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Coping with Crises

How providers can meet reproductive health needs in crisis situations

CCP, Courtesy of Photoshare

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Photo: Reproductive health care needs in crisis situations should not be neglected. A tsunami survivor and her newborn receive care in a tent in Aceh, Indonesia.

Key Points

Around the world, conflicts and natural disasters challenge health care providers to meet people's basic needs, including reproductive health care, under the most difficult conditions. What can local health care providers do when crisis strikes?

Know what to do. The materials that guide international humanitarian relief providers—particularly the Inter-Agency Field Manual and its Minimum Initial Service Package (MISP)—can inform local providers of the reproductive health care needs of refugees. Kits of supplies that are part of the MISP can be ordered. Disaster preparedness training courses can help providers and government officials respond effectively when crises occur.

Plan ahead. Make emergency preparedness plans that consider staffing, logistics, supplies, infrastructure, establishing relationships with news media, and coordination with other organizations. Plan for contingencies.

Offer care immediately if a crisis occurs. Coordination is desirable but takes time, while health needs are urgent and great.

Collaborate with international relief agencies as soon as possible to help provide sustained, integrated emergency care. Offer whatever skills, services, and knowledge you have.

Coordinate with other relief and health care organizations for efficiency and speed. One organization or person should serve as the focal point for reproductive health care.

Focus on refugees not living in camps. Refugees dispersed among the host communities need as much help as refugees in camps, and local organizations may be able to serve them better than relief agencies can.

Seek help from the survivors. Some refugees may be health care professionals themselves. Often, they can contribute their skills to care for others.

Work toward recovery. When the international relief workers leave, local health care organizations and providers take back the full responsibility for serving people's needs. With adequate support, capable health care services with a strong reproductive health care component can speed the transition from relief to recovery.

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Crises Pose Major Challenges for Reproductive Health Care

Every year armed conflicts and natural disasters kill hundreds of thousands of people and inflict great suffering. Armed conflicts tear societies apart and disrupt people's lives, often for years. Natural disasters devastate whole regions without warning, as the December 2004 Asian tsunami, the August 2005 New Orleans hurricane, and the October 2005 Pakistan earthquake have demonstrated. Health care systems, often struggling to meet people's needs in the best of times, can be quickly overwhelmed by the added burden of injury and infectious diseases. At the same time, health systems themselves may be crippled by disaster or conflict.

EC/ECHO, New Delhi/Alam Aftab

Contrary to common perception, the needs of refugees who are dispersed within local communities are usually greater than those living in camps. Survivors of the October 2005 Pakistan earthquake, seen here, receive blankets at a relief distribution site.

As a result, many people's reproductive health needs—including safe motherhood, protection from and response to sexual and gender-based violence, prevention and treatment of HIV/AIDS and other sexually transmitted infections (STIs), family planning, and adolescent reproductive health—are often neglected. Unless concerted attention, effort, and resources can be mobilized, meeting people's immediate needs becomes impossible, and many lives are put at risk.

Refugees dispersed within communities depend on existing local services.

As of mid-2005 some 45 countries, predominantly in Africa and Asia, faced crises related to armed conflicts or natural disasters (123). Today, nearly 40 million people have fled their homes as a result of conflicts and now are living as refugees outside their countries or, more often, as displaced people within their own countries. Natural disasters affect millions more (see box, pp. 4–5).

Although the United Nations (UN) formally distinguishes refugees from internally displaced persons (IDPs), according to whether or not they have crossed an international border (*106*), in general, this report uses the term "refugees" to include all people displaced by crises, whether internationally or within their own country. Whatever their status, people who have been uprooted by armed conflicts or natural disasters have similar needs for protection, food, shelter, and health care, including reproductive health care. No international treaty defines responsibility for the protection of people displaced within their own country, however, as is the case for international refugees (*20, 106*).

There is a common perception of refugees as people crowded into camps with few amenities. In reality, people living in refugee camps are usually better off than refugees who are dispersed within local communities. Food, water, and basic health care are more likely to be available in camps (*18, 55*). Where refugees are dispersed, their status and needs are unknown, and it is more difficult for relief

Millions Need Care in Crises

Every year natural disasters such as earthquakes, floods, and tsunamis cost many millions of people their homes, property, means of making a living, and even their lives. Armed conflicts kill or displace millions more.[1]

Conflicts displace more than 40 million. The United Nations High Commissioner for Refugees (UNHCR) estimates that, as of January 1, 2005, there were more than 19 million people "of concern to the UNHCR," including over 9 million refugees, who had left their countries, and more than 9 million internally displaced persons, asylum seekers, returned refugees, and others (97) (see Table 1). Including Palestinian refugees and many internally displaced persons not formally categorized as "of concern to the UNHCR," the estimated number of people dislocated by civil conflicts rises to more than 40 million (*25, 86, 95*) (see Table 2).

Table 1. Persons of Concern to the UNHCR, January 1, 2005, by Region and by Status

Region	Population of Concern
Africa	4,861,000
Asia	6,900,000
Europe	4,430,000
Latin America and Caribbean	2,071,000
North America	853,000
Oceania	82,000
Total	19,197,000

Status	Population of Concern
Refugees	9,237,000
Asylum seekers	839,000
Returned refugees	1,495,000
Internally displaced persons	5,426,000
Others	2,201,000
Total	19,197,000

Note: Totals may not equal sums due to rounding.
Source: United Nations High Commissioner for Refugees 2005 (101)

[1] The United Nations High Commissioner for Refugees (UNHCR) provides estimates of the numbers of refugees and others displaced by conflict situations. Although no single institution has a similar role for natural disasters, the Centre for Research on the Epidemiology of Disasters (CRED) publishes data on victims of disasters obtained from a wide variety of sources (14). Data on the number of refugees are usually given in terms of prevalence–that is, the number as of a given date (often January 1st). Data on the number of victims of natural disasters are usually given in terms of incidence–that is, the total number affected in a given period, usually one year.

agencies to meet their emergency needs (*53*). Out of sight of international relief agencies, these people must depend on existing local services for health care and other needs.

Conventionally, in a crisis situation, humanitarian and relief workers have focused on providing basic emergency services such as food, water, shelter, security, and primary health care, with a focus on controlling infectious diseases (16). These are priorities in a major emergency because many lives are at risk.

Reproductive health care is also a serious public health issue in crises. More attention to reproductive health care, and to providing it immediately—particularly emergency obstetric care—saves lives in refugee settings (*7, 121*).

Increasingly, international relief agencies are making reproductive health care a key emergency service. National and community reproductive health care organizations and providers, too, can become better prepared and able to respond—particularly to the needs of refugees living outside camps or beyond the reach of relief agencies.

This issue of *Population Reports* is intended to help national and community reproductive health care providers respond to crisis situations and to collaborate with international relief agencies. (For more on the steps that health care providers can take to prepare for crises and tools they can use, see p. 12.) This issue also discusses how relief agencies can address the reproductive health needs of refugees as part of emergency care. Through cooperation and collaboration, international relief agencies and national and local reproductive health programs can help people survive an emergency, sustain their health, and rebuild their lives.

Range of Reproductive Health Care Needed in Crises

According to the United Nations High Commissioner for Refugees (UNHCR), meeting a range of reproductive health needs is crucial in a crisis situation. These needs include: safe motherhood, protection from and response to sexual and gender-based violence, prevention and treatment of STIs including HIV/AIDS, family planning, and adolescent reproductive health (*63, 93*).

Safe motherhood. After the tsunami 400,000 refugees sought shelter in camps around Banda Aceh, Indonesia. An estimated 25,000 of these were pregnant women. The local health care system could do little for them, however, because the tsunami had destroyed most of the clinics and killed most of the midwives (9).

In many developing countries maternal mortality is one of the leading causes of death among women of reproduc-

Table 2. Estimates of Internally Displaced Persons (IDPs), by Region, January 1, 2005

Region	IDPs
Africa	13,200,000
Near East	2,100,000
Asia and the Pacific	3,300,000
Europe	3,000,000
Americas	3,700,000
Total	25,300,000

Source: Global IDP Project 2005 (*25*)

Many of these people have been displaced for years. UNHCR estimated that, as of January 1, 2004, in developing countries there were 38 "protracted situations"–that is, crises involving 25,000 or more people in exile for five years or more (99).

