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Addressing the health rights and needs of older adults in humanitarian contexts: the importance of person-centred approaches

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Humanitarian health responses often fall short in delivering inclusive assistance that upholds the rights of older people and meets their health needs. Here, we define older people as those who self-identify or are recognised as such within their specific social and cultural contexts, which allows us to account for different life expectancies and changes in social roles across settings. At the same time that responses fall short, environmental disasters, armed conflict, disease outbreaks, displacement, and the effects of the climate emergency often disproportionately affect older adults. Consequently, a substantial and growing proportion of the older population is excluded from humanitarian health assistance and experience poor health outcomes. This Series paper adopted a multimethod approach that combined existing evidence syntheses, an additional literature review, an expert consultation, and case studies from health programmes in Afghanistan and Gaza, occupied Palestine, to examine the health needs and rights of older people in contexts affected by humanitarian crises. Using an ecosystem of determinants approach, this Series paper highlights how factors across humanitarian crisis contexts—including rights, equity, and inclusion; enabling environments and relationships; and essential needs and supports—interact to shape physical and cognitive health, functional ability, mental wellbeing, values, lived experiences, priorities, and preferences among older people. The Series paper further explores the complexity of older people's health needs, including the impacts of multimorbidity, frailty, and polypharmacy, and examines the importance of person-centred care approaches that respond to individual circumstances and priorities. Additionally, the Series paper explores person-centred care as a pathway to advancing health equity and upholding the rights of older people and examines barriers to implementing person-centred care approaches in contemporary humanitarian responses.

Introduction

Delivering comprehensive, holistic care in contexts affected by humanitarian crises presents a multitude of challenges, particularly given the diverse health-care needs of affected populations. These challenges rarely manifest uniformly and often become more complex when the health needs of affected people are disaggregated by demographic, socioeconomic, cultural, and other intersecting factors. Although core humanitarian principles emphasise a commitment to impartiality (defined as non-discriminatory and needs-based care), disparities in access to appropriate and quality care based on gender, race, class, age, sexuality, and disability remain persistent and widespread.[1–4] Historically, the specific needs of children and women of reproductive age have received concerted attention in humanitarian responses across health, nutrition, protection, and other sectors.[5,6] However, recognition of age-specific needs throughout the life course has been slower to materialise, with implications for the provision of tailored services to other age groups, including adolescents (defined by WHO as those aged 10–19 years)[7] and older people (defined as those who self-identify or are recognised as such within their specific social and cultural contexts).[2,8]

Meeting the health needs of older people requires more than focusing on age alone. Older people's health needs are shaped by intersecting axes of inequality, across which age interacts with other characteristics, such as gender, disability, and displacement status, that further influence health needs and access to services.[2] An intersectional approach is therefore essential for understanding and addressing the health needs of older people in contexts affected by humanitarian crises.

Importantly, older people should not simply be categorised as at risk in ways that overlook their unique capacities and capabilities and the pivotal roles that older people often perform within their communities and social networks.[9] Older people act as formal and informal community leaders, caregivers, sources of memory and knowledge, providers of coping support, mentors, and communicators. In addition, older people help families and communities to navigate the challenges posed by humanitarian crises by acting as first responders.[10]

This Series paper aims to advance understanding of the diverse and interconnected determinants that shape older people's health needs in contexts affected by humanitarian crises and to explore how person-centred approaches can support more responsive and integrated responses. The Series paper moves beyond a focus on health conditions alone by examining how factors across four interconnected dimensions of an ecosystem of determinants shape older

Lancet Healthy Longev 2026; 7: 100927

Published Online October 28, 2026
https://doi.org/10.1016/j.lanhl.2026.100927

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

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Key messages

- Efforts to address the health-care needs of older people in contexts affected by humanitarian crises are often isolated and have low coverage because of systemic and structural barriers.
- Older people's physical health, cognitive health, functional ability, mental wellbeing, values, lived experiences, priorities, and preferences are shaped by interacting factors in contexts affected by humanitarian crises, including: rights, equity, and inclusion; enabling environments and relationships; and essential needs and supports.
- Additionally, the health needs of older people before, during, and after a humanitarian crisis are diverse and are shaped by dynamic interactions among biological, social, environmental, and other factors across the life course. Although substantial heterogeneity exists within this age group, older people are more likely to experience chronic diseases, physical disabilities, mental health conditions, multimorbidity, frailty, and functional decline.
- Humanitarian health programmes have historically adopted disease-specific or injury-specific life-saving approaches that introduce standardised interventions without sufficient contextualised, integrated, and person-centred adaptation. A person-centred and inclusive approach applied throughout all phases of humanitarian response is urgently needed to address the complex and interconnected health, social, and functional needs of older people, including their individualised access to essential services such as shelter, nutrition, water and sanitation, health care, assistive technologies, and social care and support.
- A person-centred and inclusive approach can help to ensure that older people's priorities and preferences are recognised while upholding their agency, dignity, autonomy, and right to participate in decisions affecting their lives.
- Although applying a person-centred approach in resource-austere settings poses numerous challenges, some of these challenges can be addressed at a higher level by tackling ageism within the health-care and humanitarian workforce, strengthening training, ensuring older people's participation in service design and delivery, and investing in more coherent, intersectoral humanitarian responses.

