Older adults in humanitarian settings 1

Overlooked and underserved: older adults in humanitarian contexts

Vânia de la Fuente-Núñez, Favila Escobio, Javier Manrique, Maya Abi Chahine, Ritu Sadana, Elburg Van Boetzelaer

Although not every older person is equally at risk, older people are among those most affected by humanitarian crises. Despite long-standing calls for more inclusive humanitarian action, older populations continue to be overlooked in preparedness, response, and recovery efforts. This Series paper critically examines the current policy landscape of humanitarian health care in relation to older populations and highlights a persistent gap between rhetoric and implementation. Additionally, factors contributing to the exclusion of older adults are documented, with factors operating at the institutional, interpersonal, and individual levels. These factors range from self-directed ageism and interpersonal neglect to systemic failures such as insufficient data, policy gaps, and service designs that fail to address the specific needs and rights of older adults. Drawing on available evidence, the paper also presents the severe consequences of the neglect of older populations, including avoidable deaths, worsening health outcomes, and increased care dependence. This Series paper calls for urgent action to ensure that older populations are meaningfully included in humanitarian action and serves as the foundation for the remaining papers in this Series.

Lancet Healthy Longev 2026; 7: 100921

Published Online October 28, 2026
https://doi.org/10.1016/j.lanhl.2026.100921

This is the first in a Series of three papers about older adults in humanitarian settings (papers two and three appear in *The Lancet Healthy Longevity*). All papers in the Series are available at www.thelancet.com/series-do/older-adults-humanitarian

Independent researcher on healthy ageing and ageism, Barcelona, Spain (V de la Fuente-Núñez MD MA); **HelpAge International, London, UK** (F Escobio MD); **Convite AC, Caracas, Venezuela** (J Manrique MD); **American University of Beirut, Beirut, Lebanon** (M A Chahine MA); **WHO, Geneva, Switzerland** (R Sadana ScD); **Manson Unit, Médecins Sans Frontières, London, UK** (E V Boetzelaer PhD MPH); **MSF Operational Center Brussels, Belgium** (F Escobio); **Department of Global Public Health & Bioethics, Julius Centre for Health Sciences and Primary Care, University Medical Centre Utrecht, Utrecht University, Utrecht, Netherlands** (E V Boetzelaer)

Correspondence to:
Dr Vânia de la Fuente-Núñez, Independent researcher on healthy ageing and ageism, Barcelona 08012, Spain
vaniadelafuente@outlook.es

Introduction

Older populations are disproportionately affected by humanitarian crises and yet are largely overlooked in preparedness, response, and recovery efforts.[1] Humanitarian crises are large-scale emergencies caused by an event or series of events (eg, natural hazards and climate-related disasters, armed conflicts, public health threats, forced displacement, or human rights violations) that result in an important threat to the health, safety, or security of a community or large group of people and require international intervention beyond the capacity of a single agency. The global risk of disasters and humanitarian crises has increased over the past decade,[2] with the number of people requiring humanitarian aid more than doubling in the past 5 years.[3] Humanitarian crises have also become more protracted and complex. Natural disasters, which are intensified by climate change, frequently co-occur with famine and disease outbreaks, compounding the overall impact of humanitarian crises and prolonging humanitarian needs.[4,5]

Humanitarian crises disproportionately affect low-income and middle-income countries (LMICs), where more than two-thirds of older people live. By 2050, 80% of people aged 60 years or older are projected to live in LMICs,[6] potentially increasing their exposure to crises. In countries prone to conflicts and disasters, the percentage of population aged 50 years or older is projected to grow from 12·3% (219·9 million) in 2020 to 19·2% (586·3 million) by 2050.[1] Older adults also constitute a substantial proportion of internally displaced populations and refugee groups—as high as 30–65% in contexts with high proportions of older adults in the population and in which younger people and individuals without mobility limitations have migrated elsewhere, returned home, or integrated into local communities.[7] In upper-middle income and high-income countries, crises can affect a considerable number of older people because older adults constitute a substantial share of the population. In Ukraine, older adults (60 years and older) constitute 30% of people in need of assistance due to the conflict.[8] Displaced populations also tend to grow old away from home, reaching old age in rescue shelters, host communities, or internally displaced populations or refugee camps. Refugees live away from their homes for 20 years on average, and people who are internally displaced are often away from home for more than 10 years.[9]

Although not every older person is equally at risk, older people tend to be disproportionately affected by crises,[1,10,11] particularly women, those living in poverty or isolation, and individuals with mobility challenges, low health literacy, sensory or cognitive impairments, or chronic illness.[12] However, older adults are often overlooked during humanitarian response efforts and have inadequate access to health care and nutrition. Additionally, older adults are at greater risk of being left behind during displacement efforts owing to underlying health conditions, reliance on caregivers, strong community ties, and societal pressure to avoid burdening their families.

Despite repeated calls for inclusive humanitarian health efforts, substantial gaps remain between existing guidance, policy, and law and the practices of front-line health workers. Older populations continue to be underserved in these contexts.[1] These persistent gaps call for a critical examination of the current policy landscape of humanitarian health-care efforts in relation to older people, the barriers that hinder the implementation of inclusive humanitarian health efforts, and the consequences of the systematic exclusion of older adults. In response, this paper maps the humanitarian health policy landscape for older adults,

Key messages

- Older adults are disproportionately affected by humanitarian crises but remain systematically overlooked in preparedness, response, and recovery efforts despite repeated calls for inclusion.
- Although humanitarian frameworks and guidance endorse inclusivity, these frameworks rarely translate into age-responsive policy or programming that reflects older people's complex, intersectional health needs.
- The exclusion of older people from humanitarian health-care efforts results from interacting institutional, interpersonal, and individual barriers, with ageism acting as a cross-cutting driver.
- Institutional barriers include policy and legal gaps; scarce age-disaggregated data that render older adults invisible in planning; insufficient funding; and exclusion from decision making.
- Interpersonal barriers involve ageist attitudes among humanitarian workers and families, expectations that families will care for older adults, and poor technical expertise in geriatric care.
- Individual barriers include self-directed ageism, in which older adults might deprioritise their own health needs or internalise beliefs that declining health is inevitable, leading to delayed or forgone care.
- The exclusion of older adults from humanitarian health-care efforts leads to severe consequences, including increased mortality, worsening of chronic conditions, high susceptibility to acute illnesses, increased disability and care dependence, declining mental health, rising system costs, eroded trust, and the silencing of older people's knowledge and voices.
- Urgent action is needed to address the persistent exclusion of older adults from humanitarian health-care efforts.

identifies the drivers of the exclusion of older adults in humanitarian health care, and analyses the resulting harms. The paper also sets the stage for the remaining articles in the Series, which provide an overview of the specific health-care needs of older adults in humanitarian crises (Series paper 2) and offer actionable recommendations to address existing gaps (Series paper 3). Together, the Series aims to build a comprehensive framework for improving health outcomes in older populations in humanitarian settings. Rather than using a fixed age range to define older populations, the authors consider older people as those who self-identify or are recognised as older within their specific social and cultural contexts. The authors consider this approach important given the different life expectancies and changes in social roles across settings.[13–15] Wherever individual studies have defined older populations using a specific age cutoff, the authors report the age cutoff used in each study.