Natural disasters affect 200 million in 20 months. From January 2004 to September 2005, natural disasters displaced, injured, or killed nearly 240 million people (see Table 3). The December 2004 tsunami alone devastated communities in 12 Asian countries and killed more than 225,000 people. Floods affected more than 33 million people in China, India, and Bangladesh during the period (*15*).

Table 3. Natural Disasters and People Affected, January 2004 to September 2005

Type of Disaster	Events	People Affected
Earthquakes	43	892,000
Wind storms	197	56,415,000
Floods	256	164,338,000
Volcanic eruptions	8	132,000
Tsunamis and tidal waves	13	1,357,000
Other	757	16,523,000
Total	1,274	239,657,000

Source: Center for Research on the Epidemiology of Disasters 2005 (*15*)

tive age (*124*). In most crisis situations about 15% of pregnant women suffer life-threatening complications of pregnancy and delivery, about the same percentage as among pregnant women in general (65, *93*). But maternal complications are far riskier for women in crisis situations. The majority of refugee women are in countries where pregnancy can represent a serious health threat even in normal times (*48*). In crisis situations the need for emergency services to treat obstetric complications is acute, both because trauma, malnutrition, and psychological distress are widespread (38) and because many health care personnel and facilities are no longer available (*18, 62*).

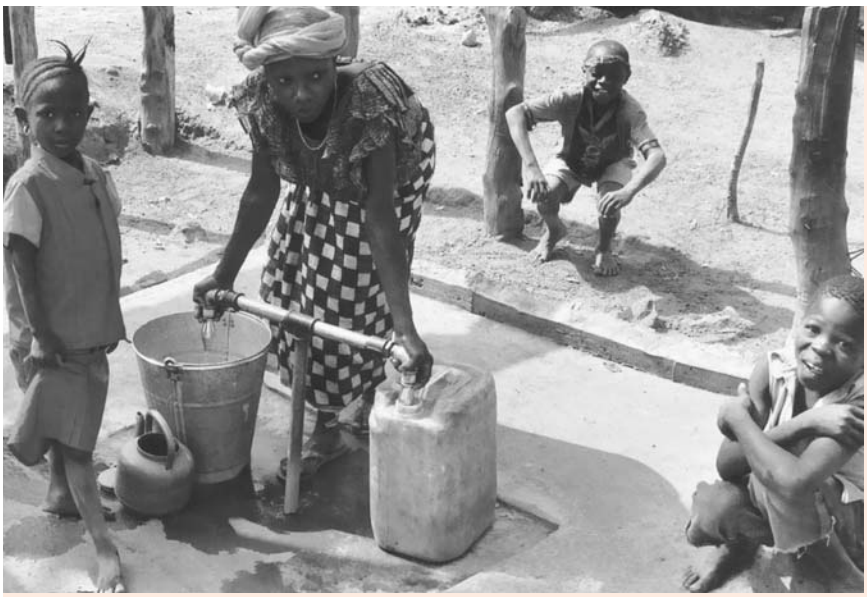
In crisis situations emergency services to treat obstetric complications are desperately needed.

Better care could prevent most maternal deaths. A study among Afghan refugees in camps in Pakistan found that, compared with women who died of other causes, those who died of maternal causes had faced greater barriers to health care. These barriers included failure to recognize the problem, the decision of family members not to seek care, lack of emergency transport to a health facility, and not receiving good quality, timely treatment (*7*).

Sexual and gender-based violence. Armed conflict and its aftermath unleash widespread sexual and gender-based violence—that is, acts of violence committed against females because they are female and against males because they are male (*112*). Sexual and gender-based violence includes sexual violence, domestic violence, emotional and psychological abuse, sex trafficking, forced prostitution, sexual exploitation, sexual harassment, harmful traditional practices (such as female genital cutting and forced marriage), and discriminatory practices.

The victims are most often women and girls, although men and boys are also subject to sexual violence (*121*). Violence occurs during all phases of conflicts—before and during flight, in camps, and during repatriation (50, *93*). In particular, rape used as a weapon of war has been documented in Algeria, Bangladesh, Bosnia and Herzegovina, Indonesia, Liberia, Rwanda, and Uganda (122).

While rape and other forms of sexual and gender-based violence take place in all societies at all times, conflicts often increase the incidence. The main factors behind increased sexual and gender-based violence are loss of security, psychological trauma, ethnic tensions, and the breakdown of family and community life. Other factors include overcrowding in camps and predominantly male camp leadership who do not see preventing gender-based violence as a high priority (*96, 114, 118,* 122). In some



Nell Kussian, CCP, Courtesy of Photoshare

Putting water supply points in well-lit, well-traveled locations, as in this Ghanaian refugee camp, helps women stay out of remote parts of the camp where they might be attacked.

Reducing Violence Against Women: Health Care Providers Can Help

Darfur, Sudan: "The soldiers and Janjawid [militia] arrived by car, camels, and horses. Some 15 women and girls who had not fled quickly enough were raped in different huts in the village. The Janjawid broke the limbs of some women and girls to prevent them from escaping. After the rapes, they looted the houses."

—A female refugee interviewed by Amnesty International (*1*)

Northern Uganda: "I was taken under a tree. They told me to lie upside down. I refused. One of the rebels told me I was stubborn, and they would teach me a lesson I would never forget. Two rebels spread my legs and tied them with ropes. Then they started piercing my private parts with a knife and cut the area open up to my anus. They beat me and left me unconscious."

—A female refugee interviewed by Isis-Women's International Cross-Cultural Exchange (120)

Violence against women is a serious and common problem in crisis situations. What can health care providers do? Awareness is the first step. Providers who are unaware, indifferent, or judgmental often miss opportunities to help their clients (*34*). Providers need to become more aware of the situations in which violence against women occurs and learn what they can do to help protect women (*112*).

Caring for survivors of violence. The best way to determine if a female client has been abused is to ask her about it. Women who have experienced violence may be willing to discuss their experience. They typically do not disclose such information on their own, however, but might if someone they trust raises the issue, such as a counselor, health care provider, or close friend or relative. Women are more likely to disclose violence and other abuse to a female health care provider than to a male provider (*34*).

Health care providers often do not ask women about violence, however, because they feel unprepared to address clients' needs. Humanitarian and local health care providers need training in counseling women subject to violence and abuse. They should be alert to physical injuries, health conditions, and clients' behavior that may indicate trauma from sexual violence or other abuses.

If a woman discloses abuse, providers can take the following steps to support her (*17, 34, 94, 112,* 113):

- **Provide appropriate care.** If a woman has been sexually assaulted, appropriate medical care includes a medical exam, treatment of any injuries, preventing unwanted pregnancy, treatment for STIs, including post-exposure prophylaxis against HIV/AIDS, and counseling. Providers should also refer women for other levels of care needed, such as referral to

instances peacemakers and humanitarian workers have been the perpetrators, exchanging food for sex by threatening to withhold food rations (71, *92*).

Domestic violence also wells up in many refugee settings. Men compensate for the loss of control over their lives by exerting violent control over their spouses (*57*, 71). In some cases, domestic violence is more common than violence by those outside the family. For instance, in a study among conflict-affected populations in East Timor, nearly half of women reported abuse by intimate partners, both during the crisis and afterwards. By comparison, 24% of women reported violence by perpetrators outside the family during the crisis; 6%, after the crisis (*36*). During the crisis the perpetrators outside the family were mainly militia members, soldiers, and police. After the crisis about

hospital for surgery, and offer transportation when needed. In addition, providers should offer information about other available services, such as counseling, economic assistance, or legal advice, and refer as requested by the survivor. (For further information see the WHO report, "Clinical Management of Rape Survivors," available on the Internet at http://www.rhrc.org/pdf/Clinical_Management_2005_rev.pdf)

- **Document the woman's condition.** Documenting a woman's injuries and symptoms helps medical staff to follow up. Documentation also can help providers to understand the types and extent of sexual violence and to monitor and evaluate care.
- **Support women's self-esteem.** Health care providers can reaffirm to each client that the violence against her was not her fault and that no one deserves to be beaten, raped, or assaulted under any circumstances.

