Older people in crises:

A review of MSF's approach to vulnerability and needs

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DOCTORS WITHOUT BORDERS

Contents

Executive summary

In this study, we examine the policy and practice of Médecins Sans Frontières (MSF) in response to the health and nutrition needs of older people in two recent emergencies: the acute emergency following the Haiti earthquake of January 2010; and the slow-onset emergency in South Sudan up until January 2012. More generally, we examine whether MSF collects data on older people's health needs, and to what extent it addresses the needs of older people within its policies.

With so many of MSF's programmes and policies focusing on children under five, we look at the extent to which MSF adheres to organisational norms (that women and children are inherently vulnerable in crisis, and the tendency to prioritise these groups) and how this affects its assessment of and response to the needs of other population groups.

By analysing interview data from medical managers responsible for MSF's programmes in Haiti and South Sudan, we investigate whether demographic data and health and nutrition data are collected or collated for the over 45s.

Our findings indicate that, in the emergencies in both Haiti and South Sudan, there was a lack of purposeful policy regarding MSF's response towards older people, and a failure to collect and store data on older patients visiting MSF clinics.

We also discovered a lack of consistency between the responses in the two settings, finding that – contrary to our expectations – MSF's response to older people was better in the acute emergency setting than in the slow-onset emergency. For example, in Haiti there was evidence of MSF digitally collating demographic data for older age groups and addressing chronic diseases. There was also more evidence of a desire to do more for older people in Haiti than in South Sudan.

Possible reasons for this disparity include the high level of resources available in post-earthquake Haiti, and the focus on under five malnutrition in South

Sudan. In addition, the many challenges of the situation in South Sudan – including remote locations, instability caused by conflict, and poor access to the population – are clearly all barriers to providing an acceptable response to older people's health needs.

While we found no policies directly related to older people in either setting, there was indirect evidence of older people's needs being assessed in country-level policies through the lens of vulnerable groups and chronic disease, and some evidence of their needs being addressed through indirect approaches outside the usual protocols. This suggests that MSF is not directed by organisational norms, such as focus on children under five and pregnant women, and that these norms are open to challenge.

As a result of our findings, we recommend that, in order to understand the demographics and needs of the over-45 population group, there is a more purposeful collection and collation of data at the clinic level. We also recommend greater collaboration between MSF operational centres so that data sharing and learning can be maximised, and so that innovative approaches to address older people's vulnerabilities and needs are promoted.

While we do not endorse a policy prioritising older people, we do recommend that MSF's tendency to prioritise the under-fives is consciously acknowledged. At the same time, we recommend a more comprehensive humanitarian approach that understands which people are in the greatest need and how best to help them.

As one of the first reviews to employ a comparative method to assess MSF's response to older people, this study should provide a baseline of knowledge on MSF's response to this group's needs. However, more research is necessary if we are to provide guidance on how optimally to address the needs of this vulnerable group.

Key concepts:

Old age

In Western literature, definitions of older people in developed societies vary, though the term is usually applied to adults aged either 60 or 65 and above. In settings where life expectancy is relatively low, chronological age is less relevant.[1] Life expectancy at birth in Sudan is 59 for men and women; in Haiti it is 60 for men and 63 for women.[2] As a result, the age at which a person is considered 'old' will be different from more developed nations. Old age, therefore, needs to be redefined according to the context. Social markers which relate to a distinct life stage may be more useful in providing definitions, for example being a grandparent.

In this study we have chosen to define 'old' as 45 years and above. While somewhat arbitrary, it was chosen to reflect the differences in life expectancy in Haiti and South Sudan, and to represent the 'third generation' in both settings.

Ageing populations

An ageing population occurs when there is a demographic shift towards the number of people in the older population, usually leading to an uneconomically active population becoming increasingly reliant on a diminishing economically active population.[3] This shift is generally seen as a challenge because of the decrease in tax revenues coupled with an increase in people with high health and social care needs. Many developing countries are likely to experience the challenges of an ageing population in the near future,[4] with older people accounting for over 20 percent of the population in developing countries by 2050 (the same ageing demographic currently experienced in developed countries).[4]

Emergency contexts

Acute humanitarian emergencies are often the result of a single sudden-onset event such as a tropical storm, earthquake, tsunami or outbreak of conflict.[5] Slow-onset emergencies do not emerge from a single, distinct event but build up gradually over time, often based on a confluence of different events such as drought or protracted conflict.[5]

Key issues:

The health needs of older people

The needs of older people in developing countries are varied. Older people suffer from the diseases and conditions common to their community, such as cholera and malnutrition,[6] while also suffering from high levels of non-communicable diseases such as diabetes, high blood pressure, cancer, dementia and obesity.[7] Strength, mobility, hearing and eyesight are all likely to deteriorate with age, affecting quality of life and potentially preventing older people from accessing aid.

Older people are not a homogenous group and not all older people are vulnerable. However, older people's ability to access aid, healthcare and other services may be inhibited because of their age.[8] Older people may face discrimination by aid workers who do not consider them a target group, or by members of their own community who may isolate them.

The role of older people

Although the health needs of older people are likely to be high due to their susceptibility to chronic and communicable diseases, this does not mean that older people are a burden on society. Many older people are very active within their communities and provide vital family, economic and community support. Older people may play an especially important role in countries where there are fewer parents to care for young children due to AIDS, economic migration or conflict.

Older people may also play an important role due to the wisdom and support that they can offer their community. In some developing countries, older people are seen as connecting a society with its past and providing access to it via memory and oral histories.

The nutritional needs of older people

Older people have different nutritional needs to other population groups, due to the physiological changes caused by ageing as well as to financial and psychological factors.[9] As a consequence, their needs may need to be addressed with different emergency supplements. The World Health Organization (WHO) has developed guidelines on how to promote healthy ageing through nutrition programmes.[10]

The tools for assessing malnutrition in emergencies may not be appropriate for older people. There is evidence, for example, that mid-upper arm circumference should be used instead of body mass index when screening for malnutrition in older population groups.[11]

There is little academic and 'grey literature' material (i.e. not published commercially) on the most appropriate methods for assessing and addressing malnutrition in older people in crises.[12] The Global Nutrition Cluster (GNC) and HelpAge International (HelpAge) are due to publish a training module on older people's nutrition in emergencies as part of the Harmonised Training Package supported by the GNC in 2012.

Abbreviations:

MSF	Médecins Sans Frontières	**OCBA**	Operational Centre Barcelona
OC	Operational Centre	**OCG**	Operational Centre Geneva
OCA	Operational Centre Amsterdam	**OCP**	Operational Centre Paris
OCB	Operational Centre Brussels	**WHO**	World Health Organization

Chapter 1: Introduction

There is emerging evidence that the needs of older people in crises have not been properly addressed by emergency aid.[13] There are often very high death rates amongst elderly populations in emergencies, partly due to their inherent vulnerability and partly due to services that inadequately deal with their needs.[14,15] Issues with mobility and vision – both of which may deteriorate with age – can mean that older people are more at risk in crises and are less able to access care.

There is also strong evidence that there are high morbidity and mortality rates in older people due to communicable and non-communicable diseases which can be exacerbated in emergencies.[16] Poor outcomes for older people could suggest that humanitarian aid is not targeting those most in need.

For humanitarian organisations, any failure to treat vulnerable groups should be a major issue. MSF, as a medical humanitarian organisation, is committed to providing free, impartial aid without discrimination and based on need alone.[17] Whilst no self-respecting humanitarian would deliberately exclude an individual or group from healthcare on the grounds of their religion, race or gender, people may be excluded if their needs are not identified or if there is a failure to provide appropriate assistance or services that take their vulnerabilities into account. Vulnerable groups – including older people, lactating women, disabled people and ethnic minorities – are likely to bear a disproportionate share of health problems.[18] Thus specific interventions are often necessary to prevent these groups from suffering disproportionately.

To investigate whether older people are being overlooked by humanitarian organisations – and specifically by MSF – this study reviews MSF's policy and practice regarding older people in two countries, comparing and contrasting MSF's response to older people in an acute emergency setting (post-earthquake Haiti) and a slow-onset emergency setting (South Sudan). These countries were chosen as they fitted the study criteria specified (see Methodology).

