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 ‘four-levels health-care model’) developed for camp settings 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 (morbidity, mortality), 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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The views expressed here are the personal opinions of the authors and are not intended to reflect those of MSF. Special thanks to Iza Ciglenecki, Philippe Calain, Jean-Marc Biquet, Marc Poncin and Bruno Jochum for their contributions to this article.


Displacement and discrimination – the Bambuti Pygmies
For generations the Bamputi Pygmies were nomadic forest-dwellers but in 2004 they too fled the war. Now they live on the outskirts of Goma with little if any support from humanitarian agencies. They have no electricity or running water; straw-covered roofs on makeshift shelters provide poor protection from the frequent rain.

“We can’t plant seeds here,” said Bambuti chief Mupesa Muhindo, scratching the ground, which is littered with lava. “It’s not possible to cultivate the land.”

Life is hard for all IDPs but even worse for the Bambuti, whose lives are blighted by violence and daily discrimination. Discrimination against Pygmies is deeply ingrained at all levels of Congolese society. They have great difficulty accessing any kind of public or social service, and are routinely turned away. Such attitudes mean parents rarely register new births so total population numbers are unclear but it is estimated that there are about 30,000 in North Kivu and 200-500,000 in DRC as a whole.

Muhindo says he cannot pay school fees or afford school uniforms for his children. “Pygmy children don’t study,” he said. “Because we don’t have any education, we can’t consider ourselves people like others.”