Preventing violence in camps. Health care providers in refugee camps can take several steps that help prevent violence against women (*4*):

- **Work with camp management.** To reduce vulnerability among refugees, providers can help camp management committees to locate water collection points and latrines in places that are well-traveled and well-lit.
- **Work with refugee health care providers.** Providers should try to locate health care providers within the refugee population. Refugees who are providers may already be aware of the violence and could be trained how to handle it.
- **Advocate leadership by women.** Providers can support female representation on governing councils for refugees in camps or communities.
- **Work with security forces.** Providers can work with security forces to create awareness of women's needs for protection in and around camps.
- **Involve the community.** Community-based strategies can reduce emotional and social harm and promote community support for survivors. In the long term, sexual violence can be reduced by reaching out to community leaders and men to change attitudes that permit abuse of women. These kinds of community-based strategies for social change are most feasible in the recovery phase, when communities no longer face immediate disruption.

two-thirds of perpetrators were neighbors or other community members (*36*).

Conditions in refugee camps can expose women and girls to violence (50). In some camps women must wait in line to fetch water until late into the night, when they are vulnerable to attacks (61). Sexual attacks occur when women are doing other daily chores, too, such as collecting firewood in isolated areas, or when they have to use latrines in remote parts of the camp. Young children also are vulnerable to sexual predators when they are either separated from their families or are left unprotected in camps. (For information on how health care providers can address sexual violence in conflict situations, see box, p. 6.)

HIV/AIDS and other STIs. Of the 45 major crisis zones in the world, 28 are in Africa and 12 are in Asia—the continents where HIV/AIDS is most prevalent (123). Coupled with crisis situations, HIV and other STIs can spread rapidly, especially where HIV prevalence is already high. Poverty, powerlessness, food insecurity, and displacement often make refugees more vulnerable to sexual transmission of HIV (*82*).

For example, in Liberia the prevalence of HIV was estimated at about 8% before the civil war. The war brought widespread sexual violence, including mass rapes and abduction of women and girls to act as sex slaves for soldiers. STI screenings after the war showed that 93% of male combatants and 83% of female combatants had at least one STI. Projecting from these high STI rates, health care providers in the country now estimate that HIV prevalence is much higher than before the war (51).

Family planning. In general, family planning is as much in demand during a crisis as it was beforehand (37). Yet refugees may have far less access to contraception because services and supplies have been disrupted (*57*). The result can be more unintended pregnancies (*18, 62*) and rising abortion rates (60). Also, women who rely on contraceptive methods that require continual supplies, such as pills or injectables, may have to discontinue use abruptly when they flee their communities. Many women who use IUDs or implants no longer have access to safe removal and replacement (*31*).

Adolescent reproductive health. Worldwide, approximately 6.6 million adolescents are displaced by armed conflict (*54*). In crisis situations social support networks weaken and often break down entirely (*18, 48*). Adolescents, especially girls, are at particular risk of forced sex and of sexual coercion in exchange for food, shelter, and protection (*93, 105*).

In crisis situations unsafe sex and other risk-taking among youth often increase. In a refugee camp in the Republic of Congo, girls as young as 10 to 12 years old were reported to be sexually active, often with adult men (*100*). In a refugee camp in Kenya, a study found that despite the availability of free condoms and other reproductive health

In crisis situations sexual risk-taking among youth often increases.

care, about 70% of young men and women had unplanned sex without condoms (*84*).

Health Care Providers Face Unique Challenges in Crises

Crises pose enormous and unique difficulties for reproductive health care providers (*55, 121*). Although reproductive health care in crisis situations is similar in many respects to care in more stable settings (*30, 59*), there are important differences.

Crises disrupt services. In a crisis situation transportation and communications are often disrupted, distribution networks dissolve, and infrastructure is partly or completely destroyed (*18, 48, 121*). The local health care system itself may have suffered severely. Hospitals may have been looted, and medical staff may have fled or been killed (*48, 74*). Providers may even face armed factions that want to take control of health care facilities (*3*). The post-conflict period often remains unstable, as security is lacking and permanent peace appears uncertain (*76, 121*).

Crises overwhelm health systems. When a crisis strikes, reproductive health programs often cannot accommodate the huge numbers of refugees who urgently need services (*105*). For example, during the Great Lakes crisis in Africa in the early 1990s, one million Rwandans fled their homes in just a few days to surrounding Zaire, Tanzania, Burundi, and Uganda, countries that had limited health services to begin with. The sheer number of people was enough to overwhelm the capacity of any agency (*66*).

Crises come on top of existing problems. Since most conflicts occur in developing countries, where health conditions often are poor, many displaced groups already suffer from ill health, including malnutrition and STIs (*18*). Moreover, most refugees have few possessions left and cannot afford to buy health care, food, or much else.

Conflicts and natural disasters differ in important ways. Most communities are surprised by a natural disaster and have little chance of responding adequately, unless they have emergency plans already in place (*26*). In contrast, conflicts usually result from worsening political or social conditions, which may provide warning before the situation deteriorates into violence and chaos.

Conflicts are unstable, preventing providers from responding effectively. Episodes of tension and violence can punctuate periods of relative calm. In contrast, in a natural disaster the extent of the damage can be determined, and relief workers and providers can respond more quickly (*56*).

Conflicts by definition involve groups fighting each other. One or more of the opposing sides, including the govern-

International Relief Agencies Provide Reproductive Health Care

Reproductive health program directors should be aware that a number of international organizations provide reproductive health care as part of their relief efforts in crisis situations. Key organizations that conduct research and training, provide monitoring and evaluation, and offer technical assistance to local organizations include agencies of the UN, several international nongovernmental organizations (NGOs), and donor agencies such as the United States Agency for International Development (USAID) and the European Commission Humanitarian Aid Office (ECHO). (For a list of organizations that focus on reproductive health care in crisis situations and their Web sites, see box, page 18 and http://www.populationreports.org/j53/j53tables.shtml)

UNHCR. The United Nations High Commissioner for Refugees leads the coordination of international response to refugee situations. Its primary purpose is to defend refugees' rights and provide care for refugees. UNHCR supports reproductive health care for refugees worldwide (*98*).

RHRC Consortium. The Reproductive Health Response in Conflict Consortium, formerly the Reproductive Health for Refugees Consortium, promotes and provides reproductive health care in crisis situations. The consortium consists of seven organizations. Four provide reproductive health care directly to refugees—CARE, Marie Stopes International, the American Refugee Committee, and the International Rescue Committee. JSI Research and Training Institute and the Heilbrunn Department of Population and Family Health, Mailman School of Public Health at Columbia University, conduct research and training and provide technical assistance to local organizations. The Women's Commission for Refugee Women and Children is an advocacy organization.

Member organizations have provided funding and technical assistance to cooperating local organizations during emergencies. The Consortium also has played a key role in developing materials, tools, and other resources for use in crisis situations (see Table 4, p. 13 and Web Table 1).

The Inter-Agency Working Group on Reproductive Health in Refugee Situations. The Inter-Agency Working Group (IAWG) focuses on strengthening reproductive health care for refugees and internally displaced persons (*93*). The IAWG comprises about 30 organizations, including reproductive health NGOs, UN agencies, and academic institutions (*62*). It was established in 1995 following the first symposium on Reproductive Health in Refugee Situations, organized by the United Nations Population Fund (UNFPA) and UNHCR.

UNICEF, UNFPA, and UNRWA. Among UN agencies, the United Nations Children's Fund (UNICEF), UNFPA, and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) all have become increasingly involved in serving refugees (*72*).

UNICEF had worked in about 60 conflict-affected countries as of 2003, the date of the most recently published estimate (102). UNICEF is the lead agency in the Safe Motherhood Initiative, a global effort to reduce maternal mortality. In this role UNICEF provides clean delivery kits for use in conflict situations (89, 91). For example, in 2003 UNICEF distributed approximately 26,000 clean delivery kits to almost 100 facilities throughout Somalia (90).

UNFPA is the largest supplier of emergency reproductive health supplies and equipment (*105*). UNFPA currently supports emergency reproductive health projects in more than 50 countries (*104*, 107).