people's physical and cognitive health, mental wellbeing, functional ability, values, lived experiences, priorities, and preferences. Drawing on existing evidence syntheses of older people's health needs, an additional literature review, an expert consultation, and two case studies, we explore approaches that centre older people's needs, priorities, preferences, capacities, and lived experiences. Using established person-centred care approaches,[11] we highlight how person-centred approaches can help to address the complex and interconnected health needs of older people affected by humanitarian crises.

We recommend that readers engage with this paper alongside the two other papers that comprise *The Lancet Health and Longevity* Series. The first paper in the Series, Overlooked and underserved: older adults in humanitarian contexts,[12] critically examines the current policy landscape of humanitarian health care as it relates to older people, highlighting a persistent gap between policy commitments, including frameworks, documents, and recommendations, and their implementation.[13–18] The paper further documents the factors contributing to the exclusion of older people, operating at institutional, interpersonal, and individual levels. Drawing on available evidence, the paper presents the severe consequences of this neglect, including avoidable deaths, worsening health outcomes, and increased care dependence. The third paper in the Series, PARTICIPATE: a rights-based framework to include older people's health-care needs in humanitarian crises,[19] introduces a rights-based framework for age-inclusive humanitarian public health approaches. The framework translates five fundamental rights into concrete actions for humanitarian actors. PARTICIPATE aims to ensure the meaningful inclusion of older people in humanitarian responses to reduce excess mortality, morbidity, disability, exclusion, and care dependence while upholding the dignity, autonomy, and inherent worth of older people.

See Online for appendix

Methods

This Series paper adopted a multimethod approach combining an evidence synthesis, a targeted literature review, an expert consultation, and two case studies from health programmes in Afghanistan and Gaza, occupied Palestine.

First, we conducted a systematic review (published elsewhere)[20] to map the existing evidence base on the health needs of older people and age-inclusive health care in humanitarian contexts. Second, we conducted targeted, purposive searches to identify additional literature, including reviews and rapid needs assessments, to conceptualise the broader ecosystem of determinants that affect the health needs of older people in humanitarian crises. We also searched for literature on person-centred approaches to health care for older people in humanitarian crises. These purposive searches were intended to identify key concepts and illustrative evidence rather than to comprehensively identify all relevant literature. We searched MEDLINE, Google Scholar (first five pages, approximately 50 entries), and the HelpAge International website using the search strings "humanitarian AND older people AND needs" and "humanitarian AND older people AND person-centred".

Third, in November, 2024, we conducted online consultations with experts to gather insights into the health needs and other essential needs of older people and their access to services for older people in humanitarian crises (appendix pp 2–4). The consultations captured perspectives based on practitioners' direct experiences and observations, which are less likely to have been identified in existing evidence syntheses or studies. Given the exploratory aim of the consultation, participants were purposively selected to ensure the inclusion of individuals with relevant expertise and direct experience of humanitarian responses involving older people. Selection was based on professional expertise, sectoral background, and geographical area of work.

Participants were identified through the authors' professional networks. However, we sought to include a range of perspectives by selecting practitioners working across different sectors, including health, protection, food security and nutrition, and water, sanitation, and hygiene (WASH), and across diverse humanitarian contexts (appendix p 5). We acknowledge that recruitment through professional networks might introduce selection bias and might not capture the full range of perspectives among humanitarian actors. This limitation was considered during the interpretation of the consultation findings. Responses were analysed inductively, with two authors (JM and JS) independently grouping the findings into key themes.

Discussions between the authors and journal's editorial team determined that this low-risk expert consultation did not require procedural ethics oversight. Nonetheless, the consultation followed foundational ethical principles, and informed consent was obtained from all participants. 18 participants chose to be named as the Collaboration Group for *The Lancet* Series on Older Persons in Humanitarian Settings, and one participant chose to remain an anonymous key informant. Five prospective participants did not respond.

Finally, two case studies were developed to show the diversity and interconnectedness of older people's healthcare needs and relevance and feasibility of person-centred care approaches in Afghanistan and Gaza, occupied Palestine (CM and MHH).