MSF has a long history of working in Haiti due to inadequate healthcare provision within the country. After the earthquake of 12 January 2010 killed an estimated 222,000 people and left 1.5 million homeless, MSF mobilised the largest emergency response in its 40-year history. Later that year, more than 180,000 people were infected with cholera in less than three months.[19] Almost all Haitians suffered health and nutrition problems as a result of the crisis which hit their country; however, the aid response to older people was probably weaker than to other vulnerable groups. HelpAge's report on Haiti three months after the earthquake highlights reported incidents of older people being abandoned in camps, at risk of abuse, unable to access food or to protect themselves.[20,21]

MSF has worked in Sudan for the past 20 years. In January 2011, South Sudan seceded from the North, leading to the formation of the Republic of South Sudan in July 2011. South Sudan's health system is extremely weak and under-resourced. Major health concerns include the effects of violence, as well as maternal and child health and chronic child malnutrition. There is also a high prevalence of communicable diseases, such as cholera, tuberculosis (TB), HIV/AIDS and malaria, and outbreaks of the parasitic disease kala azar (visceral leishmaniasis).[22] Targeted interventions specifically to help older people are clearly necessary, and yet these cannot be put into place before first understanding what their needs are.

This study proposes that MSF has prioritised women of reproductive age and children at the expense of other vulnerable groups, and that this has become embedded in the norms and values of MSF. These norms are reflected in a vast array of policies and programmes focusing on the under-five population group. Although women and children are also inherently vulnerable in crises, the norm to prioritise these groups may prevent the comprehensive assessment and response to other groups' needs. An organisation is understood as a social entity with collective goals and an institution as a structure which governs behaviour of a collective of individuals.[23] There may be a reluctance to veer away from the perceived values and norms of the organisation. However, the La Mancha (2006) agreement advocates that MSF should seek to challenge evidence of a status quo,[24] and this is what this report aims to do. We are asking whether MSF

should be addressing older people's health and nutrition needs, whether and how they have done so far, and how we can improve policy and practice.

MSF has five different operational centres (OCs) which independently manage their projects in line with the broader aims of MSF.[25] This study analyses the responses of the different OCs in the two settings. We hope that the recommendations which result from this analysis will highlight the strengths and weaknesses of MSF's response to older people and inform MSF's future policy and practice.

Chapter 2: Literature review

A systematic search strategy was carried out to find recent relevant research discussing older people's needs in Haiti or South Sudan. The selection and subsequent consideration of relevant publications (published articles, books and grey literature) was based on relevance to the research question and concepts used, as well as on contextual relevance to humanitarian response to older people and supporting policy.

Generally there were very few articles on the issue of emergency care and nutrition needs of older people, with the exception of reports published by HelpAge. A systematic search of over 5,000 relevant health journals found only a few articles discussing responses to older people in emergencies. This suggests that policy regarding older people is still seen as a niche concern and does not feature in the comprehensive policy frameworks and research of most other humanitarian organisations.

Search strategy:	
Databases searched:	Ovid Medline, Embase, Global Health, Social Policy and Practice
Journals searched:	British Medical Journal, The Lancet, Tropical Medicine, International Health
Humanitarian organisations' literature:	Feinstein (Tufts), Chatham House, DfID, Epicentre, Help Age International, MSF
Standard search terms:	<(health or nutrition* diet* or dietary requirements or nutritional requirements) AND (old* or older or geriatric or aging or ageing or elderly or over 45s) AND (humanitarian or crisis) AND (South Sudan or Haiti)>
Additional terms:	Same search terms used without (humanitarian or crisis) and without (South Sudan or Haiti)
Search dates:	February – April 2012
Total number of articles found:	2,274
Articles found to be relevant:	13
Grey literature	22 articles from international agencies including MSF

An extended literature review was carried out both prior to the interview stage and then later, so as not to be unduly influenced by existing thinking. The review's purpose was to ascertain what was already known on the topic and to gain a broader picture in terms of theoretical debate and how this might relate to the policy problem and context under study. There was a notable lack of reports and data on what the needs of older people in crises are, and the tools that can be used to assess and address their specific needs.

Four articles discussed the prevalence of disease for older people. Two relevant studies located in *American Journal of Tropical Medicine & Hygiene* focused on infectious disease spread after the 2010 Haiti earthquake; one on cholera[26] and one on malaria.[27] The cholera article addressed the importance of a comprehensive approach to the health of communities when planning services in resource-poor settings.[26] The second article suggested that in Haiti in 2010 those over the age of five had nearly three times the prevalence of malaria than the under fives.[28] Further analysis of the data by narrower age categories would allow for a greater understanding of age groups most affected. In addition, preliminary results from a study of data from MSF cholera treatment centres in Haiti indicates that individuals over 60 years old are more likely to present with severe dehydration as opposed to mild dehydration when compared with younger adults. In addition, after controlling for other factors, individuals aged over 80 years have 11 times the mortality of younger adults in cholera treatment centres.[29] MSF has produced very few reports on older people specifically. One exception was an MSF report on kala azar treatment in East Africa. The study found that older people were six times more at risk than younger people of death or severe adverse reactions during treatment for the disease.[14] The issue about older people being susceptible to infectious diseases is a point of concern. However, the tools for how to address this concern are less well established.

Gaps in nutrition provision and the challenges to overcome these gaps have been points of debate within the academic community for at least eight years.[30] One research paper highlights how the nutritional needs of older people and the chronically sick are often not well known and need to be reviewed.[30] As a result, action to provide supplementary feeding programmes to all those in at-risk sub-groups is recommended. It is also proposed that, to understand the nutritional needs of older people, those working in humanitarian settings will need to focus on community capacities and social support networks.[30] The opposite view is promoted by researchers who advocate that responses to older people's needs should be done through systems already in place to help people of other ages too. There was a successful example of this combined approach in a study by Shane et al 2011.[31] Participants in Haiti and Belize were screened for refractive error and treated with ready-made spectacles. All adults aged between 18 and 102 whose eyes fit a certain specification were provided with ready-made spectacles. There was no specific treatment of older people, but it enabled them to access healthcare for a need that predominantly affects them.

With regard to related guidance or practical support, an "EquiFrame Manual" was developed by researchers at Trinity College Dublin.[32] The 'Manual' is used to identify "*the degree of commitment of a given policy to specified Vulnerable Groups and to Core Concepts of Human Rights*."[32] The framework was used by the researchers to assess national health policies in terms of their commitment to 12 vulnerable groups drawn from four African Country partners, including older people. This is a potentially useful tool that could help identify weak policy areas and systematically address inclusion of vulnerable groups into national health policies. HelpAge have also outlined some guidelines for emergency practice regarding older people. One article highlights the necessary actions to provide a more equitable service, including measuring the needs and capacities of older people by methods such as collecting data disaggregated by sex and age. Such actions would allow older people to participate in policies affecting them, coordinate with others, build shelters with age-friendly features and target vulnerable older people.[33] Another report discusses key challenges for older people in crises and effective responses to these, such as the use of donkey cart ambulances to reach isolated older people.[34]

It is suggested that older people may be more likely to suffer in humanitarian crises. Seventy-one percent of those who died in the Hurricane Katrina disaster were over 60.[35] Higher death rates amongst older people are to some extent expected with the global demographic shift towards more elderly populations. However, older people may also have died in the Katrina disaster due to preventable causes, such as lack of information and access to cars, transport and medication.[15] This suggests that better policies could have prevented some of these deaths. Humanitarian aid is sometimes unfairly distributed, and older people as a group often have

much higher health and care needs than other demographic groups.[36] HelpAge found that of 1,912 aid projects worldwide, only 18 had any activities specifically aimed at older people. In the aftermath of Hurricane Katrina, only 0.2% of the money generated by the UN Consolidated Appeals Process and Flash Appeals was allocated to projects with specific assistance for older people.[35]

In summary, there appears to be a dearth of research in this area. Aside from research produced by specialised humanitarian actors such as HelpAge, there is very little evidence that other humanitarian actors are involved in the debate. Although some of the issues facing older people in terms of disease prevalence and health risks have been researched, there is a lack of clear guidance on how best to form policies to address these issues. Some discussion of how to measure vulnerability was found, but there needs to be more research in this area to enable humanitarian actors to know how to measure vulnerability in population groups so that they can target the most vulnerable.