Current policy landscape of humanitarian health-care efforts for older populations

Frameworks such as the Sustainable Development Goals and the Sendai Framework for Disaster Risk Reduction emphasise inclusive, equitable access to health services and resilience-building, implicitly covering older populations.[16,17] The Universal Declaration of Human Rights affirms the rights to health and non-discrimination, which are foundational to protecting older adults during crises.[18] The UN High Commissioner for Refugees (UNHCR) published guidance on responding to non-communicable diseases (NCDs) in humanitarian settings, representing a welcome step towards addressing the health needs of older people, who are disproportionately affected by these conditions. WHO's Progress Review of the Decade of Healthy Ageing likewise underscored persistent gaps in legal protection and stressed the need to integrate older adults into emergency preparedness and response strategies.[19] Nevertheless, existing frameworks and tools have failed to adequately address the often complex, chronic, and intersectional health and care needs of older populations.[1,20–22]

Existing guidance aimed at enhancing inclusive programming and age-sensitive service delivery, such as SPHERE's Humanitarian Inclusion Standards for older people and people with disabilities,[23] UNHCR's policies on older refugees,[24,25] and Inter-Agency Standing Committee's various guidelines and resources,[26–28] has been poorly implemented in practice.[20] Instead, existing guidance is often treated as supplementary information and remains on the periphery of humanitarian efforts.

The absence of a legally binding UN Convention on the Rights of Older Persons, which would promote, protect, and respect their rights, including the right to health, represents a major institutional gap in global policy. Additionally, the absence of a designated lead organisation mandated from the outset of each humanitarian crisis to coordinate the response and ensure the inclusion of older adults further contributes to the ongoing neglect of older people in humanitarian efforts. The forthcoming UN Convention on the Rights of Older Persons, initiated by a 2025 UN Human Rights Council resolution (A/HRC/58/L.24/Rev.1) that established an intergovernmental working group to draft the treaty, offers a key opportunity to advance the protection of older people's rights, including in humanitarian contexts.

Underlying factors contributing to the exclusion of older people from humanitarian health-care efforts

Following the socioecological model,[29] we classified barriers contributing to the exclusion of older populations

from humanitarian health-care efforts into three levels: institutional or societal level, interpersonal or community level, and individual level (figure 1). Although not the sole barrier, ageism is identified as a fundamental driver of this exclusion, manifesting across all three levels. Ageism is defined as stereotypes, prejudice, and discrimination directed at others or oneself on the basis of age.[15] Ageism frequently intersects with other forms of bias, such as sexism, racism, and ableism, compounding the disadvantages faced by older populations, including those in humanitarian settings.[15,30]

At the institutional level, considerable policy, programmatic, and legal gaps exist. Access to health programmes such as sexual health services, assistive devices, and cash assistance is often restricted through age-bounded targeting (eg, sexual and reproductive health programmes for women of reproductive age), mandates focusing on younger groups (eg, cash-transfer programmes), and, at times, arbitrary age cutoffs.[31] There is also a scarcity of tools and training to support tailored health-care responses for older people. In some situations, triage decisions have explicitly or implicitly de-prioritised older adults.[15]

Institutional ageism can also subtly shape response planning. When impact is measured through economic recovery, agencies might prioritise younger individuals perceived as economically productive, inadvertently overlooking the needs of older survivors. This narrow focus fails to recognise that many older people continue to work, contribute economically, and often serve as heads of households while caring for orphaned grandchildren. In 2017, approximately 5% of households of Syrian refugees in Lebanon were headed by older adults (60 years and older).[32] The design of humanitarian health responses can also generate systemic barriers to care. Many programmes are structured around centralised health-care facilities, disregarding the mobility challenges faced by some older adults. Similarly, health information is often designed without accessibility in mind, relying on formats that exclude people with sensory impairments, cognitive decline, low literacy, or digital illiteracy, and people who speak minority languages.[30]

Another major institutional barrier is the exclusion of older adults from data collection efforts, including the widespread failure to collect data from older populations or to disaggregate the collected data by age throughout the humanitarian programme cycle.[30,33–35] An analysis of data collection and use throughout the humanitarian programme cycle revealed that although older people are often identified as vulnerable, their inclusion rarely extends beyond the stereotypical label.[34] Only five of 23 humanitarian needs overviews in 2023 specifically assessed the needs of older populations.[34] Another study examining five major disasters found that only one in four humanitarian needs assessments mentioned older people, and only one in ten provided specific data or analyses on older populations.[35] In the absence of more systematic approaches, HelpAge International conducts rapid needs assessments in emergency situations that specifically aim to identify the needs of older populations. However, the quality of these assessments is often poor, and the assessments are not conducted consistently across all humanitarian crises. Rapid needs assessments are also typically performed at the local rather than national level, limiting their generalisability to the entire affected population and reducing the likelihood that these assessments will be included in humanitarian needs overviews. Few studies have explored the adequacy or effectiveness of humanitarian health responses for older adults,[36,37] and research on the health needs of older populations remains scarce, with substantial gaps in areas such as palliative care, cancer, and neurocognitive disorders.[38] Specialised surveys, including surveys on violence against women, often set an upper age limit of 49 years, thereby failing to capture violence against older women.[39] When data on older populations are collected, the data are generally grouped under a single category, such as older than 60 years, rather than being differentiated into distinct age cohorts. Such oversimplification hinders a nuanced understanding of the diverse needs within the older population, resulting in inadequate programme design and resource allocation.[35] At the same time, data collection efforts in humanitarian settings fail to measure ageism and its intersection with other forms of bias, resulting in an inadequate understanding of how multiple, overlapping forms of disadvantage affect older adults, both individually and cumulatively.[30]

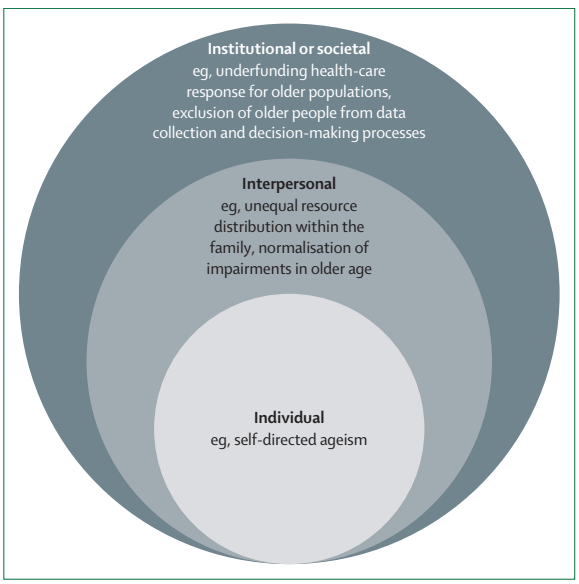


Figure 1: **Factors contributing to the exclusion of older people from humanitarian health-care efforts**

Given the existing gaps and deficiencies in age-inclusive data collection efforts, humanitarian health efforts remain ill-equipped to measure and address the specific challenges and needs of older adults during crises. NCDs and long-term care needs that are more prevalent among older populations are underestimated and consequently

For more information on **HelpAge International**, see https://www.helpage.org/

ignored in humanitarian health-care responses.[12] Given that data inform priorities for donors, UN agencies, and other actors, the scarcity of data on older populations perpetuates their invisibility and exclusion from humanitarian funding decisions and response plans.

