africa Hall Branch
Account number C/A 3712-609-6470-4 (Birr)
or to
The International Banking Division
Account number C/A 6050092-2 (Foreign currency)