Research problem

There is growing concern with the lack of adequate care provided in terms of nutrition and healthcare in emergency settings to older people. This is the reason for this report being commissioned. It was thought that

this response may be exceptionally inadequate in situations where MSF is responding to acute emergencies. This study compares two types of emergency settings to discover MSF's response to older people, to learn through these cases if there are gaps within MSF's response and to consider how MSF may be able to improve this response in the future.

Overall aim: To examine MSF operations and to assess whether there are areas in which MSF's response to older people's health and nutrition needs may be improved.

Specific objective: To identify the presence of MSF policy and activities regarding inclusion of older people in health and nutrition needs assessment and response, and to search for any gaps within this policy.

Research question: How does MSF's policy respond to the health and nutrition needs of older people in an acute emergency (Haiti) and slow-onset emergency (South Sudan) occurring between January 2010 and January 2012?

Hypothesis: MSF's policy response to the health and nutrition needs of older people is less adequate in acute emergency than slow-onset emergency settings.

Chapter 3: Methodology

Methodology

The study aimed to investigate MSF's policy regarding older people. Firstly a policy review was conducted, and secondly a comparative analysis of policy and response between the case study locations was undertaken. As there are no MSF policies directly addressing older people, MSF policy was analysed to identify whether older people are targeted through the prism of vulnerable groups and the treatment of chronic disease. The first stage of the research for this report was a policy review which considered MSF policy relating to the five MSF operational sections at a strategic/global level. Medical managers at headquarter level were also interviewed or completed a questionnaire on the presence of policy which addresses older people. The questions focused on whether health or nutrition of older people needs were assessed; whether there were programmes which addressed health needs specific to older people; and

whether there were programmes that took into account particular vulnerabilities of older people or addressed their potential role as a primary caregiver. This review provided the context within which country level responses to older people could be analysed at a deeper level.

The central element of this report is a comparative analysis of MSF policies in Haiti and South Sudan between 2010 and 2012. Data was gained from MSF operations teams working in Sudan and Haiti. The study asked medical managers in case study locations to provide any demographic data, any disaggregated data, and any health or nutritional data which is disaggregated by older age groups (over-45s). Managers were also asked to provide assessment reports, country policies, project proposals, project progress reports and project evaluation reports.

In order to measure MSF's response to older people the study had to develop criteria for ranking policy response through a selection of elements considered to reflect a group's inclusion or exclusion from aid. Normative judgments about what excludes someone from emergency aid had to be made. These were informed by the WHO's 2008 *Older People in Emergencies: Considerations for Action and Policy* document. It was decided that three key elements were important and could feasibly be investigated by the research. These elements or competencies were: whether MSF had collated demographic data for the over 45s; whether it had collated health or nutrition data for the over 45s; and whether it had policies for the relevant time period that addressed older people/ vulnerable groups/chronic disease. These competencies were investigated through interview and survey methods to key actors involved in operational management in the two case study locations, Haiti and South Sudan.

Cases were selected on the basis of feasibility and because they fit the criteria specified by the study. The study specified the inclusion of a slow-onset emergency and an acute emergency, and specified contexts where MSF was running a basic healthcare programme as well as responding to a recent emergency. The time period 2010-2012 was used to narrow the focus of the study to the most recent MSF responses in order to understand "current" policy decisions as much as possible. Haiti was chosen as an acute emergency which fit these descriptors. There were a few locations where MSF worked which could have been chosen for the slow-onset emergency setting, including South Sudan, Somalia and Ethiopia. South Sudan was chosen for issues of feasibility as MSF has a high presence of activities in that area. The study investigated the work of two to three operational centres per case study location. This study used evidence provided by three OCs which have projects in South Sudan, and two OCs working in Haiti. A third source of data for Haiti was provided by intersectional evaluation reports.

Analytical framework

Sociological institutionalism, also known as normative institutionalism, informed this research. Sociological institutionalism, a theory which emerged within organisational theory, understands organisations to be primarily connected to the culture in which they exist.[37] The theory advocates that bureaucratic practices and work structures spread, not necessarily

due to their rationality, but because they are understood as socially appropriate practices. This framework was chosen because it was thought that MSF might understand the prioritisation of children and mothers to be socially appropriate. This would indicate that MSF might have a tendency to set projects which respond to these groups, possibly without always assessing who has the greatest level of need. MSF's focus on these population groups may mean that they are not collecting data to inform an understanding of how they can help other groups, such as older people.

MSF, along with other humanitarian organisations, may be justified in prioritising young children, especially the under fives. Young children are inherently vulnerable, and in many countries where MSF works, they are highly susceptible to neonatal infections and have low immunity and high rates of mortality.[38] Young children's inherent vulnerability is likely to make them, as a group, one of the neediest groups in emergencies. Mothers may also be given precedence because of their role in caring for young children, alongside their own vital health needs. The prioritisation of women and young children may have additionally been driven by the UN Global Health Agenda and the Millennium Goals which aim to decrease infant and maternal mortality.[39]

This external drive is likely to influence all humanitarian organisations' policies. For MSF, the focus on women and young children may have prevented the organisation from adapting its policy to complement social and familial changes. For example, the AIDS pandemic and labour migration means that there are fewer parents of young children available to care for their children, with a resulting increase in older people who are primary caregivers to young children.[40] Policies need to adapt to reflect new dynamics if MSF is to ensure it is still targeting the most in need.

This study expects that, if MSF adheres to these norms, it will negatively affect its response to the health needs of older people. It is also expected that MSF's policies will alter in different emergency settings depending on the degree to which the organisation has been focused on the social norms of the institution. The study predicts that MSF's policy response to older people will be worse in an emergency setting than a slow-onset emergency setting. This expectation derives from the idea that

social norms will be more deeply embedded in an emergency setting, because there is less time for planned strategy, and the organisation will be more likely to depend on well-accepted and ingrained social and organisational norms. Some of MSF's policy documents, such as OCG's operational policy, suggest that MSF's organisational strategic norms, once embraced, may be difficult to challenge:

> *"Our organisation is suffering from a « this is not MSF » syndrome which tends to restrict initiative and progress, and to favour the implementation of standard rules without an understanding of their raison d'être and their natural need to evolve with time"* [41]

MSF may be reluctant, as many organisations are, to change. Organisational culture prescribes "the way we do things here".[42] Although change can be difficult, MSF endeavours to question its priorities to ensure they are meeting its aims as an organisation.[43]

Risks of project (with mitigation strategies highlighted in brackets):

Poor buy-in from contributing stakeholders (obtain desk support for participation)

Poor agreement between editors (final arbitration mechanism)

Chapter 4: Policy review

This section aims to analyse MSF's response to older people in operational level policy, to provide context in which the country level policies could be examined (see annex 2). There are no MSF operational policies which directly guide the responses to older people. Due to this, policies have been examined for their mention of older people through indirect means, such as citation of vulnerable groups, chronic disease programmes, outreach programmes and mobility/vision programmes. The highest policy directives, such as the MSF Charter,[44] were examined, as well as policies related to operational level activities. Policy information was gathered from policy documents and interviews with medical managers responsible for operational activities. The responses and policies mentioned refer to MSF and its work generally, not to the specific countries which will be examined in chapter 5.

The discussion highlights a potential tension between different MSF policy priorities. Some policies cite that they are guided to treat those most in need, whilst others describe a 'treat what we meet' mantra. 'Treat what we meet' or interventions based on clinic presentation, sits uneasily with the principle of impartiality. If efforts are not made to locate those who are potentially too ill to access health clinics, or if data and knowledge about older people, and their needs is not gathered, then MSF cannot be sure that they are treating those most in need.

The MSF Charter

MSF's Charter can be considered as the highest organisational directive which should, along with the 1996 Chantilly and 2006 La Mancha agreements, guide operational level strategy and policy. In terms of addressing vulnerable groups, the Charter says the following:

> *"Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed, gender or political convictions... Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions."* [44]

The La Mancha agreement states that "Providing medical assistance to the most vulnerable people in crisis due to conflict is a key MSF priority... We must question our acceptance of this status quo and try to address what we are neglecting today."[43] This agreement affirms MSF's commitment to identifying and addressing the needs of the most vulnerable.