Funding is also insufficient, leading to substantial gaps in health-care services for older populations. An analysis of 16 221 global humanitarian initiatives implemented between 2010 and 2014 revealed that projects specifically targeting older adults accounted for less than 1% of all funded programmes.[33] According to an analysis of broader development assistance for health in 2020, only 9% of funding is allocated to individuals 60 years or older, although older adults bear 26% of the overall health burden in LMICs.[40] Between 1999 and 2013, the share of development assistance for health devoted to NCDs was only 2·3%. Disease categories that are particularly important at older ages, such as mental health conditions, including Alzheimer's disease, received 0·3% of all development assistance for health.[41] In this context, the unprecedented funding reductions and historic shortfalls in humanitarian and development aid observed in 2024–25[42] risk exacerbating existing funding gaps, reducing investment in health-care services for older people in humanitarian settings and entrenching inequities.

The exclusion of older individuals in decision-making processes constitutes another institutional barrier. Despite their extensive experience and potential contributions, older adults are not included in the planning and implementation of humanitarian programmes.[43] Reports from the field have revealed that international non-governmental organisations exclude older populations from their efforts because older groups are considered to fall outside their mandate. Among nearly 9000 individuals who were 50 years or older and affected by natural hazards and climate-related disasters, conflicts, or socioeconomic crises in 11 countries across Africa, Asia, Latin America, and the Middle East, 77% reported that aside from HelpAge International, no humanitarian agency had ever inquired about the services available to them.[1] This exclusion of older people from humanitarian decision making perpetuates a cycle in which the unique needs and perspectives of older populations are overlooked, leading to services that fail to accommodate the complexities associated with ageing in crisis contexts.[44]

At the community level, ageist attitudes among humanitarian health-care workers and family members can exacerbate the exclusion of older adults and reduce their control over health-care resources. Because impairments are incorrectly viewed as a natural aspect of ageing, barriers to health-care access faced by older adults are normalised, stifling efforts to promote inclusivity within humanitarian response.[30] Resource allocation norms within low-income families also tend to prioritise the needs of younger family members at the expense of older family members, a dynamic that can have more dire consequences in humanitarian crises.[45] Older populations are also disadvantaged by ageist assumptions among aid workers, who often presume that family members will provide care for them. In practice, family support is frequently unavailable, leaving many older people without the assistance they need. Poor technical expertise in geriatric care further exacerbates the inadequacy of health-care services available to older people in crisis settings.[46]

At the individual level, self-directed ageism can lead older adults to deprioritise their own health-care needs or mistakenly believe that declining physical and mental health is a natural and unavoidable part of ageing.[15] Consequently, older people might delay or forgo seeking medical care, increasing their risk of preventable illness, complications, and mortality.[30] This pattern is particularly evident among older individuals with disabilities who, owing to internalised ageism and ableism, might also avoid using mobility aids and assistive devices or isolate themselves.[30] Self-directed ageism in humanitarian settings can also affect how older individuals perceive their own self-worth, leading older people to view themselves as a burden on their families and society. Such perceptions of diminished value can further discourage older people from seeking assistance.[46]

The factors operating at the institutional, community, and individual levels do not act in isolation; rather, the factors interact and collectively contribute to the marginalisation of older adults from essential health-care services.[15] An older woman might internalise beliefs that she is a burden or that seeking help is futile. Such beliefs might discourage the woman from accessing available health-care services, even when she needs care. Her family and community might unintentionally reinforce the woman's beliefs by overlooking her health needs or prioritising the health needs of younger family members. At the institutional level, the absence of targeted outreach, inaccessible facilities, or age-disaggregated data can further reduce the likelihood that a woman's health needs will be identified and addressed. Together, these factors contribute to a woman's exclusion from essential humanitarian health-care services.

Toll of exclusion from humanitarian health-care efforts

Countries affected by humanitarian crises tend to have fragmented, under-resourced health systems that struggle to meet the needs of older adults, with inadequate access to essential services and gaps in geriatric care, including effective primary care, outreach services, and home-based support for older adults in need.[47] Humanitarian health responses might, therefore, be constrained by the principle of equivalence, which requires services to align with what is realistically available and sustainably deliverable in the specific context. Universal health coverage also remains far from reality in most parts of the world.[48] The prevalence of unmet health needs among older populations (60 years and older) exceeds 50% in several countries, including Haiti, Morocco, Rwanda, and Zimbabwe.[49] Consequently, when

crises occur, already fragile health systems become even more overwhelmed, making delivery of timely and effective care to people who need it difficult. This strain on health-care services can disproportionally affect older people whose health might be directly compromised by immediate injuries resulting from events such as earthquakes or war and by the broader disruptions that follow. When humanitarian health-care efforts also fail to account for the needs of older people, older populations are left with inadequate or no support, heightening the risk of avoidable mortality, morbidity, and care dependence (figure 2). The exclusion of older adults from access to essential non-health services such as water, sanitation and hygiene, shelter, and nutrition further compromises their health. Inadequate nutrition can exacerbate chronic conditions such as diabetes, and poor housing conditions can increase the risk of falls and related injuries. See the Panel for a case study on the exclusion of older populations from health-care services during Venezuela's crisis.

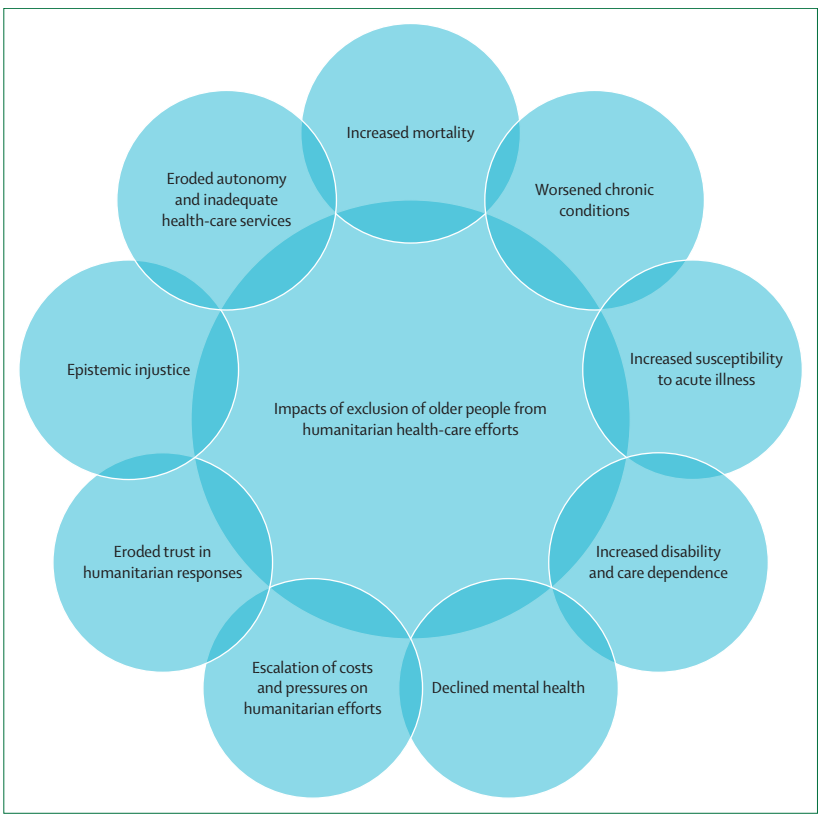


Figure 2: **Effects of exclusion of older people from humanitarian health-care efforts**