Following the 2004 tsunami UNFPA helped reproductive health care providers in Indonesia to re-establish services. UNFPA continues to provide the refugee camps with reproductive health kits for midwives and personal hygiene packs for women and girls (108). (For information on ordering reproductive health kits, see Table 4, p. 13.)

UNRWA works exclusively to provide emergency aid, relief services, education, and health services to Palestinian refugees (88). These services include family planning and maternal and child health care (81, 111).

The International Medical Corps (IMC) has responded to conflicts and disasters in more than 40 countries and currently works in 20 countries. IMC helps local communities by providing reproductive health care including maternal and child health care and HIV/AIDS and STI prevention, and by providing training to increase awareness of sexual and gender-based violence (42). Health professionals from the IMC also recruit and train local doctors, nurses, and other health care providers to ensure that health programs are sustainable once the crisis has passed (41, 43).

Refugees International (RI) is an advocacy organization dedicated to improving the reproductive health of refugees. In 2004 Refugees International had programs in over 60 countries, including Sudan, where it provided relief in the Darfur region. Among its services RI addresses sexual violence, family planning, and emergency obstetric care (69).

Yoshi Shimizu, International Federation of Red Cross and Red Crescent Societies

Coordinating with other relief and health care organizations improves the efficiency and speed of efforts on the ground. In Sonagazi, Bangladesh, Red Crescent volunteers use a megaphone and motorcycle to broadcast cyclone warnings among rural villagers.

US government agencies. Within the US government, the State Department Bureau of Population, Refugees, and Migration and the USAID Office of Foreign Disaster Assistance share primary responsibility for refugee assistance programs (87). The Office of Foreign Disaster Assistance provides substantial assistance in humanitarian crisis situations (85). Recently, USAID has provided funds for reproductive health care in crisis-affected areas of Sudan and tsunami relief in Indonesia, Sri Lanka, and elsewhere (87).

ECHO. The European Commission Humanitarian Aid Office funds refugee projects worldwide, including emergency reproductive health care (*23*, 109). The ECHO program, Aid for Uprooted People, focuses on creating conditions that foster long-term development. In Asia and Latin America it provides funds to refugee camps, for repatriation, and to assist with reintegration into communities (58).

ment, may have no regard for the health and welfare of the refugees. Refugee camps are not sanctuaries and have been attacked. Health care staff themselves can be the targets of armed groups. In contrast, a natural disaster often evokes an outpouring of support, and the government of the affected country takes on the responsibility of mounting a response (*56*). As a result, survivors of natural disasters often receive more aid and support than survivors of armed conflicts.

Conflicts force some people to live as refugees for years (110). In contrast, natural disasters displace most people for weeks or months rather than years, although the damage and disruption may take a long time to repair (*26*).

International Response Improving

Reproductive health care for refugees has improved in the past decade, but gaps remain (*59*). The less familiar the type of service, the less likely that it is provided (*12*). For example, services to address sexual and gender-based violence and STIs are more limited than either maternal health care or family planning services. Also, family planning services vary in the availability of contraceptives and the skills of providers (*100*).

Russ Vogel, CCP, Courtesy of Photoshare

Helping to speed the transition from relief to recovery, construction workers in the village of Nusa, Subdistrict Lhoknga, Aceh, Indonesia, begin renovating a health clinic destroyed by the December 2004 tsunami. USAID Indonesia is funding the renovation through the Health and Environmental Services Programs.

In the last 20 years the international community has paid increasing attention to the reproductive health needs of refugees (*80*). Leaders of these efforts are UNHCR, the Reproductive Health Response in Conflict Consortium (RHRC Consortium), and the Inter-Agency Working Group on Reproductive Health in Refugee Situations. UN agencies, international nongovernmental organizations (NGOs), and a few donor governments all provide substantial support for reproductive health in crisis situations (72, *80*) (see box, pp. 8–9).

Reproductive health care for refugees has improved, but gaps remain.

Following a natural disaster or armed conflict, local NGOs and community organizations are often the first to respond. They typically have an advantage over international relief agencies because they know the area and its people (*72*). Few local reproductive health programs, however, have the mandate or funding to provide full services in a crisis situation.

Community-based programs and organizations, including reproductive health care providers, can play important roles in improving response to crisis situations. Community involvement is particularly valuable where many international aid organizations, local NGOs, local self-help groups, district public health systems, and regional administrations are all operating at the same time. Working together, local services and relief agencies can help avoid duplication of services and wasting of resources (73).

For example, the Colombian organization PROFAMILIA has provided reproductive health care to refugees from the continuing armed conflict and political violence in that country. PROFAMILIA found that local organizations were already providing services in some communities. As a result, they were able to re-allocate funds to other projects and thus help to assure that, overall, more people received services (73).

Community-based organizations also can identify and raise awareness of specific problems, identify appropriate preventive measures, and sometimes take the lead in helping survivors (*93*). For their part, international NGOs and relief agencies that collaborate with communities can help build the capacity of local institutions and bolster the confidence of their service providers (*6*).

Not Enough Funding

An effective and coordinated humanitarian response to an emergency requires substantial sums of money (*103*). Relief agencies often cannot provide complete reproductive health care for refugees because they lack the funds for this purpose. More and more, donors are allocating money for specific programs and telling relief agencies how they want their money spent (*49*).

Just a few bilateral donors, chiefly the United States and the European Union, provide most of the financial assistance for reproductive health care in crisis situations.

Overall levels of funding for humanitarian assistance increased from $2.1 billion ($2.8 billion adjusted for inflation) in 1990 to $5.9 billion in 2000 (*49*). Since 2000 funding for reproductive health care in crisis situations has declined, however, as donor priorities have shifted to other areas of humanitarian assistance (*100*).

Donor funding tends to focus on a few large-scale emergencies. Often, political priorities within donor countries determine how much funding goes to specific emergencies. In addition, emergencies that are covered extensively by the news media tend to generate more public interest and thus attract more money (*49, 100*).

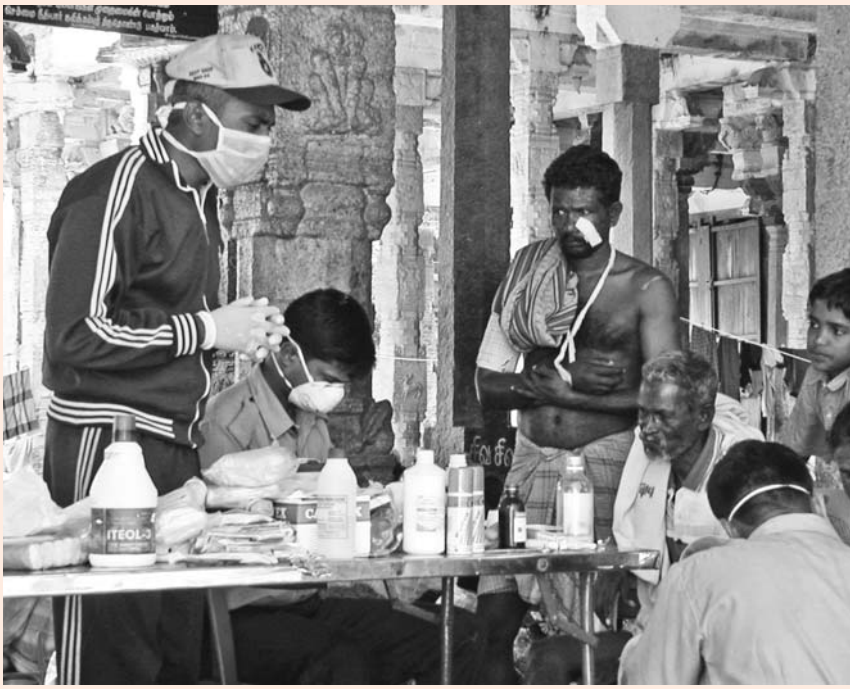
Sometimes, donors focus on one aspect of reproductive health at the expense of other important aspects. Funding for HIV/AIDS programs in conflict situations has increased in recent years. Some donors see AIDS prevention as separate from other reproductive health care, however, rather than an integral part. The perception that comprehensive reproductive health care in crisis situations is not as important may lead to decreased funding (*49, 100*).