Operational level policy – setting intervention priorities

MSF has five OCs based in Paris (OCP), Brussels (OCB), Barcelona (OCBA), Amsterdam (OCA) and Geneva (OCG). Each OC independently decides its operational policies and manages its humanitarian assistance programmes. Four out of five operational level policies were examined for their reference to vulnerable populations and priorities.[a] OCA's current operations policy 2011-2014 is summarised as focusing on saving lives, protecting dignity and alleviating suffering.[45] It is also committed to expanding "outside what are traditionally thought of as 'humanitarian contexts'". Its policy states that:

> *"In the choice and implementation of our interventions, the principle of impartiality guides our actions. We follow its simplest form: to provide aid to those who need it most… We must avoid the complacency of busy clinics and continually ask ourselves, "Who should be here? Who is not coming?"* [45]

This final comment shows that OCA is trying to challenge the organisational norms that may have formed over time and to ensure that it is constantly adapting its perception to ensure that it is targeting its support towards the most in-need groups. Geneva's Operational Policy 2011-2014 also outlines a commitment to search for and include the most affected or most vulnerable groups:

> *"In many settings, certain groups of population have a reduced access to health facilities due to increased vulnerability. Where it is relevant, active efforts should be made towards these groups within the larger community to ease their access to the specific cares they may need… The notion of 'active impartiality' only makes sense if these particular efforts are effectively made within our projects to identify and care for the people who are most affected by the crisis situation."* [41]

This statement suggests that MSF can only state that it is addressing the most vulnerable if it knows about the population on whose behalf it is intervening. Treating those most at risk in the clinic, for example, may not include those with the most serious health problems, as some of the most at-risk people may not be able to access health clinics.

OCBA's Operational Prospects for 2011 states that it will prioritise activities in urban contexts and the Middle East.[46] OCBA's operational policy prioritises important areas including secondary care, sexual and gender-based violence care, infectious diseases, nutrition, helping displaced populations and the care of chronic diseases.[46] These priorities reflect a mixture of acute care provision and longer-term projects.

The Operational Prospects for Brussels 2011-2013 states that emergencies will be prioritised. However, the strategy highlights the importance of a balance between default and choice interventions. Choice projects are described as those which "tackle specific areas where medical interventions can make an important difference to populations that find themselves completely neglected".[47] This policy suggests that acute treatment will be prioritised but that other treatments, if they substantially help those who cannot otherwise access care, are also justifiable.

Operational level policy – assessing and responding to older people

Data was collected from medical managers at headquarter level who commented on whether MSF had policies about older people; whether nutrition needs of older people were assessed; whether there were programmes which addressed health needs specific to older people; and whether there were programmes that took into account particular vulnerabilities of older people or addressed their potential role as a primary caregiver. Data was collected through email questionnaires or face-to-face interviews.

While there was no official 'policy' as such concerning older people, WHO guidelines were seen as guidance utilised in MSF programming. One respondent perceived that policy for older people was implemented through the tackling of non-communicable diseases.

> *"Globally speaking, there is no policy in our medical department dedicated to specific groups, but rather on disease/health service."* M1[b]

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a OCP's policy was not examined because it did not respond to the study's request for policy documents.
b Names of medical managers have been anonymised. Each number preceded by M represents a different respondent.

With regards to awareness of criteria used to assess or respond to older people's nutrition needs, there was minimal awareness:

> "In Angola (Malange 2000) we started a nutrition programme as a response to an emergency, but when the emergency was over we ended up with feeding centres full of older people who were just thin or having oedema… We decided that if there was no change in weight after three months, we would discharge the patients from the feeding programme and refer them to a food distribution programme." M2

Such anecdotal evidence indicates that older people are not always responsive to programmes designed to help younger patients. When asked about whether there were criteria to measure older people's nutrition needs in the field, one manager replied that there was:

> "Only anthropometric criteria for severe and moderate acute malnutrition. These criteria differ per project and per country." M2

There is evidence that this criterion is not appropriate for older age groups because of age-related changes to people's physiologies, which make body measurements an unreliable way to diagnose malnutrition in older people. Respondents were asked whether they knew of programmes which addressed health needs related to older age, such as high rates of chronic disease, conditions affecting mobility, eyesight, hearing and vulnerability to disease outbreaks. All respondents indicated that there were examples of specific programmes which had targeted one of these needs, for example cataract surgery. However, there was a consensus that there are few tools available for management of conditions related to the elderly in acute emergencies.

Respondents were questioned about the visibility of older people in crisis and strategies to identify and respond to this group. 'Community outreach' was overwhelmingly cited as a key strategy to target all vulnerable groups. There was evidence that outreach programmes often include support to female heads of households who generally have poor access to services.

> "This community approach is not specific to older people, but is globally covering all groups – often more linked to high disease burden than specific group population." M1

> "In Africa, in urban settings, where there is less reliance on family, there is more opportunity for [community outreach programmes]." M3

Respondents also commented on the role of older people as carers for orphaned grandchildren or sick adult children, where there is a high prevalence of HIV/AIDS. It was asked whether this is taken into account when designing programmes, for example nutrition programmes for orphans:

> "Although not protocolised, often ways are sought to give extra support, for example referring to food distributing agency, or seeking extra support from the centre itself, in the form of food, home visits etc." M2

It was acknowledged that, whilst not part of a specific protocol, children are often monitored bearing in mind the issue of older people as primary carers in terms of ways to give extra support.

Discussion: Who is targeted?

We will examine the discrepancy in how vulnerable groups are defined between MSF's global policy and lower-level operational policy and practice. The target to treat those who need it most will also be examined. The MSF Charter specifically dismisses any action that discriminates on the grounds of race, religion, creed, gender or political convictions.[44] Similarly, one MSF operational strategy refers to non-discrimination principles on the basis of "political affiliation, race, religion or sex, and *any other similar criteria*". The addition of any other similar criteria suggests that the team would not want to discriminate on the basis of age. However, the policy also states which people it would expect to include as 'vulnerable' within crises, and older people are not on the list. The focus is on equal treatment for people of different race, religion, sexuality or political persuasion. On the other hand, the same team highlights the objective to make an epidemiological shift towards non-communicable diseases. This focus on non-communicable diseases may be an advantage for older people who are predominantly afflicted by chronic diseases.

One policy's definition of impartiality focuses on provision of aid to "those who need it most". As increased co-morbidity develops with age, this suggests older people would often be prioritised in basic healthcare settings, if not in emergency responses. However, none of the operational policies

examined focus on older people as a group and their potentially high level of care needs. There is also evidence that some MSF responses are not treating those most in need, but are operating a 'treat what we meet' policy.[48] This suggests that the experience in the field does not always reflect formal policy.

A failure to target the older population could occur for several reasons. It may be that there is not sufficient experience in the field to treat the diseases suffered by older people. It may be that, while the experience is there, the clinical resources to diagnose and treat these conditions are not available. Finally it is possible that this vulnerable group are thought of as a lower priority. The prioritisation of young women and children in humanitarian responses may be an informal guiding principle within MSF, even though this is not always in line with treating those most in need. It may be that to treat those "most affected", more work needs to be done to ensure that such people are found.

In some contexts where there are higher numbers of older people, such as Iraq, MSF has had specific programmes to meet their needs. Unfortunately organisations like MSF may not be able to justify running specialist health programmes where there are only a few older people with high medical and care needs. As with everything that MSF does, choices have to be made. But if these choices come into conflict with treating those who are most in need, then they require closer examination. MSF is tasked with deciding whether it can do what it already does and meet the needs of older population groups. Older people may be the minority in certain contexts, and their numbers may persuade MSF to think that the issue should not be a priority. At the same time, older people may have very high health and nutrition needs, signifying that they are in great need. Incorporating an adequate response to older people within aid programmes that help people of other ages too could be the best option.

Global policy objectives for older people in MSF medical strategies

Some MSF policies address the La Mancha objectives to address vulnerable groups; other policies, however, do not cite vulnerable groups as key targets. The survey and interview data suggest that different MSF OCs have different frameworks for action and policy on older people. One source stated that the WHO's 2008 *Older People in Emergencies: Considerations*

for Action and Policy Development guided their policymaking on older people. The WHO document outlines how to make health policies inclusive of older people and advocates for "mainstreaming" emergency policies to include older people within a comprehensive approach.[49] It argues that it is a lack of awareness of older people's issues, not of tools to address them, that has meant these policies have yet to make an impact.