Increased mortality

During crises, older populations face a higher risk of having severe health effects than other age groups. The mortality rate among people 50 years or older in the South Sudan crisis of 2012 was reported to be four times the mortality rate among people aged between 5 and 49 years.[58] Another study examining mortality in forced displacement settings found that, during the 1984–85 displacement from Ethiopia to Sudan triggered by war and famine in the Tigray region, the highest death rates occurred among adults 50 years or older and children younger than 5 years.[59] Climate-related disasters also disproportionally affect older populations.[60] A retrospective analysis of mortality following the earthquake in Nepal in 2015 showed a similar pattern. The results in their study showed a clear age gradient in earthquake mortality, with older people experiencing substantially higher mortality rates than younger age groups. This pattern became especially pronounced in adults 65 years and older, with mortality generally rising steeply among people 80 years and older. Geographic differences in mortality were also observed, which may reflect variation in earthquake exposure and severity, as well as other contextual factors such as housing conditions and access to rescue and healthcare services.[61] Similarly, the highest age-specific death rates resulting from the 2004 tsunami in Indonesia were reported among adults aged 60–69 years (22·6%) and adults aged 70 years or older (28·1%).[62] Nevertheless, robust comparative estimates of excess mortality among older people in humanitarian settings relative to non-crisis contexts remain scarce, reflecting persistent gaps in age-disaggregated mortality surveillance and reporting.

Worsened chronic conditions

Older people often have one or multiple chronic conditions, such as cardiovascular disease, diabetes, and chronic lung disease.[47] In humanitarian crises, disruptions in routine care and medication supplies are common,[1,12] chronic disease management is not typically included in the health response, and medications might not be affordable.[63] As a result, chronic health conditions can worsen, leading to acute exacerbations, adverse complications, and rapid deterioration in health outcomes, including life-threatening consequences.[21,63–67] Examples of chronic health conditions include heart attacks and strokes, which are two to three times more common in conflict settings and after climate-related disasters than in normal circumstances.[68]

Even a short lapse in care for NCDs can result in disability and avoidable death.[68] A person with type 1 diabetes is at greater risk of serious complications or even death if insulin is unavailable for just a few days.[69] Access to health care among older people is inadequate across humanitarian settings. Across five Latin American countries, 42% of older adults (60 years and older) who were internally displaced, migrants, or refugees did not receive treatment for a range of health conditions.[9] Another report, drawing on needs assessments conducted in 11 countries over a 13-month period, revealed that 26% of older adults (50 years and older) could not access health services.[1] An assessment of older refugees (60 years and older) from Syria living in Lebanon revealed that only 1·5% had good access to health care,[70] and another assessment of the needs of older people (60 years and older) in Ukraine following Russia's attack

Panel: **Case study—Older adults left behind in Venezuela's complex humanitarian crisis**

Since 2016, Venezuela has been experiencing a complex humanitarian emergency, marked by economic decline and the deterioration of state structures and services, severely affecting livelihoods, health care, and security.[50] By 2024, nearly 8 million people had left the country,[51] and an estimated 3·5 million older people (≥60 years) who remained in the country faced considerable barriers to accessing health and social care services.[52]

As in other crises, the humanitarian response in Venezuela has largely excluded older populations from ongoing efforts. Although older people are recognised as a priority group in the humanitarian response plan,[53] findings from a published report,[54] which analysed data from multiple rapid needs assessments across various regions, reveal a stark gap in health-care provision for older adults.

One report indicates that up to 80% of households headed by older adults or including older household members do not have access to essential health services, including vaccination, hospitalisation, medications, and specialised care such as surgery, internal medicine, and palliative care.[55] By comparison, a national household survey found that 69·9% of households in the general population, potentially including households with older people, reported limitations in access to health services over a similar period.[56] Disparities are also evident in access to medications for non-communicable diseases. Estimates indicate that 48–95% of households headed by or including older people are unable to obtain required medications,[55] whereas 30% of households in the general population reported an inability to obtain required medications.[56] Similarly, access to sexual and reproductive health care appears to be more restricted among older people. In the states covered by one assessment, more than 90% of households headed by or including older people reported that older household members had no access to services such as cervical cancer screening, menopausal symptom management, or incontinence treatment.[55] By comparison, a separate survey of women aged 10–49 years in selected states found that 64% reported lacking access to sexual and reproductive health services.[57] These findings highlight the systemic neglect of older adults in the country's humanitarian response, leaving older people without essential medical support.

revealed that 43% of older people had problems accessing medicines and assistive devices.[71] Older people with mobility issues might also struggle to reach centralised health-care facilities, and community-based health programmes frequently exclude older people.[7] Despite these persistent gaps, NCDs are increasingly being recognised as an essential component of humanitarian health responses.[72–74]

Increased susceptibility to acute illnesses

Owing to age-related declines in immune function, older populations in humanitarian contexts are more susceptible to acute illnesses, with increased prevalence and severity of infectious diseases.[47] Older people are also more susceptible to dehydration, hypothermia, and hyperthermia,[47] which can exacerbate pre-existing health conditions or result in fatal outcomes from newly acquired infections. Studies examining cholera outbreaks in Haiti and Zimbabwe have shown that older adults are more susceptible to cholera. Specifically, people aged 60–79 years were found to have a 3·8 times higher risk of death from cholera and a 1·9 times higher risk of severe dehydration than younger people.[75]

Increased disability and care dependence

People with disabilities are one of the most socially excluded groups in crisis-affected communities, and up to 14 million older adults with disabilities might be affected by humanitarian crises.[76] Disabilities might predate the humanitarian crisis or emerge as a result of injuries or untreated chronic conditions during the crisis, leading to complications such as diabetic foot, blindness, or strokes.[36] Yet, programmes targeting people with disabilities often overlook older adults with disabilities, thereby restricting access to needed health care.[30] Such exclusion stems in part from the widespread misconception that impairments are a natural and inevitable part of ageing, which undermines efforts to eliminate existing barriers and ensure equal access to humanitarian aid.[30]

The need for assistive technologies rises during humanitarian crises owing to impairments resulting from conflicts and because displacements and disasters can lead to the loss of previously owned assistive devices. However, assistive technologies are generally not prioritised in emergency responses,[77] and, when assistive technologies are available, older people face access barriers. Older people might be denied access owing to misconceptions that they are incapable or unwilling to adopt assistive devices or because priority is given to younger age groups.[1,30] The effect of inadequate access to assistive technologies is severe for older people because impairments such as mobility limitations and vision loss become more common with age,[47] making assistive technologies essential. A field survey conducted in crisis settings, including Lebanon, South Sudan, and Ukraine, found that more than 80% of older people (60 years and older) had poor eyesight and nearly half had impaired hearing, yet assistive devices were largely unavailable to older people.[78] Without essential assistive devices such as canes, wheelchairs, glasses, or hearing aids, older adults might have not only increased immobility, social isolation, and loss of independence but also a deterioration in physical and mental capacities.

