CDC'S RESPONSE IN DARFUR

This broadcast is presented by the Centers for Disease Control and Prevention. CDC. Safer, healthier people.

We're speaking with Leisel Talley, an epidemiologist in the International Emergency and Refugee Health Branch at the U.S. Centers for Disease Control and Prevention. We'll be speaking about CDC's response to the recent Darfur crisis. The crisis began in February 2003. Leisel, can you say at what point CDC became involved in this international response?

Well, initially CDC was involved in the discussion on the Darfur crisis with the various United Nations agencies. Our first response was when we sent a team of epidemiologists to Chad to assess the nutritional and health status of refugees crossing from Darfur into Chad in May 2004. This was followed by a nutrition and food security assessment of the greater Darfur region in August 2004. And CDC has continued to be involved in Darfur through a series of annual nutrition and food security assessments of internally displaced persons and the resident populations. In September of this year, we completed the third annual nutrition food and security assessment of Darfur in collaboration with the World Food Program and UNICEF.

You mentioned the survey that was completed on nutrition, food and security in the Darfur region. Can you explain the process that was used to conduct the survey?

Sure. Using population data provided by the U.N. we were able to select 90 locations across all three states of Darfur or in other words 30 locations per state that consisted of both villages and camps for internally displaced persons. And we included internally displaced persons and residents. The sampling methods we used allowed us to get a representative sample of the overall population at the individual state levels as well as the regional level, and in the 2006 survey we completed 87 of those 90 locations. We lost three due to the active fighting that was going on in September. We access the locations either by road or helicopter depending on the security situation. For the survey we used household questionnaires and we also assessed the nutritional status of children six to 59 months of age. The household questionnaire included such questions on displacement, access to services like water and sanitation, health care, general food rations and then more detailed questions on immediate and long term food security.

Can you describe the results of the survey?

Using population data provided by the United Nations we were able to select 90 clusters or locations across all three states, or in other words, 30 locations per state which consisted of villages and camps and included internally displaced persons and resident population. The sampling methods we used allowed us to have a representative sample for both the individual state levels and the regional level. We were able to complete 87 of the 90 locations and we lost three locations due to the insecurity in the 2006 survey. We access these locations by road or helicopter depending on the security situation. Household questionnaires were administered and we also assessed the nutritional

status of children six to 59 months of age. The questionnaire included questions on displacement, access to services such as water and sanitation, health care, general food ration and then more detailed questions aimed at assessing the immediate and long term food security situation of households.

Can you provide the results from the 2006 nutrition, food, and security survey?

Yes. Despite the limited access and significant security constraints in 2006 we've actually seen a decrease of the prevalence of acute malnutrition from 2004 into 2005 and then a stabilization of the rates in 2006. The most recent survey which we conducted in August and September of 2006 found that 12.9% of children six to 59 months of age were acutely malnourished or wasted, meaning that they were too thin. We do continue to see variation across the states in the rates of malnutrition with north Darfur having the highest rate of malnutrition at 16%. Measles coverage and vitamin A coverage have been persistently low in all surveys. In 2006, we found an overall measles coverage rate of 67.3% which is well below what is needed in order to prevent an outbreak. Vitamin A coverage was also low at 38%. Fever, respiratory infection, and diarrheal disease were the most commonly reported causes of morbidity which is common for emergency affected populations as well as developing countries. Access to safe water sources and latrines have improved over the course of the year.

There are several factors that contributed to the results from another survey. Can you list them and describe their impact on this crisis?

I previously mentioned the variations that we see across the states for acute malnutrition and programmatic outcomes like measles coverage. This illustrates one of the largest influencing factors on the effectiveness of aid programs in Darfur which is access. When I use the term access, it encompasses many different aspects. One being the number of non-governmental organizations or aid agencies present in the state. West Darfur has the most non-governmental organizations per population and north Darfur actually has the lowest. And this can directly affect the number of programs being implemented. We also see variation in the programs available to communities, again with west Darfur having the greatest variation and higher levels of programming, and north Darfur having the least. Second is security which directly limits access. Leading up to and at the time of the survey in September 2006 various incidents had resulted in staff being removed from the field and pulled back to safer locations, and these interruptions in staff movement and placement continue and do have an impact on the ability to implement programs. And finally, control of the areas play an important role. There are multiple factions and parties controlling the areas of Darfur and access can be severely limited to the populations based on the ability of the United Nations and aid agencies to negotiate access to offer aid in these specific areas. So ultimately access can and has affected our ability to effectively and adequately meet the needs of the population.

