



CDC'S RESPONSE TO COMPLEX HUMANITARIAN EMERGENCIES

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Today we're speaking with Mike Gerber, Deputy Chief of the International Emergency and Refugee Health Branch at the U.S. Centers for Disease Control and Prevention. CDC has been responding to complex humanitarian emergencies for more than 30 years, working in places such as Afghanistan, Darfur, Chad and Asia for the tsunami among many others. Mike, can you explain what a complex humanitarian emergency is?

A complex humanitarian emergency is as the name would suggest, very complex. And it involves a number of factors. Often the lack of essential government, often conflict, frequently things such as famine, disease outbreaks, economic turmoil, and civil strife. So it's a series of things that come together which as one can imagine, make living a very difficult thing to do and really present tremendous challenges to the health of people who because of these factors are often displaced or find themselves refugees in other countries.

When CDC responds to such emergencies, what other partners do you work with in the field?

Since CDC is not an active agency in the field but rather a technical agency, we do inherently work with partners on a regular basis. We can group our partners into the three areas in the field of complex emergencies. Other U.S. government agencies such as the Office of Foreign Disaster Assistance at USAID, other parts of the State Department such as the Bureau of Population, Refugees, and Migration, and often other parts of the State Department as well that deal with specific health issues such as landmines and unexploded ordinance. Then we also have a whole group of U.N. organizations that really serve as our primary partners since they are the primary program implementers in the field during emergencies. Amongst those agencies would be UNICEF, the United Nations Children's Fund. With UNICEF we work on a range of issues ranging from emergency nutrition to food security and to basic health services such as mass immunization campaigns in conflict and during emergencies. We also work quite regularly with the U.N. High Commissioner for Refugees, UNHCR. UNHCR is tasked with overseeing and providing services to groups of people who cross international borders and become refugees, and they coordinate a whole series of activities ranging from basic services in refugee camps to setting up camps and then, of course, health care as well as food distribution. So they're a major one of our partners. The World Food Program is also a major U.N. partner. The World Food Program is the part of the U.N. that distributes food in secure areas during famines and during large displacements, and they regularly need assistance from CDC doing the same work we really do for all of our U.N. partners; going out and collecting primary data that can be

used for good decision making. Lastly, we work quite regularly with non-governmental organizations and they range from the Vietnam Veterans of America Foundation to the International Rescue Committee to Doctors Without Borders. So when there's an NGO that needs CDC's technical input to improve their programs, we're there to help them.

You mentioned that CDC is involved more as a technical agency in these responses and I hear you saying that you're also involved with data for decision making. Can you give us examples of places in which you've worked and the types of projects that you've worked on?

Sure, I can give two recent examples that I think will be very familiar to most people. The first one is Darfur. And Darfur, of course, is the region in Sudan that we see regularly on the news and we hear about the humanitarian crisis that's happening. People have been internally displaced, they suffer from daily acts of violence. There's obviously tremendous insecurity when it comes to access to food, access to shelter, and whether the whole world is responding enough is a question for someone else. But when it comes down to how to respond and what's needed, the international community needs basic information and you can't just go into an area and look and see what the problem is. So data are required. So CDC comes in and we'll work with our U.N. partners and our NGO partners. CDC goes out with our international partners to conduct surveys, to do other rapid assessments to help determine exactly what's needed. So where are people actually malnourished, what sort of malnourishment are they suffering from, where are foods needed and where are foods not needed. And the answers to these questions seem very basic but when it comes to transporting tons and tons and tons of food from around the world, it's really critical to have these numbers. And then when it comes to health care, there are populations that we're talking about that suffer from very specific things. So the risk of measles, as an example, is a very specific health threat. To address a health threat like measles, CDC can go out and do a survey to determine, number one, what coverage has been preexisting the conflict or in this case in Darfur preexisting the ongoing conflict, and determine what kind of vaccination campaign will actually be needed, and then have information so after these things are done, after food is delivered, after vaccination campaigns take place, have they been effective and have they done what we wanted. So that really is the essence of using epidemiology for data collection in emergencies is to find out what the needs are, to determine whether the needs are then being met, and to evaluate your programs.

