AMERICAN REFUGEE COMMITTEE
STATEMENT OF HISTORY
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Local Programs Assisting with Resettlement and Integration in America
ARC was founded in 1978 (incorporated in December 1978 in the State of Illinois) by Neal Ball, a businessmen in Chicago, concerned with the plight of Indochinese refugees in Southeast Asia. During 1978, Neal initiated efforts to reunite refugee families and provide the **sponsorship necessary for refugees approved for third country resettlement to come to America.** These efforts were performed ad hoc with the assistance of a Laotian refugee whom Neal had sponsored.

In 1979, Neal sought to establish an office and formalize ARC sponsorship activities. His search for a director led him to Stan Breen in Minneapolis. Stan was working in the administration of Governor Wendell Anderson and was very involved in the assistance to refugees coming to Minnesota as well as in the development of what became the Refugee Act of 1980. Stan and his wife, Aviva, had grown up in Chicago, but had settled in Minneapolis and their four children were happy in school. They did not want to uproot and move back to Chicago – hence the **ARC headquarters was established in Minneapolis in 1979.**

Neal's vision was to **mobilize the private sector – human and financial –** to identify, recruit, train, and support sponsors for refugees in camps in SE Asia. ARC's sole objective at that time was to empty the camps and integrate those that came to America into society and "help them create productive lives." The private sector focus was for two purposes – to take the pressure off of the government (official "resettlement agencies" received a certain amount of funding per refugee) and churches did the same with involvement and support from their congregations and their denominational umbrella organizations. The other purpose was to educate the private individual on the needs of the refugees, training on how to be a sponsor as well as how **being a sponsor could enrich their own lives and their community.** With ARC support, being a sponsor did not mean having to spend one's own money – but to utilize the energy of others and access community and group resources available.

ARC "domestic programs" in Minneapolis and Chicago (with some brief linkage with groups in Omaha, Seattle, Washington DC) provided valuable support to refugee communities up through 1992, including distribution of new and used household goods and clothing, ESL, legal and tax services, formalized LPN training specifically designed for the refugee community, community service, mentoring, generational counseling, etc. It was especially rewarding in Minneapolis where we were serving refugees arriving from the camps in Thailand where they also experienced ARC services. This relationship provided ARC **substantial insight into the needs and culture of the beneficiaries in both locations.** However, the relationship between the directors of the local programs and the leadership of ARC (Executive Director and Board) was often contentious with the local programs feeling slighted for attention and fundraising – various staff and groups left over the years to either work with other self-help refugee organizations locally or to form new ones utilizing former ARC staff and methodology. **In 1992 it was decided that all involvement in domestic assistance to resettled refugees be spun off into independent organizations with their own community-based boards and fundraising mechanisms.**

ARC Goes International
In the fall of 1979, the ARC sponsors were telling us that so often they would have everything ready for the arrival of the refugee family and would be notified that they were on medical hold – **if a refugee was diagnosed with an infectious disease – the whole family was automatically placed on a one-year hold for resettlement.** Neal and Stan decided that **ARC needed to respond to the health needs in the**

camps and placed a large ad in the New York Times seeking donations and volunteers. The response was overwhelming.

In early October, ARC sent a team of five health professionals to work with the Hmong living in Ban Vinai Camp near the Thai-Lao border in northern Thailand. **Two weeks after their arrival, there was an influx of approximately three-quarters of a million people from Cambodia** on the eastern Thai border, arriving in serious condition and many of them dying enroute or upon arrival. The Vietnamese invasion of Cambodia, which began in April of 1979, had progressed across Cambodia and had triggered the release of the Khmer people from the misery suffered under the Khmer Rouge regime. This regime had committed torture, murder, starvation, and slave labor of its own people with an estimated two million people perishing in the killing fields of Cambodia.