This study does not apply a universal chronological age threshold to define older populations, recognising that such cutoffs inadequately capture the diversity of ageing experiences across contexts. Instead, this paper defines older people as individuals who self-identify as older or who are recognised as older within their social, cultural, and contextual environments. This approach reflects variations in life expectancy, functional ability, social roles, and expectations of ageing across settings. When the evidence cited in this paper defines older populations using specific age thresholds, those criteria are explicitly stated.

Conceptualising an ecosystem of determinants that shape older people's health and wellbeing

Drawing on the WHO healthy ageing framework,[21] social determinants of health,[22,23] and ecological models of ageing,[13] we conceptualise older people's health needs as emerging from an ecosystem of interconnected individual, social, environmental, and health-system determinants (figure). This ecosystem is shaped by older people's intrinsic capacities, functional abilities, preferences, identities, and priorities and by the availability of supportive relationships and caregivers, accessible environments, and responsive and continuous health and care systems. These factors interact within the broader context of humanitarian crises, in which conflict, displacement, environmental hazards, and disruptions to social and economic systems can intensify existing inequities. At the core of the ecosystem are older people's physical health; frailty, multimorbidity, and medication burden; cognitive health; functional ability; mental wellbeing; values, identity, and lived experiences; and priorities and preferences. These core elements are shaped by determinants across four dimensions of the ecosystem.

The first dimension—essential needs and supports—encompasses the needs of older people. The needs of older people vary but might include access to chronic disease management, frailty care, rehabilitation, assistive technologies, continuity and coordination of care, and person-centred services that respect individual values and preferences.[14–16,20] The first dimension also includes essential services, including shelter,[17] food and nutrition,[17] and WASH;[18] social protection mechanisms such as pensions;[24–26] and affordable access to medicines and care. These services directly influence the core dimensions of the ecosystem.[27–36]

The second dimension—enabling environments and relationships—comprises the physical, social, and institutional environments that enable older people to meet their essential needs, access necessary support, and maintain the core dimensions of the ecosystem. An enabling environment and relationship includes the formal and informal health and social systems that determine whether older people can access appropriate, continuous, and quality care during humanitarian crises. This dimension also includes accessible housing and other essential infrastructure,[25] accessible health services, health information,[2,16] supportive family and community relationships,[25] informal caregiving networks,[25] social connectedness,[25] safety and protection, and opportunities for participation, agency, and decision making.[2,16]

The third dimension—rights, equity, and inclusion—reflects the extent to which older people's human rights are recognised and upheld. This dimension includes the rights to autonomy, health, non-discrimination, visibility and participation, social care, and protection from violence, abuse, exploitation, and neglect. Rights, equity, and inclusion shape, and are shaped by, the enabling environment and essential needs and supports. The interactions among rights, equity, and inclusion, the enabling environment, and essential needs and supports influence how older people experience humanitarian responses and whether humanitarian actors recognise and address older people's needs and preferences.[2]

The outermost dimension—humanitarian crisis contexts—encompasses the broader conditions in which crises unfold, including armed conflict, displacement, environmental hazards, disease outbreaks, and climate-related emergencies. Humanitarian crisis contexts influence all other dimensions of the ecosystem by shaping the availability of resources, functioning of health and social systems, and broader risks and vulnerabilities experienced by older people.

Older people might experience compounded disadvantages arising from intersecting forms of exclusion, including ageism, gender inequality, disability, poverty,