Another example of the work CDC has done recently that is I think quite well known is our work in Afghanistan. After the fall of the Taliban, CDC was extensively engaged in Afghanistan on a number of levels. In the initial phases of the emergency, CDC literally had tens of people in the field throughout a one- or two-year period working with United Nation Children's Fund, UNICEF, working with the World Health Organization, working with all the leading NGO's in Afghanistan to really determine what the health needs were in the country, and this is a country that has experienced essentially ongoing war and conflict for 25 or 30 years and people did not know how many children there were to be vaccinated, what vaccines were needed, where food and security was the worst,

where malnutrition was the worst. So we were able to conduct a national survey which truly showed all these things and in response to that, all the donors in the world including the U.S. government and all the implementing partners were then able to make good decisions on how to best meet the needs of that population.

During the response of complex humanitarian emergencies by CDC, a number of people become involved in this. What type of skills do they need to have in order to appropriately respond on CDC's behalf?

That's a very interesting question and it really highlights one of the parts of the field of complex emergencies which are quite unique. Most of the fields we deal with in public health often have to do with a specific disease and a specific group of skill sets that go along with it. In the case of complex humanitarian emergencies, we're talking about a population and that population has many health needs. So in our group at CDC we have a range of people with different backgrounds from anthropologists to medical epidemiologists to statisticians to health educators, infectious disease specialists, you name it. Because that wide range of skills is needed, we find ourselves also reaching out across CDC to our other partners. The work we do can involve nutrition, HIV, reproductive health, tuberculosis, any number of things and more recently chronic diseases as well. So we do have people with that expertise and that expertise has specifically been applied in conflict settings but we also have the much wider community at CDC that we reach out to when we need more specific expertise and expertise and capacity that goes beyond what our small group can do.

Can you describe how CDC becomes active in the response of an emergency? When do we start activity, how are we asked to become part of this arena?

Well, our goal is really to start before the emergency. We have a number of programs with partners and internally within CDC where we're constantly on the lookout for risk factors for complex emergencies, so we able to better prepare and expect when things happen. It's obviously very difficult to sort of plan your work whether it's personnel or research projects when everything can be wiped off the table when an emergency happens. So we do try to be on the lookout before things start. But when they do start, we're really contacted in the old fashioned way. It's normally a phone call from a partner in Geneva or in Washington or in London or from the field who says, our U.N. organization, our agency, our non-governmental organization, we needed CDC's help. In response to that we try to be very specific to find out what exactly they need, what their goals are, and very simple things, how long they're going to need the person for, what kind of skill set. Do they need an M.D., do they need a psychologist, an anthropologist, who do they need. And then we have a process internally where we reach out and we find the most appropriate person among CDC's thousands and thousands of technical experts to go out and help.

And then at the end of an emergency, how do we know when to draw down our deployment? How is that decision made?

What you bring up is a very interesting issue, is when does an emergency end and when does development begin. As many people who work in this field, there are equally the same number of opinions on that whole issue. For us, we tend to look at things over a longer phase of time. So for us the emergency phase is really right at the beginning when basic needs are being met and that's when we're out there working to figure out the data that needs to be collected to make good decisions. But we find that our work really does continue over time in the form of operations research projects and in the form of program evaluation. So as an example in a place like Chad when refugees first started coming from Darfur into Chad, we were out there in the emergency phase doing major surveys for the U.N. organizations and getting that basic data. And then we've been back several times as well and we've been back to collect additional data to see if those programs are being effective and then to make recommendations based on those programs. So we go out there afterwards and we continue following up and as long as the need is there, it's our intent to be there as well.

So CDC is not only involved in the response of an emergency but continued capacity enhancement and you talked a little bit about that with Chad. Can you give another example of how CDC is involved with continued capacity enhancement in a country?