Despite knowledge of the WHO's guidelines for policy and action with older people, none of the policy documents examined for this study include any analysis of disaggregated data for age groups of 14 years and above. This data is sometimes collected at the clinic level, for example when patients are registered. However, age data is not recorded on the patient tally sheet or computerised, so there is no easy access to this information. There is also no evidence of "age sensitive and appropriate" services.[49] For MSF to provide age appropriate services, it would usually be considered necessary to collect data disaggregated by age, as understanding the needs of certain health groups is essential before attempting to address them.

There is evidence that older people are included in feeding programmes, although one interviewee noted that older people often failed to gain weight,[48] and MSF health workers had to discharge such patients and refer them to food distribution programmes. This suggests that new methods need to be found to address older people's nutrition needs.

Other sections in MSF use very different frameworks. One policy framework is structured on the basis of disease or health service, and there are no policies specific to other groups, such as age or sex cohorts. Some respondents stated that, although the operations team does not specifically target old people, there was consideration of people who may lack access to healthcare, and that they considered the "less accessible and more vulnerable groups all together".

One OC has no policies specific to assessing older people's health needs, and their policies only mention guidelines for addressing vulnerable groups generally. "For example, *Rapid Health Assessment for Refugees or Displaced Populations* (MSF 2006) only mentions the elderly as part of the general vulnerable groups. The same goes for the International Federation of Red Cross & Red Crescent Societies (IFRC)'s *Guidelines*

for Assessment in Emergencies' (2008)."[48] One respondent made assurances that their framework, current and past, includes chronic diseases, but admitted that the data necessary to understand the issues concerning older people has not been gathered.

Directors stated that MSF's involvement in longer-term projects like HIV and TB indicate that it can no longer apply the "emergency only" rationale. It was largely felt in MSF culture in the 1990s that the treatment of HIV and AIDS was not something that MSF should do, because such an intervention would be addressing a long-term chronic disease rather than responding to a natural disaster or outbreak of disease, conflict or violence. Since the "emergency only" rule was relaxed by MSF in relation to HIV/AIDS and more recently to TB interventions, a debate has arisen about the lengths to which MSF should go to treat other chronic diseases such as diabetes and hypertension. Some medical directors stated that MSF should be considering how or whether to address issues such as chronic disease and palliative care.

Alternative approaches to providing care for older people

Home visits which could address isolation or immobility in older people, were considered by respondents as an area that could be expanded in order explicitly to include older people. Some respondents saw this as part of the global strategy used in some specific contexts where community health workers are employed. Most respondents said that community work would usually be linked to other vulnerability factors such as disease burden or gender/status (e.g. households headed by a single female). One respondent noted that this type of outreach work does not rely on doctors but can be done by other healthcare professionals. Overall there was a positive response to using community outreach work as a method of addressing vulnerable groups' needs. The changing roles of older people – who are increasingly becoming primary caregivers – was acknowledged, as was the need to find ways to provide extra support to them. Such examples of indirect approaches to providing appropriate care are good examples of what could potentially become more widespread practices.

While no specific MSF policies exist concerning responses to older people, there are operational level strategies which promote giving aid to the most vulnerable without unfair discrimination. There is also some evidence that OCs respond to issues that they face regarding older people using non-protocolised methods, such as home visits or the provision of extra food to older people. There may be a reluctance to offer a programme that meets the high care needs of a small minority, but this could be overcome by a policy that incorporates an appropriate response to older people's needs within a comprehensive aid programme.

Chapter 5: Findings and discussion

Results

From examining the policy context – at both the level of the MSF Charter and the operational level – there appear to be few MSF operational policies that are directly related to older people, although there is some acknowledgment of older people through the prism of vulnerable groups. The comparative case study analysis will examine the similarities and differences in MSF responses to older people between a slow-onset emergency and an acute emergency. The results are provided in table form with data provided in the form of quotations.

MSF does not have policies directly concerning older people at country level, so in order to measure MSF's policy response to older people, a number of competencies were chosen. The competencies which were thought to be important were (i) whether there had been the collation of demographic data for the over 45s (ii) whether there was any health or nutritional data disaggregated by older age groups, (iii) and if there are policies that mention older people, chronic disease or vulnerable groups. These competencies are based on practices regarded as vital to responding to older people in emergencies outlined by the WHO.[49] MSF needs to know how many older people are in the country in which they are working,

what their health needs are, and to have policies which target or identify these people or their needs.

Data collated from MSF operations centres working in Haiti and South Sudan included evidence of collation of demographic data and health data, and review of country reports, project proposals, project progress reports and evaluation reports dated between 2010 and 2012. Two OCs provided evidence for Haiti and three provided evidence for South Sudan. Not all MSF OCs were working in each context, while others were unable to respond to requests for evidence and so were not included in this analysis.[50] As only two OCs could provide evidence for Haiti, evidence was also used from MSF's intersectional report on the Haiti response, as well as the Haiti evaluation report.

The links between responses and the specific OC that provided them remain anonymous. This is because our aim was to investigate MSF's response as a whole, and to compare MSF's response between different countries and not between different OCs.

Three competencies were tested (demographic data; health or nutrition data; and policies which address older people/chronic disease/vulnerable groups) by analysing the evidence provided from the three OCs or

Competency	South Sudan/ 3 OCs		Haiti/3 OCs (or other sources)	
	Neg	Pos	Neg	Pos
collation of demographic data for the over 45s	3	0	2	1
health or nutritional data disaggregated by older age groups	3	0	3	0
presence of policies that mention older people, chronic disease or vulnerable groups	2	1	2	1
Total	8	1	7	2

Fig 1: Score for competence in policy response for older persons in acute and slow-onset emergency settings.
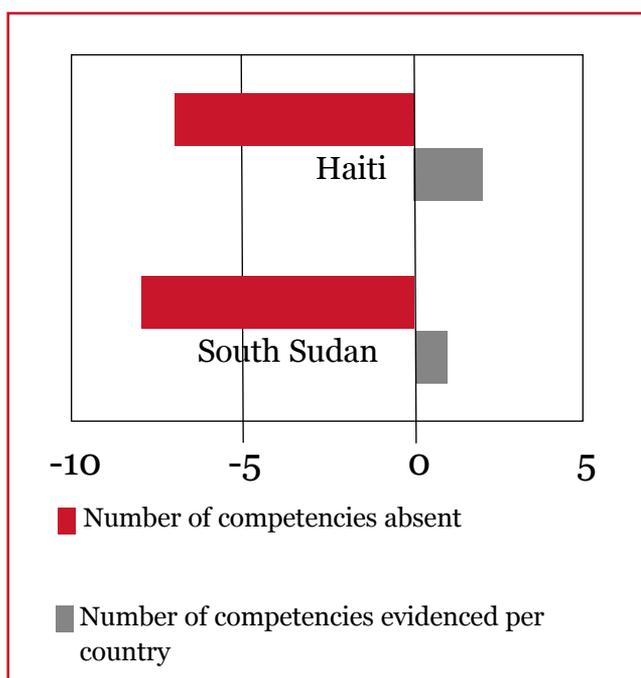

Fig 2: Illustration of competencies evidenced per country.

other sources (see Figure 1). The competency was decided as present or not, and a positive response was represented with one point. A positive score indicates a more developed response toward older people, while a negative score reflects absence of competency. As there were three OCs, and each was analysed for three competencies, the highest score that a country could get was nine.

Figure 2 shows that Haiti scored two out of nine for its OCs' engagement with the competencies measured. South Sudan scored one out of nine for its engagement with the competencies described. The results indicate that data was generally not disaggregated for older age groups. Only one of three MSF teams in Haiti collected disaggregated data for older age groups (past the clinic level); none studied did this in South Sudan. There was only one example where an OC collected nutritional data in Haiti, but it was not done for the over 45s. There was no evidence of this being done for over 45s in South Sudan. There was one example of chronic needs being addressed in Haiti and mention of vulnerable groups from one OC in each case study location.

The lack of health or nutritional data disaggregated for the over 45s past the clinic level for either context illustrates the lack of purposeful response to older people. Despite the lack of a policy framework, there is some evidence of an incidental positive result to older people through policies concerning chronic disease or vulnerable groups. Whilst the policy response to older people was minimal, there were some examples where MSF did respond to perceived needs in a way that challenges organisational norms.

The first question of the survey or interview asked the country level medical managers whether MSF collated demographic data past the clinic level for over 45s. There was minimal evidence that MSF did this in Haiti. There was no evidence of MSF doing this in South Sudan.