What To Do First in a Crisis

Crises often strike with little or no warning. What can you, as a reproductive health care provider, do immediately to begin to help? Doris Bartel, a senior reproductive health expert with the RHRC Consortium, suggests the following:

- Immediately approach someone working for a UN organization and ask which organizations and/or individuals are coordinating and implementing reproductive health care or the Minimum Initial Service Package (MISP) (see box, p.15). Offer your services and give your qualifications. If you represent your hospital or clinic, provide its roster of staff names and qualifications and the health services it can offer.
- If you or your clinic/hospital has the skills and equipment to provide any component of the MISP, start doing so immediately.
- Ask a UNFPA, UNICEF, or international NGO representative responding to the crisis to order supplies for you according to how many people you think you can serve. Also ask that they include your clinic in distribution of supplies.
- Go to the reproductive health care coordination meetings and say what you observe about the crisis and what you are doing in response. If no agency is arranging coordination meetings, arrange one yourself and determine who is doing what to carry out the actions in the MISP. Ask for volunteers to fill the gaps.
- If there are many displaced people, talk to the relief workers organizing shelter, water, latrines, and food. If you know how to set up water pumps and latrines, let them know, and set them up in well-lit places.
- Work with the people distributing food rations to make sure that women are equally represented on distribution committees.
- Make sure that sanitary supplies (cloth pieces or small towels) as well as clean delivery kits are distributed with food rations.
- If you notice that vulnerable groups such as children are being neglected by the food distribution system, make this known to the UN representative in charge of food distribution.
- Do not forget to get enough rest and nutrition. Taking care of yourself will help you take care of others as well.

Source: Bartel 2005 (*5*)



EC/ECHO South Asia Office

Immediate care is always the top priority in crisis situations. In Tamil Nadu, India, relief personnel treat survivors of the 2004 tsunami.

Reproductive Health Care Providers Can Help

How can family planning providers do more to help in crisis situations? Health care providers understand people's needs and have experience meeting them, but few have worked in humanitarian relief (32). By learning more and being prepared, family planning providers and managers—whether at the community level or internationally—could help in several ways:

- Join the Inter-Agency Working Group (IAWG);
- Develop emergency preparedness plans for their facilities, organizations, and communities, including establishing a relationship with the news media;
- Follow guides to crisis care, particularly the Minimum Initial Service Package (MISP);
- Build links with relief agencies;
- Focus on refugees not living in camps; and
- Assist the transition from relief to reconstruction.

Join the Inter-Agency Working Group

Any reproductive health organization or humanitarian relief agency can join the Inter-Agency Working Group on Reproductive Health in Refugee Situations (see box, p. 9). Established in 1995, the working group seeks to improve interagency collaboration and improve reproductive health care for people in crisis situations, among other objectives (*45, 93*).

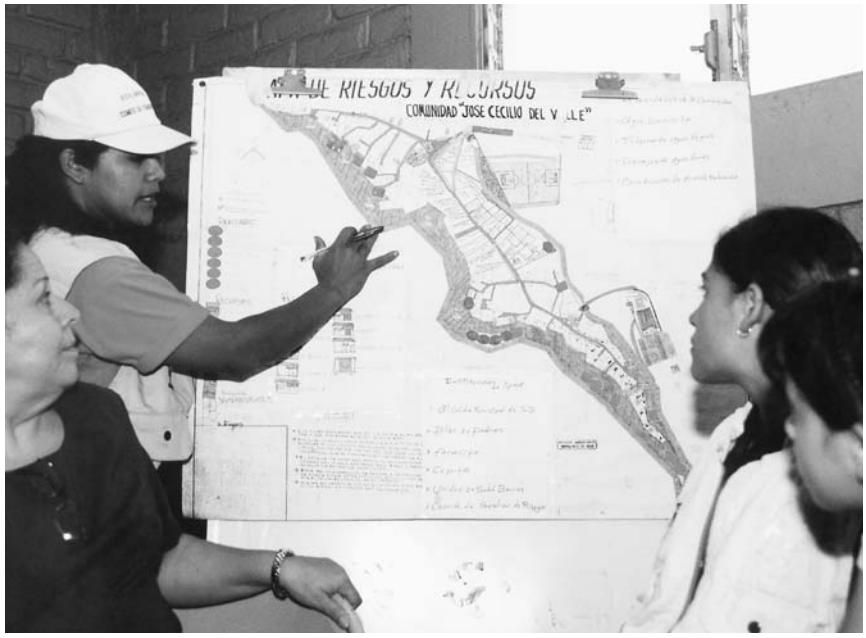
Reproductive health care providers can join the IAWG electronic mailing list to receive updates on reproductive health care in crisis situations. Additionally, providers can join or start a national, district, or local interagency reproductive health working group. These groups could serve as focal points and collaborate with relief agencies that work with refugees. (For further information contact Nadine Cornier at UNHCR, <CORNIER@unhcr.ch>)

Disaster Preparedness

A growing focus on community-based preparedness is replacing the conventional approach to disaster preparedness, which has emphasized centralized emergency response. If local communities and NGOs are trained and prepared, a quicker response can be mounted and more lives can be saved (*40*). International agencies, governments, community programs, and local health care providers can work together to build their capacity for crisis response. They can anticipate the demand for care in a crisis situation, develop effective logistics systems, create rosters of people with the skills urgently needed during crises, and establish relationships with the news media.

A focus on community-based preparedness is replacing the conventional approach.

Disaster preparedness training. Training can help international and local health care providers and government officials respond quickly and effectively when a disaster or crisis occurs. Many countries offer disaster preparedness training through the International Committee of the Red Cross (ICRC). An example is the "Health Emergencies in Large Populations (H.E.L.P.)" course, a three-week module focused on reproductive health that gives providers the tools to make decisions in large-scale emergency situations. Although intended primarily for health professionals, anyone in a decision-making position can participate (*39*).



Emergency preparedness plans should consider staffing, logistics, supplies, and infrastructure. Above, a local emergency brigade in El Salvador discusses disaster prevention and risk management, post-hurricane Mitch.

Table 4. Key Resources for Reproductive Health Care in Crisis Situations

Educational Resources

Organization: International Committee of the Red Cross **Title:** Health Emergencies in Large Populations (H.E.L.P.) Course **Description:** Three-week course with two training modules. Gives providers a better understanding of disaster preparedness. Covers reproductive health needs of displaced populations.	**Availablilty:** For more information see: http://www.icrc.org/web/eng/siteeng0.nsf/iwpList303/B46619B64E6211AF41256F40004BD259 or write to: International Committee for the Red Cross, HELP Courses 19, Avenue de la Paix CH-1202 Geneva, Switzerland
Organization: International Rescue Committee **Title:** Public Health in Complex Emergencies (PHCE) Training Program **Description:** Two-week course designed to give providers a better understanding of how to respond to the health needs of refugees and internally displaced persons.	**Availablilty:** For more information see: E-mail: shortcourse@theirc.org • Web site:http://www.theirc.org/phce Or write to the attention of Lorna Stevens at: International Rescue Committee (IRC) 122 E. 42nd Street New York, NY 10168, USA Tel: +1 212 551 3005 • Fax: +1 212 551 3185

Guides and Guidelines

Organization: CARE on behalf of Reproductive Health Response in Conflict Consortium (RHRC Consortium) **Description:** A practical guide for field staff working with displaced populations. Ten modules can be used separately or together to create a training program. Includes training materials, presentation slides, participatory exercises, and resource materials. (Draft for field testing)	**Title:** Moving from Emergency Response to Comprehensive Reproductive Health Programs **Availablilty:** Download PDF at: http://www.rhrc.org/pdf/FinManual.pdf To order printed copies or CD-ROM, write to: CARE 1625 K Street, NW, Suite 500 Washington, DC 20006, USA
Organization: John Snow, Inc./Family Planning Logistics Management **Title:** Contraceptive Logistics Guidelines for Refugee Settings **Description:** Providers can use this manual to design and implement simple contraceptive logistics systems in refugee camps where family planning programs are already in place.	**Availablilty:** Download at: http://portalprd1.jsi.com/pls/portal/url/item/E915EC0251D621B6E030007F01007A69 To order printed copies, write to: DELIVER Project/John Snow, Inc. 1616 N. Fort Myer Drive, 11th Floor Arlington, VA 22209, USA Tel: +1 703 528 7474 • Fax: +1 703 528 7480
Organization: Inter-Agency Standing Committee (IASC) **Title:** Guidelines for HIV/AIDS Interventions in Emergency Situations **Description:** Information on developing responses to HIV/AIDS during crises. A matrix that can be photocopied helps obtain information in chart form.	**Availablilty:** Download at: http://www.unfpa.org/upload/lib_pub_file/249_filename_guidelines-hiv-emer.pdf To order printed copies, e-mail martinez@unfpa.org or write to: Media Services Branch, IERD UNFPA 220 East 42nd St. New York, NY 10017, USA