ARC's First Emergency Response

ARC immediately reassigned two of the physicians to the Cambodian border and an **additional team of fifteen health professionals was immediately recruited** to depart early November for the Cambodian border. This November team included Dr. Steve Miles. The foundation for **ARC's philosophy of and commitment to training and the appropriate level of care** – that which can be taught, learned, and practiced by the refugees– was established under Steve's leadership during this service and when he returned several more times over the next two years. It was during this period that Steve also developed the **short term TB treatment model which proved to be revolutionary** for this population as well as others in the future. The international coordinating bodies on the Cambodian border were not allowing any TB treatment programs to be implemented based on the historical non-compliance rates in transient/unstable populations. The fear was well founded in that if TB patients do not complete their treatment, the remaining virus has developed resistance to the drugs and then continues to multiply and further develop the disease that is untreatable and even more deadly. ARC devised a multi-drug, short-term treatment therapy accompanied by an intensive identification and education program for TB patients and their families followed by the patient and family signing a contract which obligated them to remain residents of that camp for the treatment duration (six months). A further safeguard was that patients had to come to the clinic every day for the medication, rather than providing the six-month supply up front and if a patient did not come in, they were found by the trained health staff. In addition, if there was war activity, ARC had trained medics and entrusted them with adequate supplies of medication, which they kept buried under their huts, so that treatment could remain interrupted throughout the treatment period.

Lessons Learned

ARC's reputation was highly regarded based on its work early on in the camps on the Cambodian border, as well as throughout its service to the Indochinese refugees and returnees through 1999. This was ARC's flagship program and provided many lessons learned that are still applicable today. It established ARC's **core competency in provision of health care and training to displaced populations via the appropriate level of care philosophy which evolved over the years to embrace the primary health care (PHC) model**, emphasizing preventive/promotive health and an appropriate level of care for the context: ARC's approach involves immunizations, training community health workers and traditional birth attendants, reproductive health, health facilities management, health education, vector control for disease prevention, water/sanitation, environmental health, curative care in some contexts and in others it provides consultation and referrals for curative care and other services, capacity building and training, and involving the community through a participatory approach. In short, ARC learned through experience that many **more lives will be saved through preventing disease and promoting awareness through health education than can be saved by creating hospitals**:

- More lives will be saved by providing sanitation, clean water, health education and ORS to prevent cholera than via establishing a cholera unit to treat cholera after an outbreak;

- More lives will be saved by training traditional birth attendants than by creation of an emergency obstetrics unit;
- More lives will be saved by training community health workers to regularly visit each household and assess, educate, and refer than by waiting for the sick to come into clinics or hospitals;
- More lives will be saved by training and providing health care at the level that can be taught, learned, and practiced in the local context.

ARC's entry into Cambodia in 1990 also laid the foundation for ARC's **commitment to establishing an operational presence in the country of origin for the refugees as soon as possible** – although the 1990 entry was several years before the return of the refugee population on the border, it is also recognized that it was years late in principle and led ARC, in the future, to seek such presence early on, regardless of politics, if funding could be obtained. In Cambodia, ARC worked in several provinces focusing on health, rehabilitating health facilities, TB treatment and mitigation, water and sanitation, and on continuing education for Cambodian health professionals which also sought training and integration linkages for Cambodian health workers that had been so well trained in the border camps over 13 years. After struggling to obtain continuing core funding from U.S. Government donors ARC pieced together what funding it could from the UN, private donors, and a subcontract through a for-profit entity with a contract from the Asia Development Bank between 1995 and 1999, when it finally ceased all operations in Cambodia. The end of an era.

Important to note here that although ARC's response to the Cambodian refugee crisis was quick, effective, and emergency in nature – ARC was ill-equipped to act alone and was completely dependent upon other organizations to provide medicines and equipment for implementation of services. Luckily, the situation quickly evolved whereby international entities provided umbrella support. Also ARC attempted to maintain its commitment to all private funding – the response was overwhelming with 500K coming in quickly, but spent over the first year of operations in Thailand. It was realized that ARC had no choice but to seek UN and USG funding in order to implement viable programs.

Work Ourselves Out of a Job or Expand?

ARC was founded to assist Indochinese refugees in their resettlement and integration into America, and then evolving into assistance in the camps in Thailand. **It was understood that ARC's mission would come to a close upon resolution of the Indochinese refugee crisis.** Everyone (at HQ and in Thailand) worked with a commitment to putting ourselves out of a job. In **1984 ARC contracted with Refugee Policy Group to perform an evaluation (internal and external)** to help us determine if we should remain on that course or expand to additional areas with unmet refugee needs. The RPG report indicated that **ARC was valued, respected and needed in other areas.** It also noted that its value was rooted in its quality of work but also in its non-sectarian commitment. At the time ARC and IRC were the only two NGOs that were non-sectarian and that focused on refugees.