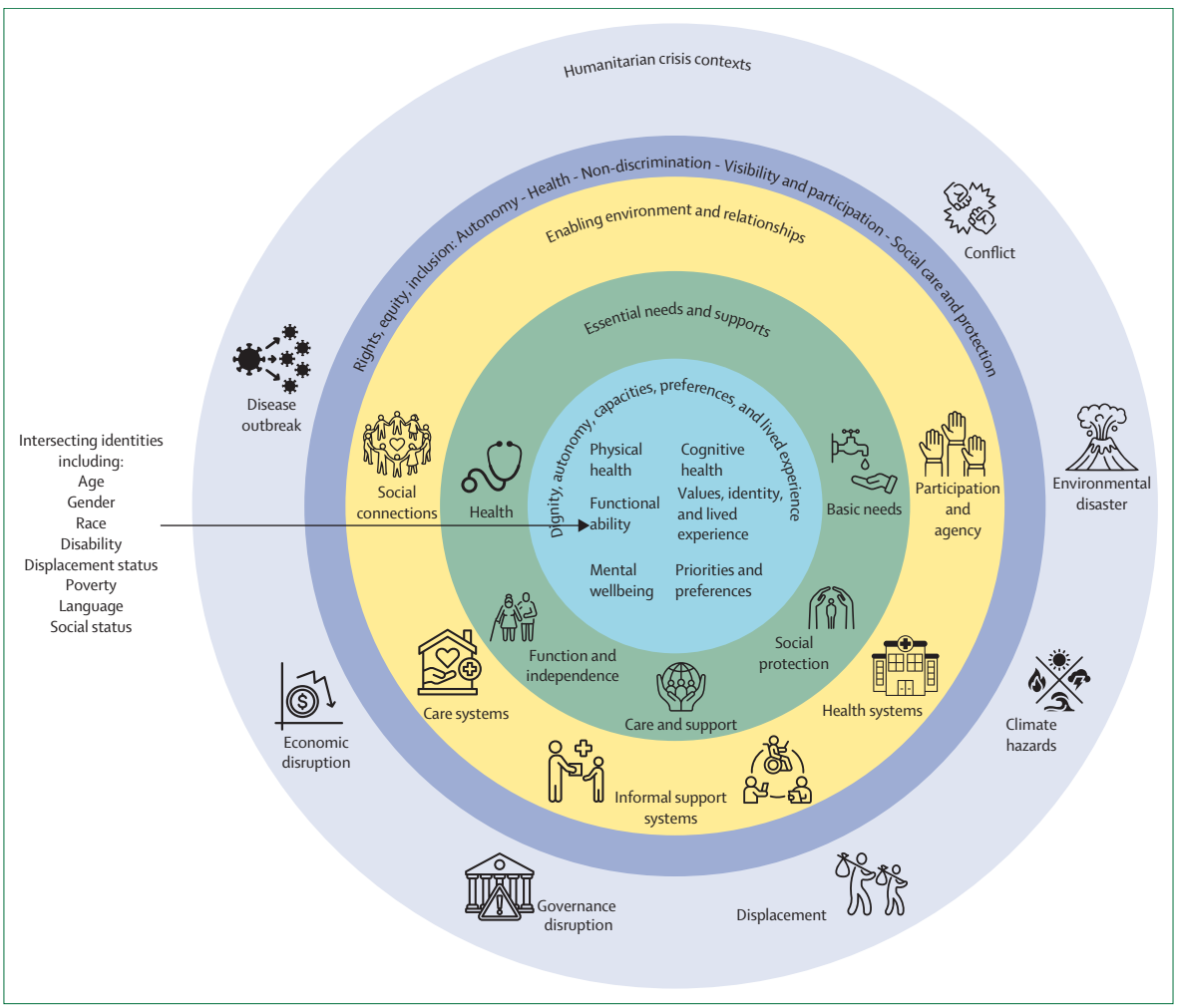


Figure: **Ecosystem of determinants that shape older people's health-care needs and wellbeing in humanitarian crises**

and displacement (figure).[37–39] These intersecting forms of exclusion influence access to, and experiences within, all dimensions of the ecosystem of determinants, while also shaping core outcomes including physical health, functional ability, mental wellbeing, cognitive health, and the ability to maintain and express personal values and preferences (panel 1). Although intersectionality is increasingly recognised as an important framework for understanding health inequities,[40] research applying an intersectional lens in humanitarian contexts remains scarce, particularly in relation to ageism.[2]

Understanding older people's health-care needs

Within the broader ecosystem of determinants, understanding older people's health needs is essential for designing person-centred, appropriate, and acceptable health-care services in humanitarian contexts. Older people represent a highly diverse population group and therefore have varied health needs resulting from dynamic interactions among biological, social, and other factors. Changes that occur during ageing result from both the cumulative physiological effects of ageing and social determinants of health that shift and change throughout the life course.[23,42]

Several evidence syntheses have examined existing literature on the health needs of older people in contexts affected by humanitarian crises.[14–16,20] Despite differences in methodology and scope, the evidence syntheses have consistently highlighted similar health conditions and functional needs, health-care needs, social and relational needs, inclusion needs, and barriers to age-inclusive health care (appendix pp 6–7).

The available evidence base is scarce, with the number of included studies in existing evidence syntheses ranging from 27 to 84 depending on the scope of each synthesis, along with variations in methodological quality.[15,20] Therefore, we complemented findings from published research with insights from humanitarian practitioners based on their direct experiences and observations. Practitioners highlighted non-communicable diseases (NCDs), nutrition, mental health, and psychosocial wellbeing as key areas

Panel 1: **Beyond age: intersecting gender, health, and social barriers affecting health-care access among older women in rural Afghanistan**

Older people's economic and other vulnerabilities have been overlooked owing to a reduction in humanitarian assistance in Afghanistan in 2024, inadequate health-system strengthening to address chronic health needs, and scarcity of age, sex, and disability disaggregated data. In Afghanistan, humanitarian responses often fail to engage female-headed households and community representatives or to address cultural dynamics. Poorly resourced organisations might struggle to adhere to universal standards because of resource constraints.