Tools and Kits

Organization: United Nations High Commissioner for Refugees (UNHCR) **Title:** Inter-Agency Field Manual **Description:** A tool for planning, implementing, monitoring, and evaluating care in conflict situations. Help field staff introduce and strengthen activities that are based on refugees' and internally displaced people's needs, interests and values.	**Availablilty:** Download at: http://www.unfpa.org/emergencies/manual/ For printed copies in English, contact: Women, Ink. 777 United Nations Plaza New York, NY 10017, USA Tel: +1 212 687 8633 ext 212 • Fax: +1 212 661 2704 E-mail: wink@womenink.org • Web site: http://www.womenink.org/
Organization: Women's Commission for Refugee Women and Children **Title:** Minimum Initial Services Package (MISP) Fact Sheet and Insert (Monitoring and Evaluation Checklist) **Description:** Description of the MISP and the contents of its reproductive health kits. Provides information about ordering the UNFPA reproductive health kits and the New Emergency Health Kit-98.	**Availablilty:** Download PDF at: http://www.rhrc.org/pdf/fs_misp.pdf or http://www.rhrc.org/pdf/fs_misp_insert.pdf For information on the New Emergency Health Kit-98, contact: IDA Foundation P.O. Box 37098 1030 AB Amsterdam, The Netherlands Tel: +31 20 403 3051 • Fax: +31 20 403 1854 • E-mail: info@ida.nl
Organization: United Nations Population Fund (UNFPA) **Title:** UNFPA Reproductive Health Kits for Emergency Situations **Description:** Materials for use in the acute phase of an emergency. Consists of 12 subkits that include condoms, delivery supplies, post-rape supplies, contraceptives, surgical delivery equipment, and blood transfusion supplies. Each subkit can be ordered separately. (Note: this kit can be used to implement the Minimum Initial Service Package.)	**Availablilty:** Order kits from: UNFPA Procurement Unit 220 East 42nd St. New York, NY 10017, USA Tel: +1 212 297 5384 Fax: +1 212 297 4916 E-mail: myint@unfpa.org or dsmith@unfpa.org Or from: UNFPA Emergency Relief Office 9 Chemin des Anemones 1219 Geneva, Switzerland Fax: +41 22 979 9049 E-mail: unfpaero@undp.org Web site: www.unfpa.org
Organization: United Nations Children Fund (UNICEF) **Title:** Clean Delivery Kits **Description:** These clean delivery kits can be used by traditional birth attendants or by pregnant women themselves. Each kit contains a plastic sheet, two pieces of string, one clean razor blade, and one bar of soap.	**Availablilty:** Kits can be made locally or ordered from: UNFPA Procurement Unit 220 East 42nd St. New York, NY 10017, USA Tel: +1 212 297 5384 • Fax: +1 212 297 4916 E-mail: saunders@unfpa.org or contact UNICEF country office

Additional information on resources can be found in Web Table 1 at http://www.populationreports.org/J53

Also, the International Rescue Committee (IRC) offers a two-week training program, "Public Health in Complex Emergencies." This course addresses key public health issues, including reproductive health care, that providers face in emergencies. The course is intended for medical coordinators, public health coordinators, program managers, and district medical officers from international and national health organizations (44).

In addition, numerous training tools specifically address reproductive health in conflict situations. For example, CARE, on behalf of the RHRC Consortium, has developed a series of 10 training modules, "Moving from Emergency Response to Comprehensive Reproductive Health Programs." (For more information on training, see Table 4, page 13 and Web Table 1 at http://www.populationreports.org/j53/j53tables.shtml)

Logistics. Uninterrupted flow of supplies is a basic requirement for good-quality reproductive health care at any time (*2, 22*). Crisis situations, however, present special logistical challenges. In most crisis situations adequate storage facilities are not available, and program managers must find ways to minimize damage to supplies (*19*). Also, roads are often impassable, fuel supplies are not adequate, utilities no longer work, and security is compromised (*27,* 75).

Crises often undermine existing contraceptive logistics systems that were weak to begin with. Nonetheless, any reproductive health program can design and use a basic logistics management system in crisis situations to help decide what supplies to stock, how much to stock, and when to reorder. Principles of contraceptive logistics are generally the same in a crisis situation as at other times (*22*). A logistics management information system (LMIS) identifies, at a minimum, stock on hand, stock on order, and average monthly consumption (*19*). Storage and transportation of contraceptives are necessary infrastructure.

The DELIVER project of John Snow, Inc. (JSI) has developed a manual, *Contraceptive Logistics Guidelines for Refugee Settings,* which outlines basic principles of logistics management. The manual explains how to calculate contraceptive needs, how to develop a basic LMIS, and how to store contraceptives, among other information.

In planning logistics for emergencies, reproductive health care providers should understand that demand for contraceptives continues. In fact, demand often becomes more urgent. Many people lose access to sources of supplies and services that they had relied on, including contraceptives and condoms to prevent STI transmission, as well as supplies and equipment to treat complications of labor and delivery and to treat the consequences of sexual and gender-based violence (37).

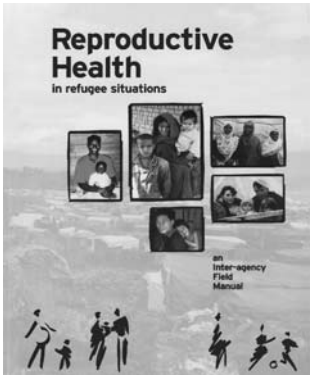
Some government officials have said that in crisis situations people do not need family planning services because they will not be having sex or, alternatively, because they will want more children to rebuild their families in the face of so much loss of life (37). While some refugees may feel this way, many others want to avoid pregnancy in a crisis because they have few resources and face the trauma and uncertainties of displacement (35).

Family planning statistics help to demonstrate the extent of the need. In Indonesia after the December 2004 tsunami, for example, the immediate need for family planning was estimated at approximately 80,000 contraceptive units (including condoms and other methods), while the available stock was about 16,000 units (9, 67, 83).

Create a skills roster. To respond effectively in a crisis situation, providers must be able to quickly identify people with essential skills (33). It can help to collect information in advance on the availability of health care providers and others with family planning and reproductive health skills. Gathering information from refugees in camps can also be useful. Many refugees have training in health care and some may be health professionals, but their skills can be incorporated into the overall effort only if they are known to relief organizers (*18*).

Without a skills roster, expertise can go unused. For example, in Tanzanian camps after the Rwandan genocide, some providers knew how to insert and remove implants. Relief workers did not know about these providers' skills, however, so women who needed such services did not have access to them (33).

Establish a relationship with the news media. As part of disaster preparedness, governments and humanitarian agencies should have a plan of working with the news media in crisis situations (77). In times of conflict and natural disaster, radio and other media can provide survivors with information about the security situation and about where to find shelter, food and water, and health services including reproductive health care (21). The broadcast media may well be the only working means of communicating with the public.



The Inter-Agency Field Manual helps programs introduce and strengthen reproductive health activities that respond to refugees' needs and reflect their values.

Minimum Initial Service Package Guides Crisis Care

The Inter-Agency Working Group designed the Minimum Initial Service Package (MISP) to guide quick response during the early, acute phase of a crisis. It lists a series of high-priority actions and the basic health care equipment, supplies, and materials needed. Reproductive health care providers can familiarize themselves with the MISP and integrate it into emergency preparedness training and response plans. (For further information on the MISP fact sheet and how to order its components, see Table 4, p.13.)