Into Africa

In November 1984 the Board moved that ARC establish an operational presence in **eastern Sudan to assist with the refugees from Ethiopia and ARC's first team arrived in Sudan on February 1, 1985,** partnering with a small NGO, Llamba, which had a long-term presence in the country. ARC initially focused on its core competency in health, challenged greatly in a new context which required ordering/shipping/customs clearance of all necessary medicines, medical supplies, vehicles, etc. It was further challenged
when some of the refugee camps officially became "semi-permanent" settlements and in one case with ARC as the only NGO providing services. **Due to the needs at hand, ARC expanded its services to include literacy (utilizing health education materials), small business training and income generation projects**...quite successfully.

The next expansion was into Malawi in 1988 to assist Mozambican refugees. **In Malawi refugees were integrated into villages rather than camps being created for them**, and the Government of Malawi allowed only one NGO per district. In this context, ARC was required to assess the needs of the whole district including the refugees and host population, design a program that would **strengthen/ expand local capacity and work with and through the local Ministry of Health.** This proved to be an excellent and effective model and very rewarding in that whatever services and capacity ARC was able to add would have a longer term, developmental impact. It was also in this program that ARC experienced first-hand **the importance of water and sanitation** as part of its health initiatives, as well as improving local infrastructure (roads, bridges, health facilities, transportation via bicycles/canoes, and other local facilities – all for the purpose of either access to health services, cold chain maintenance, or for community mobilization/development and related acceptance and ownership (buy-in) of initiatives. When it was possible for the Mozambicans to return, ARC convinced donors to provide **grants that could follow the pace of the refugee return and flow accordingly across the border**. ARC also obtained a U.S. Department of Defense contract for building boats and transporting refugees home via water as it was much safer due to land mines and much quicker as a route.

ARC implemented a multi-year USAID grant for health in a province of return in Mozambique. Upon completion, it was discussed if ARC should remain and access USAID funding for other areas of Mozambique – priorities had shifted from areas or return to other provinces. It was decided that ARC end its presence at this time.

"Always Respecting the Values of Those Served"

This tenet, as stated in the ARC Mission Statement, has been a valuable guide in the organization's approach and realizing the importance of working with its beneficiaries as colleagues and guides on what the community needs and how it can best be accomplished. When staff/volunteers have struggled with specific values/practices of different cultures, ARC has been able to guide them to respect the fact that it is a different culture, different belief systems that are often an evolutionary merging of different cultural influences over the centuries. Recognizing the importance of not imposing judgment or change, but to work within the culture and its leadership to understand and seek to educate through the foundations of their belief systems, with respect. This is the key to acceptance of what the organization can contribute, and to achieve mutual understanding and respect, resulting in the maximum benefit to the community. When ARC realized the importance of training and hiring female health workers in Eastern Sudan, it worked with and through the community leadership and spent many months explaining why and how this could benefit the health of the families and the community and that we had no intent to change their culture or impose our values. When ARC encountered all of the serious medical problems emanating from the practice of female genital mutilation, it sought scholars within the leadership structure and leaders within the community to educate on the devastating effects of this practice and also on the fact that it had no foundation within Islam.

Gulf War

ARC did respond to the Kurdish refugee crisis after the Gulf War in 1991. ARC provided **health and sanitation services to the refugees while in Turkey and also during their return trek home to northern Iraq**. We also briefly provided assistance to local hospitals and clinics in a major Kurdish city (beyond the U.S. safe zone) until local staff could return and fully resume services. However, security concerns brought this intervention to a quick close.

Natural Disasters

ARC has **responded to natural disasters in existing AORs** including Somalia/1998 floods and the Goma/2002 volcano. ARC learned during a severe drought in Malawi in the early 90's that if a natural

disaster occurs in an ARC AOR, we must seek ways to respond – there exists a simple moral obligation when there is capacity on site or regionally. It also becomes a question of security for ARC's core interventions and staff - acceptance by the local community is a key component of security - and in many cases, a non-response by ARC to a natural disaster in an existing ARC AoR would be viewed by the local community and officials as an imbalance in assistance and the refugees receiving more than their hosts – a delicate and ongoing issue in refugee contexts.

