Outside camp settings

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Current assessment tools and intervention strategies are based mainly on experience of camp-like situations; what is needed are innovative responses to address problems specific to open settings.

In October 2009, more than 280,000 people were displaced in the two northern DRC districts of Haut-Uélé and Bas-Uélé in Orientale province. The people of this region have suffered escalating attacks from the Lord's Resistance Army since 2008 but the geographical spread of people in this vast remote region compounded by security constraints makes it difficult for humanitarian organisations to reach them and only a small proportion of IDPs in the Haut-Uélé region receive assistance from humanitarian actors.

Communities affected by the complex patterns of violence in the entire region often flee multiple times in fear of further attacks, and new pockets of displaced people can appear overnight. In DRC IDPs generally prefer to stay in host communities rather than in camps. Around 70% of internally displaced people in DRC are staying with host families or in host communities and return intermittently to their homes. A recent ICRC report talks of the increasing 'saturation' of overburdened host communities (often resulting in further economic hardship and sometimes tensions between IDPs and their hosts); the extended displacement period; and the 'pull factor' of greater resources (including humanitarian assistance) being available in camps.[1]

This trend was also observed in Haut-Uélé, where the vast majority of IDPs were initially accommodated in host families in Dungu town, sharing resources such as shelter, water and food. However, the volatile security situation prolonged the displacement and people were left without the possibility of returning home. Over time the coping capacity of both the host and the displaced was depleted and many IDPs felt themselves too big a burden on the host community. This then resulted in the construction of 'pseudo-camps', areas inside Dungu that are inhabited only by the displaced. This situation increased the vulnerability of the displaced who, having left most of their assets with the host families, had limited possibilities to cultivate the newly settled area due to the security conditions. Some of the displaced are living in poorly constructed huts that offer inadequate protection from rain and insects. Spontaneous separation of IDPs from host communities must be considered an alarming sign of insufficiently covered needs, and seems to point to the desirability of distributing incentives or compensations (money, goods in kind, vouchers, etc) to host communities. Likewise, viable and acceptable relief options need to be found for self-settled IDPs scattered across vast areas.

The humanitarian situation in Haut-Uélé changes constantly, so that entire populations – including hosts – are cut off from assistance and live in precarious and insecure conditions. In the absence of more specific information on the most vulnerable, a common operational practice among international agencies is to target the sites where there are larger numbers of displaced. However, the concern is that the most vulnerable people might not necessarily be found there.

On the medical side this has implications for agencies such as ours, Médecins Sans Frontières (MSF), when identifying locations for fixed or mobile clinics and from where to provide services and follow-up of patients regarding nutrition, response to sexual violence, treatment of chronic diseases, and overall outreach. Moreover, the practice of providing one-off assistance – such as food and other relief items for a period of three months – is clearly an inadequate response in such conditions.

Challenges in identifying needs

The identification of needs across the region has proven difficult throughout. MSF had first set up a programme in the region in September 2008, following the upsurge of violence and displacement in Haut-Uélé. In March 2009, MSF carried out a two-stage cluster sample survey in order to better assess the situation of displaced and host populations. The survey was initially planned for a larger area but due to serious security constraints was only carried out in the town of Dungu and partially (by rapid evaluation) in the town of Doruma.

The survey showed that both host and displaced populations were living in precarious conditions because of violence, theft of livestock and other belongings, destruction of houses, and restricted access to their land. Assistance and provision of supplies by NGOs were insufficient, mainly due to the constraints of working in the area, and water and sanitation conditions were below humanitarian standards. The survey provided useful information but as it was only able to assess the conditions of the population living in the most accessible areas with the highest presence of international actors, it was only representative of a very small proportion of the affected population. It could only provide a snapshot of the rapidly changing environment, and very probably did not capture pockets of vulnerability, nor patterns of mortality over time.

Contexts like DRC reveal clear flaws in using crude mortality rates (CMR, U5MR[2]) and quantitative methods in general (sample surveys, counting population, etc). The need to select representative samples and to minimise the bias in data collection is complicated by geographical spread, compromised access and lack of reliable population figures. In chronic or intermittent emergencies like DRC, mortality rates of near-normal levels can gradually rise over time or can display peaks due to epidemics, exhausted livelihoods, collapsed health system, new waves of displacement and isolation from relief providers. This means that a one-off mortality survey might provide different results depending on its timing. Such results are of little value in the absence of mortality

surveillance to detect trends and causes of mortality over time.

It is essential to search for alternative ways to measure and monitor mortality, and to identify alternative indicators in order to best judge the magnitude and evolution of crises in open settings. This will enable a better understanding of people's needs and the ability to monitor the effectiveness of aid.

Challenges in response

In comparison to camp-like situations, the need to engage with the existing health-care system is much greater in open settings. The establishment of parallel health systems – where health services (if they exist) are often overwhelmed or have deteriorated because of the crisis – has the potential to raise equity issues between hosts and IDPs, and to undermine the quality and long-term sustainability of health-care provision. In DRC, MSF opted for a 'light support' strategy that included drug supply, limited supervision and incentives to selected health structures, so as to ensure continuity and free access.

However, the impact on the quality of care remained unknown, raising concerns about the effectiveness and appropriateness of the medical intervention strategy. In open settings, it is arduous to duplicate the 'four-levels health-care model' (from community health workers to the referral hospital) developed for camp settings[3] simply because of the immense resources needed. In the absence of a functioning referral system, few patients effectively have access to the services.

The widespread needs in open settings clearly must be addressed with innovative strategies aiming at better coverage and looking at more community-based approaches. Only with strong involvement of the affected communities can activities be maintained, even when (international) staff presence is restricted.

Conclusion

As the quantitative identification of needs in open settings is more problematic, qualitative methods must be used systematically, with a concern for vulnerabilities, capacities and coping strategies. Changes in the displaced situation have to be expected and there is a need for continual re-assessment. A community-based network could play a role in a surveillance system (mortality, morbidity), in order to monitor the evolution of a crisis; however, considerable simplification of indicators to be collected would be needed.

The traditional methodology of targeting an affected area and its entire population, providing general health care on all levels, poses extreme challenges in open settings. One option may be a shift towards more prevention and early diagnosis and treatment, with a focus on the main causes of morbidity and mortality. MSF is currently piloting such an approach, with interventions that can be implemented rapidly, using security-related windows of opportunity, particularly in remote areas. They include vaccines preventing respiratory tract infections and diarrhoeal diseases, point-of-use water treatment, prevention of malaria and targeted food supplements.

These challenges affect most of the humanitarian organisations that are trying to respond to the needs of the people affected generally in open settings. It is therefore important that more research, innovation and debate take place within the humanitarian community, with a view to improving and adapting intervention strategies to the reality of displaced populations outside camps.

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