In humanitarian settings, long-term care and home-based health-care services are also scarce, leaving older adults who require daily support from others without essential care.[66,76] Older people who rely on caregivers

might lose access to caregiver support owing to displacement, conflict, or disaster, whereas others might be left behind because of mobility limitations. The absence of structured home-based care further exacerbates risks for older adults with considerable declines of intrinsic capacity, as they might struggle to manage chronic conditions without support. A study across five Latin American countries found that 55% of older adults (60 years and older), who were internally displaced, migrants, or refugees, required daily care; however, 12% of the older adults received no support at all.[9]

Declining mental health, including cognitive decline and psychological health

Inadequate social support and the fragmentation of older people's social networks during humanitarian crises can result in isolation, loneliness, and deteriorating mental health, including depression.[11,79,80] 27% of older people (50 years and older) assessed across 11 countries facing humanitarian crises indicated that they could not cope with their situation, even with support from others.[1] Loneliness and social isolation are independent health risks, increasing the risk of developing dementia by up to 50%, risk of early death by nearly 25%, and risk of stroke and cardiovascular disease by up to 30%.[81,82]

Older people also retain detailed recollections of conflict situations, which can make psychological recovery more challenging. Studies have reported depression rates ranging from 15% to 41% among older disaster survivors; post-traumatic stress disorder has been found to affect 18% to 60% of older individuals following disasters.[36] Older survivors also have chronic post-traumatic stress disorder at rates equal to or higher than those in younger counterparts, highlighting the heightened psychological burden faced by older people in the aftermath of crises.[36] Additionally, traumatic experiences such as fearing for one's life during war are associated with a higher risk of frailty and cardiovascular disease.[83] Displacement is another aggravating factor that can undermine the psychosocial and physical wellbeing of older adults. Older adults also have a shorter time horizon for the rest of their life course than younger people. This subjective perception of future time plays an essential role in human motivation and intensifies the negative effect of crises on older people because they have fewer years to recover and start new life projects.[84]

Chronic diseases and reduced functional status further heighten the risk of mental health conditions among older individuals.[36] At the same time, the high prevalence of mental ill-health in humanitarian settings exacerbates the effects of other chronic conditions[68,85,86] and increases the likelihood of abuse and exploitation. Conditions such as depression can have severe consequences if left unrecognised and untreated, leading to social withdrawal, declining physical health, and an increased risk of death. Research has shown that older disaster survivors with depression face more than twice the mortality risk of older disaster survivors without depression.[36]

Humanitarian crises can be particularly disorientating for older adults with dementia, intensifying confusion and cognitive decline.[87] Without tailored support, older adults with dementia might wander, become lost, or struggle to follow evacuation instructions, placing them at extreme risk. The stress and upheaval associated with emergencies can also trigger or worsen dementia-related symptoms. Although dementia is beginning to receive attention in humanitarian policy, targeted programmes remain largely absent and insufficiently documented, hindering both psychological and physical recovery among older people.[30,88]

Systemic implications

The exclusion of older populations from humanitarian health-care responses not only generates excess morbidity and mortality but also places additional pressure on humanitarian efforts. When chronic and acute conditions go untreated, the conditions often progress to critical stages, increasing the demand for palliative care and intensive emergency interventions. This escalation can lead to higher health-care costs, straining already scarce resources. Additionally, the unavailability of quality health care and social support can accelerate the decline in older people's intrinsic capacity, increase care dependence, and place additional burdens on families, communities, and aid systems, ultimately hindering overall recovery efforts.

The failure to address the specific health-care rights and needs of older people further erodes trust in humanitarian responses, reducing the acceptability of these responses by local communities.[89] If older adults perceive health care as inappropriate or inaccessible, they might be less likely to engage with available services, further entrenching health disparities.

Disregarding the voices of older adults and failing to consider their specific health-care needs and preferences further constitutes epistemic injustice because such practices systematically undermine the capacity of older adults to act as knowers and contributors to discussions about their own wellbeing.[44] By not valuing the lived experiences and perspectives of older populations, health-care systems and humanitarian responses perpetuate a form of testimonial injustice, in which the knowledge of older adults is dismissed or devalued, and hermeneutical injustice, in which their unique challenges and needs are not adequately recognised or addressed in broader health-care discourse.[90] This exclusion not only erodes the autonomy of older people but also results in health-care services that are poorly designed, inaccessible, and misaligned with their actual needs, further aggravating health disparities and reinforcing the marginalisation of older populations.

Limitations

Our analysis is constrained by the availability and quality of evidence on older adults in humanitarian settings. This paper relies substantially on grey literature and programmatic reports, reflecting the broader scarcity of peer-reviewed, age-disaggregated data in humanitarian health

Older people in humanitarian settings

Older populations are disproportionately affected by humanitarian crises but are often overlooked in health-care planning, preparedness, and response in these settings. In this Series, we aim to highlight these issues and provide a framework for including the health-care needs of older adults in humanitarian crises.
Comment 1: 10.1016/j.lanhl.2026.100923
Comment 2: 10.1016/j.lanhl.2026.100924
Comment 3: 10.1016/j.lanhl.2026.100931
Comment 4: 10.1016/j.lanhl.2026.100928
Series 1: 10.1016/j.lanhl.2026.100921
Series 2: 10.1016/j.lanhl.2026.100927
Series 3: 10.1016/j.lanhl.2026.100922

research. This limitation should be interpreted as indicative of the systemic gaps in humanitarian data collection and surveillance that contribute to the exclusion of older adults from data collection efforts.

Conclusion

Although older populations are disproportionately affected by humanitarian crises, older adults remain largely overlooked in preparedness, response, and recovery efforts. This persistent exclusion directly contradicts the humanitarian principle of impartiality, reflects widespread ageism, and represents a systemic failure to address the distinct and often complex needs of older adults. As documented in this paper, barriers exist at multiple levels, ranging from self-directed ageism and interpersonal neglect to gaps in data and policy and service designs that fail to consider the needs of older adults. The consequences can be severe, contributing to avoidable mortality, worsening morbidity, and increased care dependence. Even before the current wave of funding cuts to humanitarian aid, older populations had been systematically excluded from humanitarian efforts. As resources shrink further, there is a growing risk that such marginalisation of older adults will deepen, leaving older adults even more neglected at a time when their needs are most acute. Greater attention to the realities faced by older adults in crises is, therefore, urgently needed.