ARC also responded to Hurricane Mitch in Honduras in 1999 and learned the lesson that to try to respond to a natural disaster, traditionally outside of ARC experience and donor perception, in an area **where ARC has no history, presence, experience, infrastructure/local staff, and where there are substantial numbers of other NGOs** with long term presence (and perhaps as in the case of Honduras local capacity receiving direct funding from USG) with extensive capacity and experience – that **careful consideration is needed to decide is such an intervention can be an effective and competitive entry for ARC.**

Entry to Europe, Expansion in Africa, and New Core Competencies

The arrival of the new Executive Director (ARC's fifth – three prior plus two interim) in 1992 marked the beginning of a **major growth spurt in program volume and locations in Africa, the Balkans, and SE Asia**. Some through emergency response – Bosnia/1994, Goma/1994, Macedonia-Kosovo/1999, West Timor/1999. ARC also responded to refugee emergencies in existing AORs during the past ten years including Rwanda/1996, Thai-Burma border/1997, Thai-Cambodian border/1997, and Guinea/2000/01. Through the above mentioned growth to certain geographical areas, ARC **built upon and further refined/defined its existing core competency in primary health care delivery** including preventive health, curative health, reproductive health, environmental health (fuel-efficient cookstoves/water/sanitation/reforestation/shelter) and also **acquired additional or new competence** in income generation/micro finance, and transition services related to repatriation and reintegration (shelter, legal services, community development, activity based conflict management).

ARC's entry into West Africa (Guinea 1996) was in response to a request from UNHCR triggered by a BPRM recommendation of the organization to UNHCR as it sought a new implementing partner for income generation projects. The donors identified income generation as the major need so that refugees from Liberia and Sierra Leone, integrated into the community, could **generate some income that would allow them to access indigenous services**. At first direct health assistance by NGOs was not allowed by the Government of Guinea, but after a visit to Guinea by Julia Taft of BPRM and her observation of the severe shortcomings of the local health care system, funding was provided for health interventions that could strengthen and expand the capacity of the local health services for both refugees and residents. ARC has found the **combination of health (preferably through strengthening of local capacity) income generation (micro-credit in return/stable contexts) to be an excellent intervention formula** and is now developing/documenting best practices for IGP/MC in conflict/post-conflict contexts. This integrated activity formula supports and promotes the ARC philosophy of developmental relief and consistently designing programs that **lessen dependence and create capacity for self-sufficiency.**

ARC has also realized the importance of designing activities in a way that connects people rather than inadvertently dividing them further or that works through a divided system already created by the conflict. It was in the Balkans that ARC developed its **activity-based approach to conflict mitigation** during the conflict and post-conflict periods. Some examples include:

- *Bosnia* – provision of *emergency medical supplies* during the conflict. ARC would supply different ethnic-based pharmacies with different essential drugs so that beneficiaries and the health professionals were forced to work with each other to meet the needs of the neighborhood.

- *Jajce Sawmill, Bosnia* – reconstruction and community stabilization interventions included rehabilitation of a lumber yard/sawmill and through an agreement with the management, ARC required that the same ethnic mix that existed within its staff before the war would be replicated in its current staffing and that lumber products from the mill would be fairly distributed among the different ethnic neighborhoods/communities for rebuilding homes.
- *Balkans – "Beachhead return"* – ARC would identify groups of refugees/displaced with a sincere commitment to return and then target these communities that were usually opposed to minority return. ARC would meet with leaders and residents to propose/agree upon community rehabilitation/development projects that the whole community needed but requiring the community to be open to and help facilitate the return. In these contexts, ARC would also facilitate neighborhood meetings/gatherings/activities with returnees and residents to help them reach a renewed comfort level with each other.
- *Bosnia Playground Project* – ARC utilized drawings and designs of playgrounds created by varied ethnic groups of school children and then
constructed the playgrounds while requiring that families of different ethnic background in those communities commit to and develop committees and plans for playground maintenance and administration.

ARC has strived to maintain its **commitment to training and transfer of skills at all levels with the objective of turnover of responsibility, its commitment to listening to the beneficiaries, understanding their needs and culture, and seeking to do what is most appropriate and the most sustainable....by the beneficiaries**. This is reflected in key lessons learned in its core competencies: The commitment to the Primary Health Care Model manifested ARC's commitment to the appropriate level of care but also to the health care model which is community based and will expand access to health services as well as improve the health status of the target population by its focus on preventing morbidity and mortality through public health measures and health education; The **model of regional linkage and return in the Balkans, applied as a regional strategy throughout all ARC AoRs in the Balkans, was again community based and was comprehensive in nature** – identifying and working intensively with people who truly wanted to return regardless of obstacles, working in the target communities of return to stabilize and create communities open to return, to provide shelter rehabilitation along with all other services necessary to enhance the feasibility and sustainability of the return, never just going in and only rebuilding houses. This model was lauded by donors who asked other NGOs to learn and adopt it for all programs of return.