Haiti: *"Four child categories, adolescent category, 15-48 year, and >49 year category."*

South Sudan: *"None available. Old age is very relative here. Anecdotally, we do not see many people we would classify as 'older', maybe one or two per hospital."*

In response to questions about whether health or nutrition data was collected for the over 45 age group, there was no evidence of MSF doing this in either Haiti or South Sudan.

Haiti: *"We disaggregated by four age groups, including <6 months, 6-59 months, 5-14 years and 'adults'."*

"Not available; there is no information per age group further than <5 and >5 years old."

South Sudan: *"Under 5s and over 5s only."*

Different managers collect data differently and disaggregate it into different age groups. However, none were able to provide evidence that they collected disaggregated data past the age of 14.

Country-specific policy documents referring to the years specified by the study timeframe were reviewed and analysed for any specific mention of older people/ vulnerable groups or chronic disease.

Haiti: *"Commitment to continued work on infectious disease like HIV/AIDS, TB, malaria, and an acknowledgement of 'new' non-communicable chronic disease e.g. diabetes, respiratory and cardiac diseases."*

South Sudan: Primary and secondary healthcare *"with a specific focus on vulnerable groups, including women, children, returnees and victims of violence, as well as on neglected diseases".*

"There is no non-communicable disease programme. TB does not address older adults. No data collection. It is difficult to address older people's need in a rural setting. We try to treat the emergency cases."

"There are no specific programmes for older people or for treatment of chronic disease. "

There is some evidence that vulnerable groups had been considered in both settings. However, only one of the three OC's working in each setting mentioned vulnerable groups, so MSF's policy response to older people's needs is still deficient.

The policies and interview data were also considered in terms of the saliency of older people's needs and the desire to address these needs.

Haiti: *"One remark during the evaluation [of the cholera response] last year was that medical staff felt that there was not enough attention paid to elderly people suffering from cholera. But again, we didn't look at specific data."*

South Sudan: *"There are no resources to meet chronic needs. Expansion into this would be complex and allow the project to grow beyond 'unmanageable limits'".*

MSF's tendency to adhere to its own cultural norms (and thus the degree to which policy regarding assessment and response to older people's needs is negatively affected) is less pronounced in emergency humanitarian settings than slow-onset emergency settings. Our hypothesis was negated by the results. It was expected that South Sudan would have scored higher than Haiti because of having the stability and timeframes that could have allowed for the adoption of a more comprehensive approach to older people's needs. Although the data does not draw definitive conclusions, the report nonetheless indicates that, particularly in the slow-onset emergency, there was a limited perspective to target those who did not present at the clinic level.

Comparative analysis

A comparative analysis of contexts, using the framework of sociological institutionalism outlined in Chapter 3, was carried out. The theory advocates that bureaucratic practices and work structures spread, not necessarily due to their rationality, but because they are understood as socially appropriate practices. MSF may have embraced the norm to prioritise interventions for young children and mothers as socially appropriate. It was expected that MSF would have a tendency to adhere to its own cultural norms in emergency contexts. It was expected that MSF's reliance on traditional norms is more likely when well-planned strategic policy is at a minimum, i.e. when MSF is responding to emergencies. Analysis using this framework highlights evidence concerning specific population groups and the treatment of these groups. Key similarities between MSF responses in Haiti and South Sudan included common failure to collect and record data disaggregated by age and sex, the focus on vulnerable groups and the targeting of women and children in nutrition programmes. There are noticeable differences between the contexts in terms of addressing chronic disease and MSF's perception of the appropriateness of its response to older people.

Similarities

Absence of a purposeful response to older people

The similarities between contexts included the common failure by MSF in both settings to collate health data disaggregated by adult age groups (past the clinic registers). MSF mainly disaggregated data between the over-fives and the under-fives. At the clinic level, when patients access healthcare they often register and give details including their name, sex and age. However when this data is collated (and transferred to a computer record) the data is usually only recorded in terms of the under-five population group and the over-fives. This is a problem because no further analyses to investigate which people are suffering from which illnesses can be conducted. In Haiti there was evidence of some data disaggregated by age, split into four age groups. Unfortunately the fourth and largest group (14 years old and above) is still a very large group in which many health differences will be masked. None of the heads of mission responsible for South Sudan could say that there was any health or nutrition data collected except for the under fives.

There is also evidence that no uniform data system was used in Haiti.[51] This lack of a uniform data system could impede MSF's ability to create strategic overviews or analyse and review priority group settings.[51] In Haiti an MSF review found that data collection and analysis was "far below the level required for an emergency intervention of this scale and intensity".[51] This continued to be an issue during MSF's response to Haiti's second crisis of 2010, the cholera outbreak. An emergency medical coordinator highlighted the inadequacy of teams within MSF using different data collection tools. Only one OC used a line list to collect data, which was judged by an MSF evaluator as an effective way of gaining data which can be used retrospectively.[52] MSF's general deficiency in data collection hampered its ability to share information internally. MSF's intersectional evaluation of its response to the earthquake found that generally coordination between the OCs was weak.[51]

Coordination on the collection of data would have allowed for more efficient data collection tools to be utilised and led to results that could be shared and collated. Addressing data collection challenges would allow policies to address health and nutrition needs of older people. HelpAge and the Inter-Agency Standing Committee (IASC), amongst others, have stressed the

importance of gathering data disaggregated by age and sex. If there is a lack of data on older people, it will be impossible to create meaningful policies that address the challenges they face.[53]

Vulnerable groups targeted

Vulnerable groups were addressed by policies in both contexts, sometimes specifically and sometimes through the implementation of measures that address vulnerable groups, such as outpatient feeding programmes. In Haiti, MSF priorities were established relevant to location, focusing on the shelter/housing needs, emergency obstetrics and post-operative care. The intersectional review questioned the similarity of the MSF response in Haiti between the different sections.[51] "There was limited capacity to provide other services.The operational strategy was...a choice."[51] The report suggests that the OCs' priorities were very similar and this may have led them to providing similar services and perhaps overlapping services. This implies that better coordination between OCs might have made it possible for MSF to provide a range of services. However the report also suggests that MSF chose to target these areas. There was also evidence that one OC identified an opportunity in Haiti for non-typical MSF activities such as programmes addressing chronic disease.

In South Sudan MSF focused on infectious diseases such as HIV, TB and kala azar. However, one project within South Sudan had "a specific focus on vulnerable groups, including women, children, returnees and victims of violence, as well as on neglected diseases".[54] There was also evidence of programmes that would potentially help vulnerable groups, such as mobile clinics and outpatient feeding programmes, as in the Haiti response. The difficulty of travel in South Sudan as a barrier to vulnerable groups accessing care was an issue that was raised several times.

Nutrition programmes focused on women and children

Nutrition programmes, such as therapeutic feeding programmes, provided a focus on women and children in MSF's responses in both Haiti and South Sudan. In order to provide feeding programmes that help older people, more research needs to be done into developing emergency products that are appropriate to their needs. As anecdotal evidence presented in Chapter 4 suggests, older people are not very responsive to standard child-focused feeding programmes. Nutritional surveys were done in South Sudan and in Haiti, but both surveyed only children,

due to the high levels of malnutrition in this population group. However, these malnutrition surveys could easily be adapted to survey the whole household or random members of the household to understand the prevalence of malnutrition across a population as a whole and subsequently used to analyse data specifically for one group. When a survey gathers information on only one population group, the data and subsequent response is not likely to be as useful to other groups. Collecting data across a household, as opposed to just on the under fives living there, would not cost much more in terms of resources. This would allow for greater understanding of older people's needs and would enable all vulnerable groups to be identified.

Differences

Chronic disease targeted only in emergency setting

The general differences between the MSF responses in the two locations are to be expected. Responses are adapted for the appropriate problems or contextual challenges in that country, such as responsiveness to sporadic conflict in South Sudan. More significant differences included the extent to which chronic diseases were focused on and the difference in MSF's perception of its response to older people.