The objectives of the MISP are to:

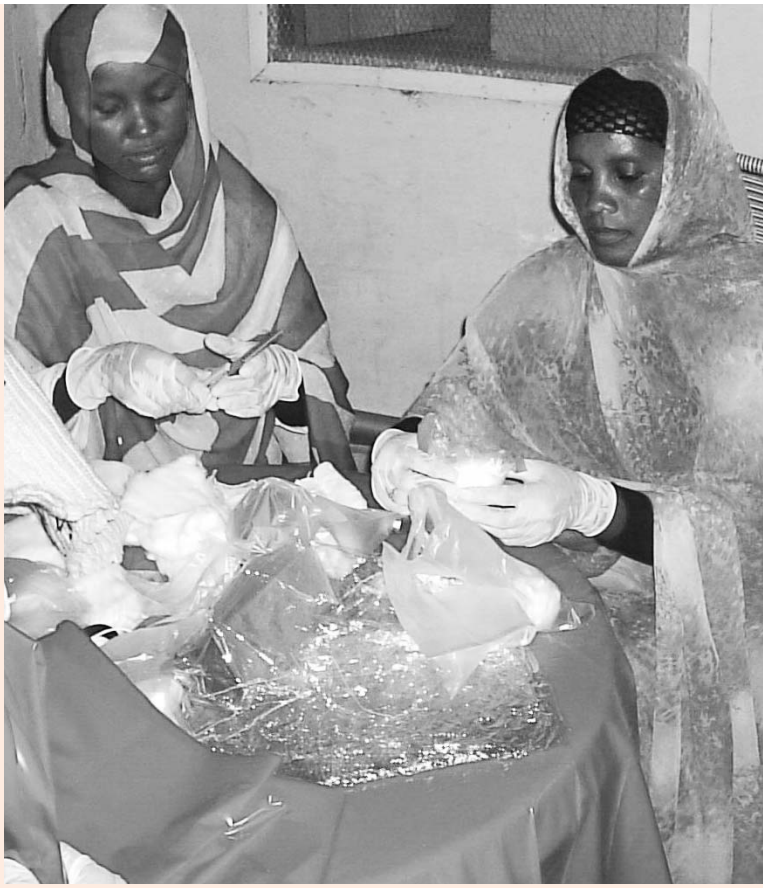
- Identify organizations and individuals to coordinate and implement the MISP (this organization or person is known as the reproductive health focal point);
- Reduce sexual violence and manage its consequences;
- Reduce HIV transmission by (1) enforcing adherence to the universal precautions for infection control and (2) guaranteeing the free availability of condoms;
- Reduce neonatal and maternal illnesses and deaths by (1) providing delivery kits for use by mothers and birth attendants, (2) providing delivery kits to midwives, and (3) initiating a referral system to manage obstetric emergencies;
- Plan for provision of complete reproductive health care, integrated into primary health care, as the situation permits (*93, 117*).

Emergency Kits Support MISP.

Three principal kits support implementation of the MISP. They are (1) simple clean delivery kits for home use; (2) the New Emergency Health Kit-98, developed and revised by WHO; and (3) the UNFPA Reproductive Health Kit (see Table 4, p.13). These kits can be ordered at any time, without waiting for an emergency situation.

Traditional birth attendants or pregnant women themselves can use the clean delivery kits. The kits can be made using simple, locally available supplies—a plastic sheet, two pieces of string to tie the umbilical cord in two places, a clean razor blade to cut the cord, and a bar of soap. These are the basic supplies needed to avoid umbilical cord infections in newborns and genital tract infections in mothers following the birth.

The New Emergency Health Kit-98 contains two different sets of drugs and medical supplies. One set is a basic unit and the other is supplementary. The basic unit should meet the needs of a population of 1,000 people for three months. The supplementary unit should cover a population of 10,000 people for three months.



Sandra Krause, Women's Commission for Refugee Women and Children

Women in South Darfur, Sudan, assemble safe delivery kits from locally obtained materials. The women are participating in a project of the American Refugee Committee and a local NGO, Ayya, to generate income for women in this strife-torn area.

The basic kit is meant for use by health care providers who may have had only limited training. It contains some medicines such as antimalarial drugs; renewable supplies such as gauze, gloves, and soap; equipment such as forceps, scissors, and syringes for surgical deliveries at health centers; supplies for some obstetric emergencies; and materials for post-rape care.

Only professional health workers should use the supplementary kit. It contains more drugs, renewable supplies, and equipment than the basic kit. (For details see http://www.who.int/medicines/library/par/new-emergency-health-kit/nehk98_en.pdf)

The UNFPA Reproductive Health Kit, which is meant to be used only during the acute phase of an emergency, consists of 12 subkits that include condoms and other contraceptives, clean delivery kits for home births, post-rape supplies, surgical delivery equipment, and blood transfusion supplies. Each subkit can be ordered separately (*93*).

News reporters often are the main source of firsthand information about the extent of crises and the problems that survivors and relief efforts face. The news media are often the first to define an event as an emergency and to raise public awareness and concern. In turn, the extent of public awareness usually determines the level of attention that an emergency situation receives (10).

To work effectively with the news media, humanitarian providers and government officials in charge of crisis response should anticipate the needs of the news media and be able to provide them with facts needed for accurate reporting (68). Organizations should designate a person with direct access to decision makers and train this person for working with the news media. Keys to working well with the media include finding ways to help the media report the news, respecting media deadlines, always being truthful and factual, and using language that is clear, concise, and easy to understand (13, 78).

Follow Guides to Crisis Care

Reproductive health field guides and other materials that humanitarian agencies use also can help local providers. The Inter-Agency Field Manual—the most comprehensive and widely used guide for refugee reproductive health programs—is a key tool for planning, implementation, monitoring, and evaluation (*93*). It can help programs introduce and strengthen reproductive health activities that respond to refugees' needs and reflect their values (*24*).

UNHCR published a 1999 revision of the manual after two years of field use and testing by staff in 50 relief agencies. The revised manual can be downloaded from the Internet or ordered by mail. (For more information on availability of the Inter-Agency Field Manual, see Table 4, p. 13.)

A key tool—the Minimum Initial Service Package. A key component of the Inter-Agency Field Manual is the Minimum Initial Service Package (see box, p.15). The package (often referred to as the MISP) is a series of activities and supplies designed to avoid maternal and neonatal deaths and illness, reduce HIV transmission, prevent and respond to sexual and gender-based violence, and plan for integrating reproductive health care with primary health care (*93*, *117*).

The Minimum Initial Service Package applies both in conflict situations and in natural disasters. It is intended for the acute phase of a crisis and can be implemented immediately, without a needs assessment (*93*). Its developers, the Inter-Agency Working Group, created the MISP to:

- Give health care providers the tools that they need to deal with critical steps in a natural disaster or conflict where many people are displaced;
- Minimize mistakes that health care workers might make because they are unfamiliar with crisis situations; and, as a result,
- Save lives.

Although relief agencies have become increasingly aware of this innovation, most have yet to implement it completely. For example, in Sudanese refugee camps in Chad, few relief workers knew about the MISP or about the importance of emergency response to reproductive health needs. Relief agencies made efforts to prevent sexual violence by setting up latrines and water supply points in safe locations and in some camps establish refugee committees with equal male and female representation. They did not, however, take other steps, also called for in the MISP, that would have helped avoid sexual violence and would have addressed other aspects of reproductive health (*116*).

Similarly, after the tsunami in Indonesia, a study found that about half of humanitarian providers interviewed were aware of the MISP, but few could accurately describe its objectives and priorities (*119*). In Banda Aceh UNFPA designated a "reproductive health focal point," recommended as the first step in the MISP—that is, an individual or organization that coordinates and implements the service package—and set up working group meetings among local and international organizations. These meetings demonstrated the effectiveness of a reproductive health focal point to coordinate emergency reproductive health care. Nonetheless, other steps called for in the MISP—for example, managing consequences of sexual violence, reducing HIV transmission by practicing universal precautions, and taking adequate measures to decrease neonatal and maternal mortality—were not put in place (*119*).

The Inter-Agency Working Group on Reproductive Health in Refugee Situations recommends that all international organizations integrate the MISP into their emergency preparedness training and response plans and increase awareness of reproductive health in these situations (*100*). Similarly, governments and particularly ministries of health can prepare for emergency situations by familiarizing themselves with its goals, objectives, and components (*116*, *119*).