Contributors

VF-N, FE, and EVB conceptualised the Series paper. VF-N wrote the original draft. FE, JM, MAC, RS, and EVB reviewed and contributed to the final manuscript. All authors had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Declaration of interests

VF-N reports receiving fees and travel support from The Fred Hollows Foundation for work related to ageism, which was not directly related to this manuscript. JM reports serving as board president of Convite Colombia and as member of the board of Convite AC and receiving travel support from HelpAge International to attend a WHO high-level technical meeting on NCDs in humanitarian settings. RS reports receiving a grant from Velux Stiftung Foundation, paid to WHO, to support policy and scientific work on healthy ageing across the life course, and receiving travel support from University of Zurich to attend a seminar on innovation in healthy ageing. All other authors declare no competing interests.

Acknowledgments

The authors would like to thank Tewodros Belachew for his input during an early discussion related to this article.

References

1 Age international, HelpAge International. If not now, when? Keeping promises to older people affected by humanitarian crises. 2020. https://www.helpage.org/silo/files/if-not-now-when-report.pdf (accessed Sept 9, 2026).
2 Inter-Agency Standing Committee and the European Commission. INFORM REPORT 2024: 10 years of INFORM. 2024. https://publications.jrc.ec.europa.eu/repository/handle/JRC136641 (accessed Sept 9, 2026).
3 Development initiatives. Global Humanitarian Assistance report 2023. June 20, 2023. https://devinit.org/resources/global-humanitarian-assistance-report-2023/ (accessed Sept 9, 2026).
4 UNHCR. Global trends: forced displacement in 2023. 2024. https://www.unhcr.org/us/sites/en-us/files/2024-06/global-trends-report-2023.pdf (accessed Sept 9, 2026).
5 UNOCHA. World humanitarian data and trends 2018. 2018. https://www.unocha.org/publications/report/world/world-humanitarian-data-and-trends-2018 (accessed Sept 9, 2026).
6 WHO. Ageing and Health. Oct 1, 2025. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health (accessed Sept 9, 2026).
7 HelpAge International. The neglected generation: the impact of displacement on older people. June 18, 2012. https://www.helpage.org/resource/the-neglected-generation-the-impact-of-displacement-on-older-people/ (accessed Sept 9, 2026).
8 UNHCR. Working with older persons in forced displacement. 2021. https://www.refworld.org/policy/opguidance/unhcr/2021/en/123481 (accessed Sept 9, 2026).
9 UNHCR, International H. A claim to dignity: ageing on the move. 2021. https://www.unhcr.org/media/claim-dignity-ageing-move (accessed Sept 9, 2026).
10 Summers A, Leidman E, Pereira Figueira Periquito IM, Bilukha OO. Serious psychological distress and disability among older persons living in conflict affected areas in eastern Ukraine: a cluster-randomized cross-sectional household survey. *Confl Health* 2019; **13:** 10.
11 HelpAge International. Hidden victims of the Syrian crisis: disabled, injured and older refugees. May 13, 2014. https://www.helpage.org/resource/hidden-victims-of-the-syrian-crisis-disabled-injured-and-older-refugees/ (accessed Sept 9, 2026).
12 Hachem S, Ali S, Al-Omari S, Abi Chahine M, Fahme SA, Mehio Sibai A. "Older people tend to be invisible": a qualitative study exploring the needs and inclusion of older Syrian refugees in the context of compounding crises in host country, Lebanon. *Confl Health* 2022; **16:** 61.
13 UNHCR. Older persons - Emergency Handbook. 2025. https://emergency.unhcr.org/protection/persons-risk/older-persons (accessed June 1, 2025).
14 WHO. Framework to implement a life course approach in practice. July 3, 2025. https://www.who.int/publications/i/item/9789240112575 (accessed Sept 9, 2026).
15 WHO. Global report on ageism. March 18, 2021. https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/combatting-ageism/global-report-on-ageism (accessed Sept 9, 2026).
16 United Nations. Transforming Our World: the 2030 Agenda for Sustainable Development. 2015. https://sdgs.un.org/2030agenda (accessed Sept 9, 2026).
17 UNDRR. Sendai framework for disaster risk reduction 2015–2030. 2015. https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030 (accessed Sept 9, 2026).
18 United Nations. Universal declaration of human rights (Resolution 217A (III)). 1948. https://www.un.org/en/about-us/universal-declaration-of-human-rights (accessed Sept 9, 2026).

19 WHO. Progress report on the United Nations Decade of Healthy Ageing, 2021-2023. Nov 23, 2023. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health (accessed Sept 9, 2026).

20 Barbelet V. Older people in displacement: falling through the cracks of emergency responses. July 2, 2018. https://odi.org/en/publications/older-people-in-displacement-falling-through-the-cracks-of-emergency-responses/ (accessed Sept 9, 2026).

21 Lupieri S. The neglected health needs of older Syrian refugees in Jordan. *Forced Migr Rev* 2018; **57:** 25–27.

22 UNOCHA. Step by step guide: humanitarian Programme Cycle 2023. 2022. https://www.unocha.org/publications/report/world/01-step-step-guide-humanitarian-programme-cycle-2023-may-2022 (accessed Sept 9, 2026).

23 SPHERE Project. Humanitarian inclusion standards for older people and people with disabilities. 2018. https://spherestandards.org/resources/humanitarian-inclusion-standards-for-older-people-and-people-with-disabilities/ (accessed Sept 9, 2026).

24 UNHCR. UNHCR's policy on older refugees, 19 April 2000 (Annex II of the Draft Report of the Seventeenth Meeting of the Standing Committee [29 February - 2 March 2000]) EC/50/SC/CRP1. April 19 2000. https://www.unhcr.org/uk/publications/unhcrs-policy-older-refugees-19-april-2000-annex-ii-draft-report-seventeenth-meeting (accessed Sept 9, 2026).

25 UNHCR. The rights of older persons in the global compact on refugees. 2018. https://www.unhcr.org/media/rights-older-persons-global-compact-refugees (accessed Sept 9, 2026).

26 Inter-Agency Standing Committee. Humanitarian action and older persons: an essential brief for humanitarian actors. Oct 1, 2008. https://reliefweb.int/report/world/humanitarian-action-and-older-persons-essential-brief-humanitarian-actors (accessed Sept 9, 2026).

27 Inter-Agency Standing Committee. Guidelines on Inclusion of persons with disabilities in humanitarian action. Nov 19, 2019. https://interagencystandingcommittee.org/iasc-guidelines-on-inclusion-of-persons-with-disabilities-in-humanitarian-action-2019 (accessed Sept 9, 2026).

28 Inter-Agency Standing Committee. The IASC gender with age marker. 2025. https://interagencystandingcommittee.org/iasc-gender-age-marker (accessed May 15, 2025).