Volunteerism and Professionalism

ARC feels strongly that **volunteerism and professionalism are not mutually exclusive concepts.** ARC beginnings and effectiveness were possible due to the spirit of volunteerism. ARC was also known for providing opportunities to qualified volunteers with no prior international experience. ARC found it very important to increase the pool of Americans with an international experience, which broadens one's perspective of the world and the forces within it, as well as to utilize the good intentions and willingness of people with skills to offer to those in need. Volunteerism more or less "died out" in the 1990's as the international arena became a career path for many, academically and professionally. ARC has seen the good in this but also recognizes there are positive and negative aspects in any trend if it becomes absolute. ARC is committed to **revitalizing volunteerism within the organization**, utilizing the energy source to bring specific and defined value added to the field and then also assist the returning volunteers in applying their knowledge and experience when they return home.

An Organization Stretched

ARC also sought to expand its technical and administrative support at the headquarters level. However, difficulties in managing program volume and related indirect cost recovery resulted in two periods of lay-offs at HQ (1994 and 1996) which resulted in a resolved approach of growing programs with a far-distant

goal of expanding HQ support when the indirect cost recovery level would allow. This plan was flawed for various reasons – lack of technical support at HQ made ARC less competitive for certain types of grants/programs as well as minimizing our capacity to even develop a competitive response to requests for proposals. There was also an increasing number of donors/grants which did not provide full indirect cost recovery. Therefore, headquarter support for programs shrunk to a level, which could do little more than react to problems and emergencies.

Also HQ funding that existed was not well utilized – with increased investment in Development but with lack of follow up and accountability. Also the goals for raising restricted funding were often tied to new initiatives and if these programs did not materialize the monetary goal was not met and also the restricted funding needs for existing programs/obligations were not being met, resulting in higher and higher uncovered costs. The Development initiatives also fell short of developing the relationships and stewardship necessary to sustain loyal donors. A new accounting software was introduced to the field without providing adequate training and support. This resulted in late, and in some cases nonexistent, reporting which made management of costs, cash flow, expense/cash projections, and indirect cost recovery even more difficult. In 1999 alone, the International Programs Department (averaging two to three full time staff) managed exploration and start up in seven AORs, provided oversight and support to nine AORs, managed closure in five AORs, and additional explorations in twelve other AORs. This intensity of growth brought the Human Resources Department into a situation where all they were able to do in some time periods was find "warm bodies" to fill positions, unavoidably resulting in many personnel issues and problems which required urgent intervention. This **level of headquarters support for the large program volume resulted in an overall reactive posture rather than the ability to plan, support, and prevent problems from occurring.**

ARC emerged from this era with some major challenges but with its reputation overall intact. More importantly it **created opportunities for ARC to regroup, heal, and build a leadership team of board and staff to guide and support programs as well as to create a common vision.** By 2004, new leadership, increased private fundraising, and improved support to the field in training and technical support had substantially enhanced the position of the organization.

INTERNATIONAL PROGRAMS LIST BY LOCATION

THAILAND – BAN VINAI REFUGEE CAMP (Hmong refugees) 1979-1981
Health / Private funding

THAILAND – KHAO I DANG REFUGEE CAMP (Khmer refugees) 1979-1982
Health / Private, some UNHCR

THAILAND – NONG KHAI REFUGEE CAMP (Lowland Lao refugees) 1980
Joint health project with MIHV volunteers, funded by ARC private monies, working within IRC/UNHCR health program

THAI-CAMBODIAN BORDER (Cambodian "displaced") 1979–1993
Health / Nong Samet/Red Hill/Bang Poo/Site 7/Site 2
UNBRO

THAI-CAMBODIAN BORDER (Cambodian – Khmer Rouge - refugees) 1997-1999
Health / water / sanitation / UNHCR

THAILAND PHANATNIKHOM TRANSIT CENTER (Indochinese refugees in transit for resettlement in third countries) 1981-1995
Health / Social / BRPM/some UNCHR for social programs

THAILAND – SIKHIU REFUGEE CAMP (Vietnamese refugees) 1990-1995
Health / BRPM

THAI-BURMESE BORDER (ethnic minority refugees from Burma) 1992 to Present
Health / BPRM
UNHCR has been unable to negotiate an assistance presence on this border – just obtained permission to establish a presence for protection issues a few years ago.

CAMBODIA (returnees and affected communities) 1990-1999
Health / water / sanitation / USAID during first five years, UNDP in latter years and some as a subcontractor within an Asia Development Bank grant to a for-profit entity assisting in the development of a continuing education program for Cambodian health staff.