So we've heard a lot of the effects of this crisis primarily impact children's health. What are CDC's recommendations to reduce the threat of children's health in these camp scenarios?

Well, the main recommendations that came out of the 2006 assessment for nutrition and health are to maintain the current level of food aid for the vulnerable populations specifically for children and women of reproductive age. At the same time though we need to improve the targeting of food aid and focus on the internally displaced populations and make sure they have access to and are receiving the general food ration. We also suggested or recommended that in areas with elevated rates of malnutrition like north Darfur, there need to be targeted programs to reduce that prevalence of acute malnutrition down to an acceptable level. And where needed, we need to insure access to feeding programs for the treatment of the children who are severely malnourished. We also need to continue to support health and water and sanitation programs to maintain the current improvements that we've seen. And it's critical that all these programs, nutrition, health, and water and sanitation are integrated so that we're working together to achieve these common goals. I mentioned that measles coverage was low and the recommendation is for there to be a mop-up campaign to target those areas that were previously not reached due to insecurity or not included in the initial campaigns. And finally the United Nations organizations have urged continued levels of funding to maintain the progress achieved in 2005 and 2006. If we see a cut in funding now, there may be a further deterioration in the health status of the population.

It sounds as though much of CDC's recommendations in this crisis have to deal with malnutrition of children and how to alleviate that, food aid, and targeting of that food aid. Which international organizations fulfill CDC's recommendations?

The World Food Program and UNICEF have been our main partners in Darfur, and in turn each of these agencies works with international non-governmental organizations at the field level. Both U.N. agencies and these non-governmental organizations use the data for programming purposes as well as for advocacy.

What would you consider to be some of the most important contributions CDC has provided in this response?

I think one of them is ensuring the quality of data through the provision of strong technical assistance to our partners in the United Nations. And also providing data that can be used for advocacy purposes. One of the things in addition that we have strived to do over the past three years working in Darfur is strengthen the capacity of our U.N. partners in the field to allow them to be able to go out and do these assessments with limited assistance from CDC.

You've mentioned that CDC, one of their roles in this response has been to provide technical assistance and capacity building for our U.N. partners. Can you describe a little bit more about how CDC has worked with our U.N. partners to increase their capabilities in continuing to do this type of work?

Sure. Beginning in 2004 with the first assessment, CDC was really responsible for designing, implementing and analyzing the results of the greater Darfur assessment. And then what we've worked to do in the subsequent years is to really strengthen the ability of the staff of the World Food Program and UNICEF in terms of how to design

and implement surveys so that by the time we've reached the most recent survey in 2006, World Food Program and UNICEF are actually designing the surveys and implementing the field work and doing some of the analysis with guidance from CDC but really taking a more active role in the survey itself.

Finally, I'd like to ask you a more personal question. Certainly as an epidemiologist at CDC working in international emergencies and refugee health has to be one of the more challenging areas in which to work in. Why have you chosen to work in this branch and in this field?

I would agree that it's a challenging field to work in and it challenges you physically and emotionally, but I think that it's important that there are people who are willing to go out to these emergency affected populations and make sure that the voice and the needs of these populations are expressed so that appropriate programs and interventions can be implemented.

I'm wondering if you have a story from a particular response that you've been involved with that may have stuck in your mind as a reason why you continue to do this type of work?

I guess I was in Ethiopia in 2003 in the Southern Nations and Nationality People's Region responding to the 2003 famine, and we were doing a nutrition assessment and we came to a house and immediately I saw the child who was severely malnourished but her parents didn't recognize it. And as we sat there and talked to her parents and encouraged them to bring the child to the feeding center which was about two hours away on foot, I just didn't think that they were going to bring her to the feeding center and that they didn't understand how sick she actually was. But by the end of the day when I got to the feeding center and was meeting with the doctor, we saw the gate open and here came this little girl and her mom. And I think that's one of the stories for me that sticks out that you actually can influence people to make the decision to bring their kids even at a significant cost to them, and hopefully have children be rehabilitated and become healthy and active again.

Okay, thank you. We've been speaking with Leisel Talley, an epidemiologist in the International Emergency and Refugee Health Branch at the U.S. Centers for Disease Control and Prevention.

To access the most accurate and relevant health information that affects you, your family and your community, please visit www.cdc.gov.