Following devastating earthquakes in Herat Province in October, 2023, which left thousands of people homeless,[41] Afghanischer Frauenverein e.V. (AFV) provided transitional shelters and crucial humanitarian assistance to families, with a particular focus on older people (>50 years) and female-headed households in the Injil and Zindajan districts of Herat Province. AFV's observations from the target villages, which were consistent with available national data, identified several economic, social, and other barriers to accessing health-care among older people, particularly older women.

The primary carer in nearly 10% of households in the villages was an older person, and many of the caregivers were women because men had either been killed in the earthquake or had left for neighbouring Iran to support their families. Older women often reported that they had not seen a doctor in many years owing to the costs of transportation and medical care. Cultural expectations often prioritise family needs over personal health, leading to self-neglect, especially among women. Compared with older men, older women reported more untreated chronic health conditions, including renal insufficiency, cataracts, osteoarthritis, chronic skin diseases, and jaundice indicative of underlying hepatic conditions, and recurrent diarrhoea associated with a lack of access to clean water. Older women also showed signs of psychological distress following severe losses, difficulties managing their roles as sole caretakers for their grandchildren, and despair resulting from disruption to family structures. Mental health stigma also prevented older women from seeking psychosocial support despite high rates of post-traumatic stress disorder.

of concern for older people in contexts affected by humanitarian crises, consistent with findings from the existing evidence syntheses.[14–16,20] Practitioners also identified additional health-related needs that were not, or were only minimally, addressed in existing evidence syntheses, including the management of multimorbidity, frailty, and polypharmacy; sexual and reproductive health and rights; access to vaccines; access to assistive technologies; and tailored health-care approaches for older people with specific vulnerabilities.

Complexity, multimorbidity, frailty, and polypharmacy

Humanitarian practitioners highlighted the complexity of caring for older people living with multimorbidity, frailty, and polypharmacy. Existing evidence syntheses have minimally addressed multimorbidity, frailty, and polypharmacy, despite their importance as prominent features of health for older populations. Older people in contexts affected by humanitarian crises frequently experience multiple interacting physical, cognitive, mental health, and functional conditions that rarely occur in isolation and require coordinated, person-centred care rather than disease-specific approaches. As one practitioner observed, "Certain groups of older people require tailored interventions in humanitarian settings to address specific vulnerabilities. Older people with Alzheimer's disease and dementia require memory support, safe and structured environments, and trained caregivers … Older people with chronic diseases such as diabetes, hypertension, and arthritis need continuity of care, medication access, and regular monitoring … Older people experiencing mental health challenges due to conflict, displacement, grief, or trauma require age-appropriate mental health and psychosocial support, including counselling, peer support groups, and trauma-informed care".

Multimorbidity commonly increases with age and is often accompanied by polypharmacy, increasing the risk of adverse drug events, drug–drug interactions, treatment burden, and functional decline.[43–45] In addition, complex interactions between communicable diseases and NCDs require integrated management approaches. Chronic infectious diseases might contribute to the development of NCDs, and many NCDs also increase susceptibility to infections and the risk of poorer outcomes. Humanitarian crises further exacerbate these risks through disruptions to health and rehabilitation services, medication supply chains, and continuity of care.

Frailty, characterised by age-related decline in physiological reserve and resilience, further influences older people's vulnerability, recovery, and ability to cope with acute stressors associated with humanitarian crises. Frailty is closely associated with multimorbidity and functional decline and is influenced by demographic and social determinants, including displacement, advanced age, female sex, loneliness, and social disadvantage.[46,47]

Addressing the health-care challenges associated with multimorbidity, frailty, and polypharmacy requires integrated primary health-care approaches centred on comprehensive assessment, continuity and coordination of care, regular medication review and prescribing when appropriate, effective symptom management, palliative care approaches when indicated, and support for self-management and caregivers. Humanitarian health responses should prioritise intersectoral and person-centred

care plans that account for multimorbidity, frailty, functional ability, medication burden, and individual goals and preferences rather than focusing on single conditions in isolation. Recognising the importance of such integrated care plans, one practitioner offered several examples: "Due to restricted mobility and livelihood challenges, older individuals often need cash assistance to meet their daily needs. Furthermore, many older people need safe and accessible shelter that accommodates their physical limitations and provides safety measures to protect them from harm. Regular and tailored distribution of these items is crucial, with a focus on addressing the unique circumstances of older adults, such as their dependency and vulnerability".