Addressing chronic diseases was present in the individual OC's strategic global plan, but of the two settings this was only evidenced in its response in Haiti. One project sought to address hypertensive crisis, cardiac decompensation, diabetic coma and cardiovascular diseases. There was no evidence from South Sudan of non-communicable diseases management. Medical managers identified barriers to provision of programmes addressing chronic diseases, including a lack of resources to address chronic needs, a lack of staff, difficulty of access and a lack of tools to assess needs. Respondents suggested that access to basic healthcare is difficult as it is. One respondent reflected how, in some ways, a long-term setting should be the ideal place to address more long-term chronic needs, but that expansion into chronic needs would be complex and allow the project to grow to "unmanageable limits".[48] Most respondents highlighted the difficulty of accessing healthcare, especially for those lacking mobility or those who are very sick, and inhibiting the provision of mobile clinic services. They acknowledged how transport and travel related difficulties also inhibited MSF's ability to actively look for those who could not reach the clinic. The finding that chronic diseases were not addressed

in the slow-onset emergency setting shows that there may be a tendency for MSF to adhere to its cultural norms more strictly in slow-onset emergency than emergency humanitarian settings.

MSF's perception of its response to older people

Evaluations of MSF's emergency work in Haiti reflected on the inadequacy of the response to older people. The intersectional review found that, amongst other vulnerable groups, the elderly were at risk of moderate and severe malnutrition because of lack of food and precarious living conditions.[51] Evaluations of the cholera outbreak also highlighted the concern of some MSF workers of their inadequate treatment of older people.[48] A few key recommendations were highlighted by the evaluation, such as extra training provided for dealing with the elderly, including closer attention to the dehydration status of older people and mobilising older people more gently to prevent embolism.[55]

South Sudan respondents articulated that either there were not many older people in South Sudan, or they were not visible. Respondents speculated that few older people were perceived by MSF as needing aid for two possible reasons: because older people have difficulty reaching clinics; or because MSF workers have difficulties visiting older patients (or any patients) outside the clinic setting. The respondents accepted that geographical factors (such as rural, mountainous and often flooded settings) coupled with a lack of infrastructure made access much more difficult, particularly for those who may be vulnerable or lack mobility. In addition, respondents also spoke of the difficulty of providing mobile clinics in South Sudan. In the past, MSF has specifically targeted older people when it has seen a pronounced need, for example in Bosnia in 1993 where MSF responded to an insulin crisis and provided assistive vision and hearing technologies.

As there is no direct response to older people in South Sudan, this implies that the needs of older people either do not exist or they have not been identified by MSF. Respondents asked, "Is the concern really relevant there?"[48] Concerns about the response to elderly people were raised in several evaluations of MSF's Haiti intervention. However, there is no recent intersectional report on MSF's response in South Sudan that would provide an equal comparison. There were perceptions from respondents that older people's needs were not well-addressed in either location. The view that this was something that should change in the near future was only reflected in MSF evaluations of the Haiti response. Judging from the views of the medical managers interviewed, it seems that addressing and responding to older people's needs in South Sudan will not be an aim in the near future.

Discussion of findings

There was one exceptional example where MSF focused on chronic diseases in Haiti. The explanation for this difference may come from the relevant OC's explicit consideration of chronic diseases in its global strategic plan. However, this was not reflected in its response in South Sudan. This suggests that, either the Haiti response was particularly innovative or unusual, or there was a better justification to target chronic diseases in this setting than in the slow-onset emergency. One MSF team involved in operations for South Sudan said that there was no non-communicable disease programme and they were not sure that there was a need for one as there were very few older people. However, the OC did provide some outpatient and mobile services which suggest that when the situation is stable they will provide services that may be particularly useful to older people. On the other hand there was a mention of vulnerable groups in a country policy for the slow-onset emergency setting, but not in Haiti. Vulnerable groups are mentioned in all MSF OCs' global strategic plans, but there are fewer citations of vulnerable groups in the more detailed country reports, progress reports and evaluation reports for the contexts studied. This suggests that global operational aims have perhaps not been operationalised; who exactly is vulnerable, and how their needs will be responded to, may not be a part of policies at a lower level.

MSF's policy response to older people was generally found to be inadequate. This is possibly due to MSF embracing cultural norms which tend to prioritise the needs of women and children. This prioritisation is not necessarily unjust or wrong. However it may be that this prioritisation prevents the provision of a more comprehensive humanitarian approach that includes older people. This cultural norm may need to be consciously acknowledged by MSF policy-makers in order to design policies and programmes which can be expanded to more comprehensively assess and respond to the needs of older people, as part of the total crisis population. The sense of unwillingness or difficulty in approaching such a change may be due to the "this is not MSF syndrome".[41]

Overall, the policy response to older people appeared to be stronger in the emergency setting than the slow-onset emergency; this suggests a negation of the supposition that MSF's cultural norms would be more closely embraced where there is less time to plan responses that are more comprehensive. More research would need to be done to know whether a difference between MSF's response to older people in slow-onset emergencies and acute emergencies is always present. The differences found could be due to context specific factors that may not be closely linked to the case study's description as either slow-onset or acute emergency. These explanatory factors could be specific to Haiti, such as resource capacity or urban location of disaster, or the explanatory factors could be specific to South Sudan such as remote rural location and scale of issue.

Perhaps there was a feeling that, in Haiti, the huge capacity (number of NGOs present, high amount of money donated in aid) allowed MSF to see consideration of more chronic long-term needs as a real possibility. This would suggest that financial implications are a strong driver of country policies. The results could also be due to the differences between the urban and rural locations of the disasters. The earthquake in Haiti caused the most damage in its capital city, Port-au-Prince, whereas South Sudan's issues are spread across its vast, inaccessible land. The

differences in MSF's response could be due to these factors and not to the slow-onset versus acute emergency distinction.

Alternatively, the key finding that the prioritisation of women (of reproductive age) and children was more tightly embraced in the slow-onset emergency could be due to factors associated with the slow-onset emergency setting. For example, it could be that the scale and longevity of a project in a slow-onset emergency overwhelms operational departments when considering priorities, and thus in making their choices they target the under-fives. This prioritisation may be a natural response to the scale of the problems faced and a justifiable way to narrow the population targeted for interventions. On the other hand, it could be that the context of the work on malnutrition directs MSF towards the under-five age group. This work focuses on providing ready-to-use therapeutic food, which is most effective for under three-year-olds. Further work needs to be done to investigate these possible explanations behind the observed differences. A future comparative report which examines a different slow-onset emergency and acute emergency could be undertaken. This would provide support or could undermine possible explanations for the differences raised by this report, which would allow MSF to have an even greater understanding of how it approaches needs in different contexts.

Chapter 6: Limitations and conclusion

Limitations

All comparative studies are limited in the extent to which they cannot be autonomous units for comparison. It is difficult to directly state causal explanations for phenomena because cases cannot be detached from the mutual influences that continuously affect each setting.[56] Within comparative research the approach is multidisciplinary. Whilst it does offer some flexibility, it is limited by the fact that there is no methodology that is specific to such an approach.

Specific to this review there are some limitations. The OCs which did respond to the study request for evidence were different in each location, e.g. OCP was

present in Haiti but not present in South Sudan. As there were different OCs operating in the study locations, this means that differences in responses could be attributable to differences in operational strategies rather than differences in response between emergency and slow-onset emergency settings. Two of the three OCs were kept constant between the locations which should minimise this risk. There were only two OCs that could provide evidence for Haiti, so the third source for Haiti was responses from the MSF evaluation team. This is useful to the review and provides a wider understanding of MSF's response in Haiti. However, the equivalent has not been produced for South Sudan which may have influenced the interpretation of the results.

Finally, the exercise is a desk-based analysis. All data presented is made available by desk-based key respondents. This means that the review does not have an outsider's view of the policy, but one firmly connected to the organisation that it aims to analyse.

Conclusion

In conclusion, the study found that there was no purposeful policy response to older people. MSF has gaps in collating disaggregated demographic, health and nutrition data for the over-45s in both contexts. This study suggests that, particularly in the slow-onset emergency, there was a limited perspective to target those who did not present at the clinic level. The policy response to older people was found to be stronger in the acute emergency location. This might be because the huge amount of resources present after the Haitian earthquake allowed MSF to consider long-term needs, or possibly because MSF's knowledge of the location before the emergency enabled a more strategic approach. Alternatively, MSF may have focused on the under-five population in South Sudan because of its work across Africa on malnutrition in this age group, or because the scale and difficulty of the work to be done there overwhelmed it and forced it to define a narrower focus.