29 Kilanowski JF. Breadth of the socio-ecological model. *J Agromedicine* 2017; **22:** 295–97.

30 The Fred Hollows Foundation. The intersection of ageism and ableism in development and humanitarian policy and practice. 2025. https://www.hollows.org/siteassets/shared-media/au/pdf/reports/fhf_cbma_policy-paper_final-tagged-202590.pdf (accessed Sept 9, 2026).

31 Elias C, Sherris J. Reproductive and sexual health of older women in developing countries. *BMJ* 2003; **327:** 64–65.

32 UNHCR, UNICEF, Programme WF. Vulnerability assessment of Syrian refugees in Lebanon (VASYR 2017). 2017. https://www.unicef.org/lebanon/media/691/file/Lebanon-report-4-2017.pdf (accessed Sept 9, 2026).

33 Shami H, Skinner M. End the neglect: a study of humanitarian financing for older people. 2016. https://www.helpage.org/silo/files/end-the-neglect-a-study-of-humanitarian-financing-for-older-people.pdf (accessed Sept 9, 2026).

34 HelpAge International. Out of sight, out of mind: the inclusion and use of data on older people in the humanitarian programme cycle. 2022. https://www.helpage.org/silo/files/out-of-sight-out-of-mind-technical-report.pdf (accessed Sept 9, 2026).

35 HelpAge International. More at risk: how older people are excluded in humanitarian data. 2019. https://www.preventionweb.net/publication/more-risk-how-older-people-are-excluded-humanitarian-data (accessed Sept 9, 2026).

36 Omari SA, McCall SJ, Hneiny L, Sibai AM. Health and well-being of older populations affected by humanitarian crises in low- and middle-income countries: a scoping review of peer-reviewed literature. *Confl Health* 2024; **18:** 73.

37 Doocy S, Lyles E, Tappis H. An evidence review of research on health interventions in humanitarian crises: 2021 Update. 2022. https://alnap.org/help-library/resources/an-evidence-review-of-research-on-health-interventions-in-humanitarian-crises-2021/ (accessed Sept 9, 2026).

38 Nouvet E, Sivaram M, Bezanson K, et al. Palliative care in humanitarian crises: a review of the literature. *J Int Hum Action* 2018; **3:** 5.

39 WHO. Violence against women 60 years and older: data availability, methodological issues and recommendations for good practice. March 27, 2024. https://www.who.int/publications/i/item/9789240090996 (accessed Sept 9, 2026).

40 Dieleman JL, Maddison E, Sadana R, Micah AE. An aging world requires more support for health systems. Dec 4, 2020. https://www.thinkglobalhealth.org/article/aging-world-requires-more-support-health-systems (accessed Sept 9, 2026).

41 Skirbekk V, Ottersen T, Hamavid H, Sadat N, Dieleman JL. Vast majority of development assistance for health funds target those below age sixty. *Health Aff (Millwood)* 2017; **36:** 926–30.

42 OCHA. UN, partners unveil hyper-prioritized aid appeal amid 'cruel math' of brutal funding cuts. June 16, 2025. https://www.unocha.org/publications/report/world/un-partners-unveil-hyper-prioritized-aid-appeal-amid-cruel-math-brutal-funding-cuts (accessed Sept 9, 2026).

43 UN. Restoring humanity: synthesis of the consultation process for the world humanitarian summit World Humanitarian Summit. 2015. https://agendaforhumanity.org/sites/default/files/resources/2017/Jul/Restoring_Humanity_Synthesis_of_the_Consultation_Process_for_the_World_Humanitarian_Summit_0.pdf (accessed Sept 9, 2026).

44 van Boetzelaer E, van de Kamp J, Keating P, et al. Involving older people in the preparedness, response, and recovery phases in humanitarian emergencies: a theoretical framework on ageism, epistemic injustice, and participation. *Lancet Healthy Longev* 2024; **5:** e76–82.

45 Aboderin IA, Beard JR. Older people's health in sub-Saharan Africa. *Lancet* 2015; **385:** e9–11.

46 Abi Chahine M, Kienzler H. Ageism, an invisible social determinant of health for older Syrian refugees in Lebanon: a service providers' perspective. *Confl Health* 2022; **16:** 62.

47 WHO. World report on ageing and health. 2015. https://www.who.int/publications/i/item/9789241565042 (accessed Sept 9, 2026).

48 GBD 2019 Universal Health Coverage Collaborators. Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet* 2020; **396:** 1250–84.

49 Kowal P, Corso B, Anindya K, et al. Prevalence of unmet health care need in older adults in 83 countries: measuring progressing towards universal health coverage in the context of global population ageing. *Popul Health Metr* 2023; **21:** 15.

50 Humanitarian Practice Network. The complex humanitarian emergency in Venezuela. 2022. https://odihpn.org/en/magazine/the-complex-humanitarian-emergency-in-venezuela/ (accessed Sept 9, 2026).

51 UNHCR. Venezuela Situation: Fact Sheet. 2024. https://www.unhcr.org/sites/default/files/2024-05/UNHCR_%20Venezuela_Situation_Factsheet_May_2024_compressed.pdf (accessed Sept 9, 2026).

52 Di Brienza Parente M. El envejecimiento poblacional en Venezuela: Evolución y perspectivas. Caracas, Venezuela: Convite A.C. 2021. https://issuu.com/conviteac/docs/enpoven-_evoluci_n_y_perspectivas_demogr_ficas_by_ (accessed Sept 9, 2026).

53 UNOCHA. Latin America and the Caribbean. Venezuela. https://www.unocha.org/venezuela (accessed Feb 18, 2025).

54 CONVITE A.C. Respuesta Integrada en Comunidades Aisladas: Un meta-análisis comparativo de nuestra respuesta humanitaria en áreas fronterizas de Venezuela y Colombia. 2023. https://conviteac.org/wp-content/uploads/2023/07/Final-Report-Learning-Grant-534-Spanish.pdf (accessed Sept 9, 2026).

55 Convite A.C. PROYECTO ENPOVEN: "El envejecimiento poblacional en Venezuela. Panorama actual". Inclusión de las Personas Mayores en la Respuesta Humanitaria: Panorama de Necesidades. Caracas, Venezuela: Convite A.C. 2022. https://conviteac.org/wp-content/uploads/2023/05/ENPOVEN_2022_1.pdf (accessed Sept 9, 2026).

56 HumVenezuela. Informe de seguimiento a la emergencia humanitaria compleja en Venezuela. 2023. https://reliefweb.int/report/venezuela-bolivarian-republic/informe-de-seguimiento-la-emergencia-humanitaria-compleja-en-venezuela-noviembre-2023 (accessed Sept 9, 2026).

57 AVESA. Indicadores de salud sexual y reproductiva en los municipios más poblados de los estuados Apure, Sucre y Táchira. 2023. https://avesa.blog/2023/04/10/indicadores-de-salud-sexual-y-salud-reproductiva-en-los-municipios-mas-poblados-de-apure-sucre-y-tachira/ (accessed Sept 9, 2026).

58 Duault LA, Brown L, Fried L. The elderly: an invisible population in humanitarian aid. *Lancet Public Health* 2018; **3:** e14.