Sexual reproductive health and rights

The sexual and reproductive health (SRH) needs of older people are frequently overlooked in contexts affected by humanitarian crises, despite being an important component of overall health and wellbeing. Older women might require support for menopause and post-menopausal health, urinary incontinence, pelvic floor disorders, vaginal dryness, infections, and access to cancer screening, among other issues,[48] and older men might require attention to prostate health, andropause, and sexual dysfunction, among other issues.[49] Older adults might also need information on sexual health, prevention of sexually transmitted infections, and safe sexual practices.[50] Key barriers include stigma and misconceptions surrounding sexuality in later life, low awareness among communities and health-care providers, insufficient training of health workers, inadequate research, restricted access to diagnostic and screening services, and the exclusion of older people from SRH programmes and policies.[51]

Addressing these gaps requires the integration of SRH services for older people into primary health-care and humanitarian health responses. Such integration should include expanded access to menopause and urologic care; incontinence management; screening and treatment services, including cervical, breast, and prostate health services; and appropriate medications and hygiene supplies. Health workers should receive training on older people's SRH needs, and community education and awareness activities can help to reduce stigma and promote access to care. Services should be age-inclusive, gender-sensitive, and accessible to older people living in remote, displacement-affected or resource-constrained settings.

Access to vaccines

Older people in contexts affected by humanitarian crises often have important unmet needs related to access to age-appropriate vaccines. Vaccinations against preventable diseases such as influenza, pneumococcal disease, and shingles are particularly important given older people's increased vulnerability to severe illness and complications. Nevertheless, older people are often not included in routine immunisation programmes in many humanitarian crisis-affected contexts.[52,53]

Addressing gaps in access to vaccines requires the systematic inclusion of older people in vaccination programmes through outreach activities and mobile vaccination services and broader integration of age-inclusive immunisation strategies into humanitarian health responses. Humanitarian health responses should ensure that older people are considered in vaccination planning, delivery, and monitoring such that vaccines are provided not only during emergencies but also incorporated into longer-term approaches to healthy ageing, including the prevention of vaccine-preventable diseases.

Assistive technologies

Assistive technologies, such as glasses, hearing aids, walking sticks, wheelchairs, and other mobility aids, are essential for maintaining independence, safety, and participation, particularly among older people living with functional limitations or disabilities. However, access to assistive technologies is frequently overlooked in humanitarian responses, with assistive technologies often prioritised for injury-related rehabilitation rather than for age-related functional needs.[54]

Addressing gaps in access to assistive technologies requires the incorporation of assistive devices into humanitarian planning, budgeting, and procurement processes. Such efforts include assessing individual needs, supplying appropriate devices, and providing training on their use, adaptation, and maintenance. Strengthening collaboration among humanitarian and health actors, rehabilitation services, and communities is essential to ensure that assistive technologies support older people's functional independence and are integrated into longer-term approaches to healthy ageing.

Availability, accessibility, acceptability, and quality of health-care services for older people

In contexts affected by humanitarian crises, health systems are often under severe strain and might struggle to maintain essential services owing to shortages of material and human resources and inadequate health financing.[55] Access to health services can be further constrained by contextual factors, including insecurity and attacks on health-care facilities and personnel, which undermine the ability to seek care safely.[56] These constraints do not affect all population groups equally; older people and other groups experiencing marginalisation or exclusion might face disproportionate barriers during humanitarian crises.[57] At the same time, services that are highly relevant to older people, including long-term care, rehabilitation, and palliative and end-of-life care, remain largely underprioritised in humanitarian responses.[54,58–60]

Humanitarian practitioners identified multiple barriers affecting older people's access to health care, which were organised according to the availability, accessibility, acceptability, and quality framework.[61] The practitioners'

observations aligned with findings from previous evidence syntheses. Accessibility-related barriers, including physical access, affordability, and availability of information, were highlighted most frequently, followed by challenges related to service availability, the appropriateness and acceptability of care, discrimination, and gaps in the quality of health-care provision.

Person-centred care approaches for older people in humanitarian crises

Tailored health care for older people affected by humanitarian crises should recognise the interconnected ecosystem of determinants that shape health and access to health-care services and the complexity of older people's health-care needs. Person-centred care is an approach that organises care around an individual's priorities, preferences, capacities, and lived experiences, rather than around specific diseases, while also recognising the influence of families, communities, and the wider social determinants of health.[62] In line with humanitarian quality standards, person-centred care requires participatory and inclusive approaches throughout the design, delivery, monitoring, evaluation, and adaptation of services, with the goal of advancing health equity and ensuring continuity of holistic care. In the words of one practitioner, "Ultimately, the inclusion of older people in decision-making processes ensures that their voices are heard and their needs are met in a comprehensive and respectful manner".