There was some evidence of older people's needs being indirectly met by programmes which provide outreach services or vision/mobility programmes, but there were also gaps in addressing chronic, non-communicable disease. There was also evidence of practice informing policy, as those at the implementation stage were actively addressing needs of older people as they identified them. The reflections from MSF evaluations that older people's needs were not well-addressed in Haiti have provided justification for this review and should encourage a proactive response to policy change. These innovative and responsive methods suggest that MSF is not solely directed by organisational norms and there can be challenges to norms. There are examples of innovative practices where MSF responded to the visible need of older people as far back as 1993 in Bosnia. However, MSF's policies still tend not to address the needs of older people. There was identification of a need in the review of the cholera response in Haiti, but little evidence that the need had been responded to. However, there has been progress on addressing the challenges faced by an increased worldwide prevalence of chronic disease in operational strategies.

This is one of the first pieces of work done by MSF that comparatively assesses MSF's response to older people. This study should provide a baseline of knowledge of MSF's response to this group's needs. However, much more work still needs to be done on researching how older people's needs can be addressed and considering how MSF approaches their needs. Prior to investment, there needs to be agreement within MSF that the inclusion of older people is warranted in its policies. Although the direct targeting of the over-45s may not be necessary, MSF needs to consciously acknowledge that there is a tendency to prioritise the under-fives in its responses.

To understand who is in most need in emergencies, MSF needs to collect more data on the health and nutrition needs of different population groups. Combining this with a deeper understanding of how MSF approaches needs and the various influences on practice, such as individual discretion and response to needs, should enable MSF to form policies which address the neediest people within that context. MSF can then deliver a comprehensive humanitarian approach that understands who is in the greatest need and how the organisation can help them.

Chapter 7: Summary of findings and policy recommendations

Summary of findings:

1) MSF has an absence of purposeful policy which assesses and responds to older people's health and nutrition needs in both contexts.

2) Key similarities between MSF responses in Haiti and South Sudan included a common failure to collect and record data (beyond the clinic register) disaggregated by age and sex.

3) The MSF response to older people was found to be better in Haiti than in South Sudan. There was evidence of demographic data disaggregated by older age groups and evidence that chronic needs had been exceptionally addressed by one OC in Haiti. This is contrary to our predictions and the reasons for it are unclear; it could be due to exceptional factors of resources in Haiti, or a general narrowing of target groups in slow-onset emergencies.

4) Overall, vulnerable groups provided the prism in which older people's needs were considered indirectly. One policy response had a specific focus on vulnerable groups. Whilst the other setting did not have this, there were programmes that would potentially help vulnerable groups such as outreach programmes. However, older people were not always listed as a vulnerable group.

5) There were perceptions that older people's needs were not well-addressed in either location. However, the idea that this was something that could or would change in the near future was only reflected in the evaluations of the Haiti response.

Policy recommendations:

Whilst MSF has made progress in addressing chronic diseases and has used its initiative to develop solutions to issues identified in the field, this report has found gaps in its approach to older people, and therefore puts forward the following recommendations:

1. There needs to be agreement within MSF that older people are a vulnerable group and as such should be included within its policies.

2. The mapping of the older population and their health needs should be included within the context of general assessments. MSF should consider incorporating data on the health needs of people in emergency locations, disaggregated by age and sex, into standard procedure policy.

3. Vulnerability needs to be included in general assessments. Within the quick and rapid assessment, we need to incorporate the assessment of vulnerability as a priority in order that vulnerable groups are not overlooked. To do this a tool for assessing vulnerability needs to be developed.

4. Policy should be developed to promote data sets between OCs to include same tools with the same expanded age range.

5. Policy should be developed on how to assess and respond to the distinct nutrition needs of older people. Mapping of the problem and the development of age-appropriate solutions.

6. Age-appropriate programmes that address health concerns predominantly affecting older people, such as chronic diseases programmes, should be promoted where applicable.

7. Policies should be promoted that address the specific difficulties that may be faced by older people or other vulnerable groups when trying to access healthcare.

8. Policy strategies that tackle chronic non-communicable diseases should continue to be developed, and ways of putting the strategies into practice should be documented and demonstrated.

Appendix 1: Planning of methodology

1) Background, key definitions. Conduct a literature search to find specific information about humanitarian responses to older people in South Sudan and Haiti.

2) Collect policy data by examining operational policy documents available online or made available by MSF staff. Develop a questionnaire/interview with the head of medical department at headquarter level. Questions to selected medical directors focus on existence of policies which address older people, health policies for older people, nutrition policies for older people, tackling the issue of "invisible" older people and addressing the changing role of older people. Collate the findings from these interviews/survey responses.

3) Gain data from MSF operations teams working in South Sudan and Haiti. Retrieve any demographic data, any disaggregated data, and any health or nutritional data which is disaggregated by older age groups (>45s). Collect copies of assessment reports, country policies, project proposals, project progress reports and project evaluation reports. Comparatively analyse data.

4) To measure the outcomes for each context, we will firstly evaluate MSF's assessment and response to health needs and compare how well MSF met the competencies in each context. The competencies will be derived from WHO's 2008 *Older People in Emergencies: Considerations for Action and Policy Development*.

To do this we will consider the three competencies we have identified (collection of demographic data disaggregated by older age groups, any health or nutritional data disaggregated by older age groups, and presence of policies that mention older people, chronic disease or vulnerable groups). In each context we will compare the three competencies against the three sources of data, which will total nine potential points per context. Thus each context will be given a rating between 0 and 9. A score of 0-3 out of 9 will be interpreted as negative response, a score of 4-6 will be a neutral response, and 6-9 a positive response. Responses from heads of missions as well as analysis of policy documents provided by operational teams will be used to produce results.

5) Use a comparative study of health emergencies in Haiti (emergency setting) and South Sudan (slow-onset emergency) to look at the way in which gaps in response of care for older persons varies in both settings between 2010 and 2012.

6) Form policy recommendations.

Appendix 2: OC Policy review

OCA Operational Policy

OCA's current operations policy 2011-2014 is summarised as focusing on saving lives, protecting lives and dignity, and alleviating suffering. "We will prioritise based on the level of medical needs, including in settings of conflict or violence. We have also expanded our intervention logic to include acute medical crises outside what are traditionally thought of as 'humanitarian contexts'."

In the choice and implementation of our interventions, the principle of impartiality guides our actions. We follow its simplest form: to provide aid to those who need it most. Under all circumstances we aim to reach those most in need within our target populations. (We must avoid the complacency of busy clinics and continually ask ourselves "Who should be here? Who is not coming?")"

OCG Operational Policy, Strategic Plan and Guiding Principles

OCG's Operational Policy 2011 outlines a commitment to search for and include the most affected or most vulnerable groups:

"In many settings, certain groups of population have a reduced access to health facilities due to increased vulnerability. Where it is relevant, active efforts should be made towards these groups within the larger community to ease their access to the specific cares they may need... The notion of 'active impartiality' only makes sense if these particular efforts are effectively made within our projects to identify and care for the people who are most affected by the crisis situation." [41]

However, OCG's definition of vulnerable groups does not explicitly mention older people, only

discriminated or excluded groups. On the other hand, OCG's Strategic Global Plan for 2012 highlighted the objective to make an epidemiological shift towards non-communicable disease. This focus on non-communicable disease may advantage older people who are predominantly victims of chronic disease. OCG's guiding principles referred to the importance of impartiality and how this is achieved: "Non-discrimination on grounds of political affiliation, race, religion or sex, and any other similar criteria." [57]

OCBA Operational Policy

OCBA's Operational prospects for 2011 highlights its commitment to work in urban contexts and the Middle East. OCBA's operational policy prioritises important areas like secondary care, sexual and gender-based violence care, infectious diseases and nutrition, and helping displaced populations. OCBA also mentions its inclusion of its chronic diseases care in its interventions. [46]

OCB Operational Policy

The Operational Prospects for Brussels 2011-2013 highlights its balance between default and choice interventions. Its priority is default situations, conflict and emergency settings where the response is immediate. However, they maintain the relevance of choice projects which "tackle specific areas where medical interventions can make an important difference to populations that find themselves completely neglected". [47]

OCP Operational Policy

OCP was contacted to provide policy documents for this study's analysis, but unfortunately did not respond. OCP has therefore not been included in the operational policy analysis of this report.

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In order to maintain the respondent's anonymity, all responses are referred to as 'interview data'. This may have been gathered from interviews in person, by email or by a survey method. Participant names were not included in any of the subsequent papers or reports. Each respondent has been given a code that corresponds to the time they were interviewed so that only the researcher can identify them.

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