Enhancing the capacity of our partners is one of the most important things that we do and that has a lot to do with the whole notion I mentioned before of sort of being prepared and preparedness is not just here but it's with the people we work with because CDC does have this very unique skill set, this very unique epidemiologic approach to emergencies. We have a whole range of tools that we can share with our partners. Examples of that kind of work building the capacity of our partners are really many. And they take place often in the form of formal course that we'll teach very specifically tailored to the needs of say UNICEF staff in the horn of Africa where preparing for a possible nutrition emergency. So we might go into that setting, take four or five people from CDC and teach very specific epidemiologic and public health skills to local people so that they'll be able to be better prepared when, in this case, a nutrition emergency happens. We also sort of have a core tenant that we build into all of our emergency work which is when we go out and do these big surveys, we make sure we're not just giving people basic orders to do something this way or that way but we make sure we work with them as partners on an equal level and work them through the process of how we decide to do what we do so when the next time comes around, maybe they're not going to need CDC to come out; they already know what to do. Maybe it's just going to be an email they'll need instead of someone actually coming out into the field.

Do you have a particular story or example of a time when CDC responded to an emergency that sticks in your mind as a point that made you proud to be working in this field?

Some of our work in Afghanistan provides a really good example of CDC's success. One of the most important and critical goals the international community had after the fall of the Taliban was to conduct a national measles immunization campaign for children. In the two years before the fall of Taliban, all of the U.N. partners and different players in the field were trying to get this done in a very complex situation in the middle of very complex violence and in the middle of tremendous social restraint that the Taliban placed on the population. This was seen as being an even more critical goal after the fall of the Taliban. We had a single woman medical epidemiologist in Afghanistan for six months working on measles coordinating the campaign between WHO (the World Health Organization) and UNICEF. In the first three months she was there she was able to organize a measles immunization campaign for the entire country, carry the whole thing out and then evaluate it. We've estimated that 35,000 childhood deaths were prevented because of this campaign and that's a very conservative estimate. So that number is something I always hang on to when things are a bit difficult in the office or in the field and think of what CDC can actually do.

How do you imagine CDC's role in international humanitarian assistance evolving over time?

If we look at trends over the past five or even ten years, what's becoming very clear is that the need for public health technical expertise in complex humanitarian emergencies in the context of famine, in the context of conflict, is simply getting greater and greater. Requests for CDC technical assistance increase literally on a monthly basis. They increase in their scope and they increase in their diversity. So I think, one might say unfortunately, that CDC has a long career in the future in this area and is going to need to continue being vigilant, looking out for emergencies before they happen, working in them with our partners during them and then following up afterwards to determine what the most effective interventions actually are.

And finally, Mike, I'd like to hear about how you personally decided to work in this area.

That's a hard question to answer. I think the simplest way of doing it is just looking at public health. There is really no example I can think of in the field of public health where community-based interventions or public interventions can really have so much impact. And the populations we're talking about who suffer through conflict and famine are in need really like no other populations in the world. And to be able to work in a field like this just provides a tremendous sense of accomplishment and feeling that you're doing good work and you're doing good work for good people. And I think the other thing to say is you're also doing good work with good people. It has never ceased to amaze me

how amazing everyone is who works in this field at CDC, in the U.N. organizations, in the countries, local staff, international staff, people who work in this area are committed and there's really nothing more rewarding than working with people who are truly committed to what they do.

Thank you, Mike. I'm wondering if you can tell us, if people have additional interest in learning more about this area and CDC's activities, where can they find that information?

People can go to CDC's website which is www.cdc.gov and in the search field put in the name of our branch which is IERHB, or you can just put in the word "refugee" and our branch link will come up. You can also go to a website which is supported by the U.S. government and really can provide a wealth of information on the field of complex emergencies which is called Relief Web, and they're at www.reliefweb.org.

Thank you. We've been speaking with Mike Gerber, Deputy Chief of the International Emergency and Refugee Health Branch at the U.S. Centers for Disease Control and Prevention.

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