Historically, humanitarian health responses have prioritised rapid, life-saving and disease-specific interventions to reduce short-term, excess morbidity and mortality.[63] Although such approaches remain useful for managing acute illnesses, injuries, and outbreaks, they often pay minimal attention to the wider ecosystem of determinants that shapes older people's health. Multimorbidity, functional ability, cognitive health, social relationships, living environments, and access to ongoing care all influence health outcomes but are not adequately addressed through disease-focused models alone. Rather than replacing disease-centred approaches, person-centred care complements disease-centred approaches by integrating clinical management with functional, psychosocial, and environmental considerations and prioritises the organisation of care around the person rather than individual health conditions (table).

The importance of person-centred care is increasingly recognised beyond primary health-care and ageing. WHO's Integrated Care for Older People approach identifies person-centred care as fundamental to improving health equity, quality of care, participation, continuity of services, and the resilience of individuals, communities, and health systems.[64] In contexts affected by humanitarian crises, the principles underpinning person-centred care support more responsive and integrated care by recognising older people's priorities, capacities, and lived experiences while addressing the broader determinants that shape health and wellbeing. Therefore, applying person-centred approaches strengthens humanitarian responses by complementing essential disease-specific interventions with care that is more equitable, coordinated, and responsive to the realities of ageing amid humanitarian crises (panel 2).

Barriers and challenges to implementing person-centred care for older people in humanitarian crises

Despite commitments to uphold rights, preserve dignity, and safeguard autonomy, humanitarian responses have been slow to integrate person-centred approaches that address the diverse health-care needs of older people, with older people's health-care needs often poorly documented and insufficiently reflected in service design, delivery and evaluation.[20] This situation reflects not only gaps in awareness and technical capacity but also broader structural features of humanitarian systems. The implementation of person-centred approaches for older people in humanitarian crises is constrained by barriers across the ecosystem of determinants. In relation to the enabling environments and relationships dimension, inaccessible infrastructure, transportation barriers, and inadequate support networks can hinder access to care and implementation of person-centred approaches. Concerning health and care systems, inadequate workforce capacity in geriatrics and low workforce sensitisation to the specificities of person-centred care, alongside insufficient age-disaggregated data, restrict the ability to design and adapt person-centred responses. One practitioner reflected on these overarching challenges, stating that "older people's health needs in humanitarian emergencies are often not well addressed, primarily due to systemic challenges and gaps in response planning. Older people are frequently excluded from assessments and surveys that inform humanitarian responses, leading to services that do not adequately reflect their needs". Within the rights, equity, and inclusion dimension, gaps in international legal protection and weaknesses in implementation and accountability mechanisms can limit recognition of older people as rights holders.[65] Finally, within the humanitarian contexts dimension, the inconsistent application of existing policies and tools, emergency-oriented programming, and short and constrained funding cycles can limit the adaptation of responses to older people's diverse needs.

Humanitarian responses necessarily involve prioritisation decisions, particularly in situations in which needs exceed available resources.[66] However, prioritisation becomes ethically problematic when prioritisation decisions are informed by assumptions about age rather than by individual needs and circumstances. The use of older age as a proxy for reduced social value, lower productivity, low life expectancy, frailty, or poor treatment outcomes can reinforce discriminatory practices and violate older people's rights to health, dignity, autonomy, and equitable access to assistance.[67] Person-centred approaches do not imply that older people's needs

	Person-centred approaches	Disease-centred approaches
Primary focus	The lived experiences of individuals; health understood in relation to all aspects of social, cultural, and political life	Specific diseases or conditions; health defined by pathology
Conceptualisation of health	Holistic; physical, psychological, and social wellbeing	Biomedical; the absence or presence of disease
Attention to social determinants of health	Central	Peripheral; often treated as external, contextual factors
Temporal dimensions	Long-term and life-course oriented	Short-term, acute; cyclical
Care pathways	Flexible and adaptive; intersectoral	Standardised and protocol-driven; often vertically organised
Success measured by	Improvements in wellbeing, function, dignity, autonomy, and quality of life	Reduction in morbidity and mortality
Role in humanitarian response	Coordinates care around a person's priorities and needs	Essential for rapid diagnosis and treatment of acute illness and outbreaks

Table: **Comparative dimensions of person-centred and disease-centred approaches**

Panel 2: Person-centred approaches in Gaza, occupied Palestine: older people as frontline health responders

Amid Israel's genocide in Gaza, access to health-care has been severely restricted, especially for the most vulnerable people. In response, Juzoor for Health and Social Development, a grassroots Palestinian organisation, provided primary health care and support while also working with older community members as central leaders in both the planning and delivery of humanitarian assistance.

Faced with the destruction of infrastructure, restricted access, and overwhelming needs, older people, including retired doctors, nurses, and community health experts, became a major cornerstone of the humanitarian response. Older people were not passive recipients of support but led every facet of the intervention, with a focus on community-based primary health and care and integrated services.