59 Godfrey N, Kalache A. Health needs of older adults displaced to Sudan by war and famine: questioning current targeting practices in health relief. *Soc Sci Med* 1989; **28:** 707–13.

60 Prina M, Khan N, Akhter Khan SA, et al. Climate change and healthy ageing: an assessment of the impact of climate hazards on older people. *J Glob Health* 2024; **14:** 04101.

61 Adhikari B, Bhandari PM, Neupane D, Mishra SR. A retrospective analysis of mortality from 2015 Gorkha Earthquakes of Nepal: evidence and future recommendations. *Disaster Med Public Health Prep* 2021; **15:** 127–33.

62 Doocy S, Rofi A, Moodie C, et al. Tsunami mortality in Aceh Province, Indonesia. *Bull World Health Organ* 2007; **85:** 273–78.

63 Akik C, Ghattas H, Mesmar S, Rabkin M, El-Sadr WM, Fouad FM. Host country responses to non-communicable diseases amongst Syrian refugees: a review. *Confl Health* 2019; **13:** 8.

64 Ngaruiya C, Bernstein R, Leff R, et al. Systematic review on chronic non-communicable disease in disaster settings. *BMC Public Health* 2022; **22:** 1234.

65 Fonseca VA, Smith H, Kuhadiya N, et al. Impact of a natural disaster on diabetes: exacerbation of disparities and long-term consequences. *Diabetes Care* 2009; **32:** 1632–38.

66 Miller AC, Arquilla B. Chronic diseases and natural hazards: impact of disasters on diabetic, renal, and cardiac patients. *Prehosp Disaster Med* 2008; **23:** 185–94.

67 Doocy S, Lyles E, Akhu-Zaheya L, Oweis A, Al Ward N, Burton A. Health service utilization among Syrian refugees with chronic health conditions in Jordan. *PLoS One* 2016; **11:** e0150088.

68 WHO. Non-communicable diseases in emergencies. 2016. https://www.who.int/publications/i/item/noncommunicable-diseases-in-emergencies (accessed Sept 9, 2026).

69 Beran D, Yudkin JS. Diabetes care in sub-Saharan Africa. *Lancet* 2006; **368:** 1689–95.

70 Strong J, Varady C, Chahda N, Doocy S, Burnham G. Health status and health needs of older refugees from Syria in Lebanon. *Confl Health* 2015; **9:** 12.

71 HelpAge International. I've lost the life I knew. Older people's experiences of the Ukraine war and their inclusion in the humanitarian response. 2023. https://www.helpage.org/resource/i-ve-lost-the-life-i-knewolder-people-s-experiences-of-the-ukraine-warreport/ (accessed Sept 9, 2026).

72 Ansbro É, Homan T, Prieto Merino D, et al. Clinical outcomes in a primary-level non-communicable disease programme for Syrian refugees and the host population in Jordan: a cohort analysis using routine data. *PLoS Med* 2021; **18:** e1003279.

73 Ruby A, Knight A, Perel P, Blanchet K, Roberts B. The effectiveness of interventions for non-communicable diseases in humanitarian crises: a systematic review. *PLoS One* 2015; **10:** e0138303.

74 Asgary R, Garland V, Ro V, Stribling JC, Waldman R. A systematic review of effective strategies for chronic disease management in humanitarian settings; opportunities and challenges. *Prev Med* 2022; **161:** 107154.

75 Kwok J, Swarthout T, Fritsch P, Raza A, Newport M. Loving the older people in times of cholera: preliminary findings from a study to analyse care and outcomes for cholera patients treated by Médecins Sans Frontieres Operational Centre Amsterdam in Haiti and Zimbabwe 2008–12. MSF Scientific Day, May 2012.

76 Sheppard P, Polack S. Missing millions: how older people with disabilities are excluded from humanitarian response. 2018. https://www.helpage.org/silo/files/missing-millions-how-older-people-with-disabilities-are-excluded-from-humanitarian-response.pdf (accessed Sept 9, 2026).

77 WHO. Global report on assistive technology. 2022. https://www.who.int/publications/i/item/9789240049451 (accessed Sept 9, 2026).

78 HelpAge International. Older voices in humanitarian crises: calling for change. 2016. https://www.helpage.org/resource/older-voices-in-humanitarian-crises-calling-for-change/ (accessed Sept 9, 2026).

79 Singh NS, Bass J, Sumbadze N, et al. Identifying mental health problems and Idioms of distress among older adult internally displaced persons in Georgia. *Soc Sci Med* 2018; **211:** 39–47.

80 Virgincar A, Doherty S, Siriwardhana C. The impact of forced migration on the mental health of the elderly: a scoping review. *Int Psychogeriatr* 2016; **28:** 889–96.

81 National Academies of Sciences E. Medicine, Division of Behavioral and Social Sciences and Education; Health and Medicine Division; Board on Behavioral, Cognitive, and Sensory Sciences; Board on Health Sciences Policy; Committee on the Health and Medical Dimensions of Social Isolation and Loneliness in Older Adults. Social isolation and loneliness in older adults: opportunities for the health care system. National Academies Press, 2020.

82 Rico-Uribe LA, Caballero FF, Martín-María N, Cabello M, Ayuso-Mateos JL, Miret M. Association of loneliness with all-cause mortality: a meta-analysis. *PLoS One* 2018; **13:** e0190033.

83 Kokorelias KM, Grosse A, Kazberouk A, Sinha SK. Exacerbated inequalities: a scoping review of the experiences of older persons during conflict situations. *J Am Geriatr Soc* 2023; **71:** 3287–96.

84 Carstensen LL. The influence of a sense of time on human development. *Science* 2006; **312:** 1913–15.

85 Hayman KG, Sharma D, Wardlow II RD, Singh S. Burden of cardiovascular morbidity and mortality following humanitarian emergencies: a systematic literature review. *Prehosp Disaster Med* 2015; **30:** 80–88.

86 Gyawali B, Harasym MC, Hassan S, et al. Not an 'either/or': integrating mental health and psychosocial support within non-communicable disease prevention and care in humanitarian response. *J Glob Health* 2021; **11:** 03119.

87 WHO. Dementia in refugees and migrants: epidemiology, public health implications and global responses. 2025. https://www.who.int/publications/i/item/9789240102224 (accessed Sept 9, 2026).

88 Alzheimer's Disease International. Forgotten in a crisis: addressing dementia in humanitarian response. 2019. https://www.alzint.org/resource/forgotten-in-a-crisis-addressing-dementia-in-humanitarian-response/ (accessed Sept 9, 2026).

89 Arakelyan S, Jailobaeva K, Dakessian A, et al. The role of trust in health-seeking for non-communicable disease services in fragile contexts: a cross-country comparative study. *Soc Sci Med* 2021; **291:** 114473.

90 Fricker M. Epistemic injustice: Power and the ethics of knowing. Oxford University Press, 2007.

© 2026 Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND IGO license (http://creativecommons.org/licenses/by-nc-nd/3.0/igo/).