INDONESIA – WEST TIMOR (refugees from East Timor) 1999-2000
Health / water / sanitation / UNHCR

EASTERN SUDAN (Eritrean and Tigrean refugees) 1984-1993
Health / income generation / BRPM/UNHCR for first 18 months, then only UNHCR

MALAWI (Mozambican refugees) 1988-1995
Health / water / sanitation / construction of health facilities and infrastructure / BPRM / UNHCR / Also a DOD contract for building boats and transporting returning refugees to Mozambique via the Shire River which was safer than traveling overland.

MOZAMBIQUE (returnees and affected communities) 1993-1998
Health / water / reconstruction / BPRM/UNHCR/USAID

TURKEY / N. IRAQ (Kurdish refugees/returnees) 1991
Health /water / sanitation / Private funding only – refugees began returning to Iraq from Turkey before we were able to access OFDA funding in Turkey – then brief intervention in Dohuk, Iraq – but fighting between Peshmerga and Iraqi secret police triggered cessation and departure before securing any public funding – an ongoing presence would have been funded by UNHCR and perhaps OFDA)

BALKANS (refugees/displaced) 1993–Present
Croatia 1993 to 2003
Bosnia 1994 to 2005
Albania 1999/2000
Macedonia/Kosovo 1999 to present
Montenegro/Serbia 1999 to present
Transition services (shelter, infrastructure rehab, legal services, activity based conflict resolution, community development, some health and social services)
OFDA Bosnia only for conflict and post-conflict emergency medical supply/rehab
USAID Bosnia only for community stabilization via playgrounds and rehab of infrastructure
BPRM/UNHCR for all locations
DUTCH GOVT for Bosnia/Macedonia/Serbia/Kosovo
IRISH GOVT for Kosovo
UNHCR

GOMA, ZAIRE (refugees) 1994–1997
Health / sanitation / environment / BPRM/UNHCR

MASISI, DRC (displaced and spontaneous returnees) 2001–2002
Water / sanitation / food security / BPRM

GOMA, DRC (displaced by Nyaragongo Volcano) 2002
Temporary shelter / water / emergency assistance / Private funding

RWANDA (returnees/affected communities) 1994–2000
Health / water / sanitation/ shelter / income generation / OFDA/UNHCR/BRPM/UNDP/USAID

RWANDA (refugees from DRC) 1998 – Present
Health / water / sanitation / BPRM / UNHCR

SOMALIA (displaced and returnees) 1993–1999
Health / food for work / water / sanitation / OFDA

KENYA (assistance to local NGO caring for AIDS orphans and caregivers) 1999-2000
Health / social service / Private

GUINEA (refugees) 1996–Present
Income generation / health / reproductive health / BPRM/UNHCR

LIBERIA (returnees, affected communities and displaced) 1999–2002
Microcredit / health / emergency assistance / BPRM/UNHCR / Irish Government
Operational presence re-established in 2003 – current focus on IDP camps and return to home districts.

SIERRA LEONE (returnees, displaced and affected communities) 2000–Present
Microcredit / Reproductive health / HIV/AIDS / BPRM/UNHCR/WORLD BANK

UGANDA (refugees from various countries in camps - Kyaka II, Kisoro, Rwembogo) 1994–1998
Health / water / sanitation / income generation / BPRM/UNHCR

SOUTHERN SUDAN (displaced and returnees) 1994 to Present
Health / reproductive health / HIV/AIDS / water / sanitation / environment / income generation / capacity building / OFDA

PAKISTAN (refugees from Afghanistan) 2002 - present
Reproductive Health BPRM / UNHCR

IRAQ (war-affected communities and returnees) 2003-2004
Community reconstruction/stabilization, wat/san, repair and supplies to health infrastructure
OFDA / UNHCR / CPA

DARFUR, SUDAN (internally displaced) 2004 to present
Health / water / sanitation
OFDA / UNHCR

THAILAND (Burmese migrants and local Thai populations) 2005 / control of infectious disease along Thai-Burmese border /USAID

THAILAND (tsunami survivors) 2005 to present / water / psychosocial / trauma counseling / fishing boat/livelihood reconstruction – private funding and potential USAID

INDONESIA – ACEH (tsunami survivors) 2005 / private funding / emergency health

SRI LANKA (tsunami survivors and affected conflict IDPs) various quick impact projects / private funding and potential USAID

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