Build Links

Better coordination between relief organizations and local health systems can lead to more integrated and efficient reproductive health care in crisis situations, both for community members and for refugees. Cooperation can combine the differing but complementary experience and expertise of relief workers and local health care providers.

Reproductive health care providers need not wait for international humanitarian agencies to ask for community assistance in a crisis situation. Instead, they can take the first step by offering their services (*28,* 47, 79). They could go to reproductive health care coordination meetings to make their observations about the crisis and explain how they are responding (*5*) (see box, p. 11).

Local agencies responding in a crisis may receive funding, supplies, and equipment from the UN and other international agencies (*46*). In Sri Lanka, for instance, Marie Stopes International, a member of the RHRC Consortium, helped a local agency mobilize teams of community reproductive health workers to help victims of the 2004 tsunami (29).

Cooperation among agencies has become more important in recent years as the nature of crisis situations has changed. Humanitarian crises have become more complicated in the last 15 years, and the number of people displaced within their own countries has increased drastically. As a result, providing adequate health services in these situations has become more difficult (*11, 64*). As the number of NGOs and other groups involved in humanitarian relief has increased to address this need, so have problems of organization, coordination, and accountability (*66*).

The services that refugees receive from relief organizations largely depend on which organizations provide care. Criteria do not exist specifying which NGOs should offer which services, which camps they should serve, or how these matters should be decided (*72*). The lack of criteria means that the kind and quality of reproductive health care that people receive in crisis situations can vary substantially, depending on which agency responds.

Focus on Refugees Not in Camps

International relief organizations and NGOs can work with local reproductive health care providers to offer care for refugees who are not in camps but instead are living in the host communities. Refugees living in communities often receive less health care than other community residents. For example, Burmese refugee women in Thailand living outside the refugee camps had less access to modern contraception and other reproductive health care than the general population, and their rates of unwanted pregnancy and maternal health problems were higher (8).

When refugees are dispersed among the general population, health care providers who are able to continue serving their regular clients—that is, if their work has not been disrupted—may be able to incorporate the refugees into their services, offering them the same quality of care (*56*). Their ability to do so, however, would often depend on the level of international support. Many programs have barely enough resources to provide basic care for their usual clientele on a day-to-day basis. Nevertheless, with adequate funding and supplies, local providers may be better able than international agencies to provide good care, because they understand the culture and people's needs, particularly if they are dealing with internally displaced refugees from within their own country (*28*).

Reproductive health care providers need not wait for international humanitarian agencies to ask for community assistance.

After the Crisis: From Disaster to Development

Even after conflicts or natural disasters end, suffering often continues. Many refugees return home to find their communities in ruins and health care and other services destroyed. People usually need continued support to help them recover and rebuild their lives (70).

Health care programs can help the survivors of crises regain responsibility for their own health and well-being (*6,* 115). Most crises eventually move from an acute stage through a stabilization phase to a post-emergency relief and recovery phase. During this transition humanitarian providers can cooperate with other local health care providers and coordinate activities that focus on sustainability to help communities rebuild as quickly as possible (*52*).

Have You Looked at These Links to Other Web-based INFO Publications and Services?

Global Health Technical Briefs (Broaden your knowledge with these succinct two-page summaries for program managers and others.)
http://www.maqweb.org/techbriefs/index.shtml

INFO Reports (Discover the latest new research and developments for reproductive health program managers.)
http://www.infoforhealth.org/inforeports/index.shtml

The Pop Reporter (Stay up to date with this weekly, customizable e-zine, providing summaries and links to research and news reports on reproductive health and related topics.)
http://www.infoforhealth.org/popreporter/current.shtml

POPLINE searchable database (Keep in touch with the World's Reproductive Health Literature.)
http://www.popline.org

Photoshare searchable database (Browse through thousands of health and development photographs categorized and indexed for easy searching.)
http://www.photoshare.org

Organizations with Web-Based Information on Reproductive Health Care in Crisis Situations

This list provides Web addresses of humanitarian organizations that provide reproductive health care in crisis situations and also of selected reproductive health organizations with experience in crisis situations.

All organizations listed provide relevant information and material through their Web sites. Some sites do not have specific URLs about emergency care, but their search engines can guide readers to relevant information. (Note: All links were live as of November 18, 2005.)

Other lists of major organizations can be found at the Web sites of Relief Web, Reproductive Health Gateway, Reproductive Health Outlook, and the UNFPA. ECHO has a list of 184 partners with whom it has a Framework Partnership Agreement: http://europa.eu.int/comm/echo/pdf_files/fpa_partners.pdf.

Humanitarian Agencies, Development Organizations, and International NGOs:

Aid to Uprooted People (AUP): http://europa.eu.int/comm/external_relations/upp/intro/
American Refugee Committee International (ARC): http://www.archq.org/
CARE: http://www.care.org/
Global IDP Survey: http://www.idpproject.org/
Interaction (American Council for Voluntary International Action): http://www.interaction.org/
International Crisis Group: http://www.crisisgroup.org/home/
International Federation of the Red Cross and Red Crescent Societies: http://www.ifrc.org/
International Medical Corps (IMC): http://www.imcworldwide.org/
International Rescue Committee (IRC): http://www.theIRC.org/
International Organization for Migration (IOM): http://www.iom.int/
Médecins sans Frontières (MSF): http://www.msf.org/
Merlin: http://www.merlin.org.uk/
Oxfam: http://www.oxfam.org/eng/index.htm
Relief Web: http://www.reliefweb.int
Reproductive Health Response in Conflict (RHRC) Consortium (formerly Reproductive Health for Refugees Consortium): http://www.rhrc.org/
Save the Children: http://www.savethechildren.org/, http://www.savethechildren.org.uk/
United Nations Development Fund for Women (UNIFEM): http://www.unifem.undp.org/
United Nations Development Program: http://www.undp.org/
United Nations High Commissioner for Refugees (UNHCR): http://www.unhcr.ch
United Nations Joint Programme on HIV/AIDS (UNAIDS): http://www.unaids.org/
United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA): http://ochaonline.un.org/
United Nations Population Fund (UNFPA): http://www.unfpa.org, especially http://www.unfpa.org/swp/2004/english/ch10/index.htm
United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA): http://www.un.org/unrwa
United States Agency for International Development (USAID): http://www.usaid.gov/our_work/humanitarian_assistance/
United States Committee for Refugees (USCR): http://www.refugees.org/
United States Department of State Bureau of Population, Refugees, and Migration (PRM): http://www.state.gov/g/prm/
Women's Commission for Refugee Women and Children: http://www.womenscommission.org/
World Bank: http://www.worldbank.org/
World Health Organization: http://www.who.int/reproductive-health/
World Health Organization, Emergency and Humanitarian Action (EHA): http://www.who.int/hac/crises/en/

Reproductive Health and Family Planning Organizations:

Advance Africa: http://www.advanceafrica.org/
EngenderHealth: http://www.engenderhealth.org/index.html
Family Care International: http://www.familycareintl.org/
Family Health International: http://www.fhi.org/en/RH/index.htm
International Planned Parenthood Federation: http://www.ippf.org/
Ipas: http://www.ipas.org/english/
JHPIEGO: http://www.jhpiego.org/
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Marie Stopes International: http://www.mariestopes.org.uk/
Pathfinder International: http://www.pathfind.org/
Population Council: http://www.popcouncil.org/
Population Reference Bureau: http://www.prb.org/
Population Services International: http://www.psi.org/
Reproductive Health Gateway: http://www.rhgateway.org/
Reproductive Health Outlook: http://www.rho.org/html/refugee.htm#
United Kingdom Department for International Development (DFID): http://www.dfid.gov.uk/
United Nations Children Fund (UNICEF): http://www.unicef.org/

Educational Institutions

Columbia University Heilbrun Department of Population and Family Health: http://www.mailman.hs.columbia.edu/popfam/index.html
Johns Hopkins Bloomberg School of Public Health Center for International Emergency, Disaster and Relief Studies: http://www.jhsph.edu/dept/IH/Centers/refugee_disaster_response.html

Journal

Forced Migration Review: http://www.fmreview.org/

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