At the core of Juzoor's work are its community health centres and the shelters it oversees, many of which were established, staffed, and run by older health-care workers and volunteers. The clinical expertise, long-standing community relationships, and practical experience of older health-care workers and volunteers made them uniquely positioned to respond. Older health-care workers and volunteers coordinated mobile health outreach, managed sub-clinics, and helped to evacuate and re-establish care centres under the threat of bombardment.

Even amid repeated displacement and extreme insecurity, older team members remained the most steadfast, quickly adapting and ensuring continuity of care. Older team members also played a central role in identifying needs and ensuring that older people's comprehensive and interconnected needs were not sidelined in the broader response through advocacy efforts, ongoing monitoring, proactive efforts to ensure integrated health and care service provision, and participation in consultations with older people to capture their recommendations and insights.

Juzoor's experience in Gaza recognises that older people are not simply an at-risk group but are essential frontline responders who provide leadership, experience, and contextual knowledge during emergency responses. Integrating older people's perspectives and leadership into health responses strengthens the steadfast continuity of caregiving, enhances trust, and offers a replicable model for inclusive, integrated, and community-driven emergency response grounded in person-centred and community-centred approaches.

should be prioritised over the needs of other population groups. Rather, decisions affecting older people should be based on equitable, fair, transparent, and individualised assessments that recognise diverse capacities, preferences, and contributions.[62]

These challenges are further compounded when health systems are disrupted by the targeting of and damage to infrastructure; the displacement, detention, killing, or injury of health workers; and compromised supply chains, often at the same time that demand for services increases. As mentioned previously, although humanitarian responses have historically prioritised the delivery of immediate life-saving interventions, a growing number of complex and protracted crises requires greater attention to continuity of care over years and, in several cases, decades.[68] Strengthening person-centred approaches therefore requires not only technical guidance and workforce capacity but also an overhaul of dominant structures and intervention logics, including urgent changes to humanitarian financing, accountability mechanisms, information systems, and genuine investment in meaningful participation.

Conclusion

Building on the first paper in this *Lancet* Series[12] and as a precursor to the third paper,[19] we have synthesised findings from a review of the literature, a survey of humanitarian practitioners, and case studies from Afghanistan and Gaza, occupied Palestine, to provide an overview of the diverse and interconnected health-care needs of older people affected by humanitarian crises. Drawing on an ecosystem of determinants perspective, we have highlighted how older people's physical health, cognitive health, functional ability, mental wellbeing, values, identity, lived experiences, priorities, and preferences are shaped by interacting factors across contexts affected by humanitarian crises. These

Older adults in humanitarian settings

Older adults 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

interacting factors relate to rights, equity, and inclusion; enabling environments and relationships; and essential needs and supports. The ecosystem of determinants perspective emphasises the need to move beyond narrow, disease-focused approaches and consider the broader conditions that influence older people's health in humanitarian crises. We have also emphasised the importance of incorporating person-centred and rights-based approaches because these approaches are essential to ensuring that older people's rights, priorities, and lived experiences are recognised and addressed. We recognise that good practices are present, as shown by the case studies from Afghanistan and Gaza, occupied Palestine. However, good practices remain fragmented and are often dependent on individuals or organisations rather than being systematically embedded across the humanitarian sector.

Despite a growing awareness of the heterogeneous, interconnected, complex, and context-dependent needs of all people affected by humanitarian crises, regardless of age, we have identified several key dimensions that continue to undermine the design and delivery of person-centred humanitarian health services for older people.

Amid a persistent mismatch between the number of people in need of humanitarian assistance worldwide and available material, financial, and human resources and the political will required to meet those needs, questions of inclusion related to age and other demographic factors are often delayed and deprioritised.[12] Further funding cuts to aid budgets and humanitarian organisations risk reversing the small progress made towards inclusive humanitarian responses, as organisations are pressed to prioritise immediacy over equity and the realisation of rights. Fewer than 0·1% of projects registered on UN Office for the Coordination of Humanitarian Affairs' financial tracking system between 2019 and 2023 mentioned older people. When specific groups are already structurally excluded, hyperprioritisation and so-called tough choices clearly risk deepening the exclusion of those groups.[41,69]

To achieve meaningful changes across these dimensions, the third paper[19] in this *Lancet* Series presents a rights-based framework that identifies several concrete actions to advance efforts to uphold the rights of older people, listen to them, recognise and incorporate their capacities, and adequately meet their diverse, complex, and interconnected health-care needs in humanitarian crises.

Contributors

EVB and FE contributed to the conceptualisation, methodology design, and first revision of the manuscript. JM and JS performed the data analysis, research, and development of the original draft manuscript. JS performed the second revision of the manuscript. CM and MHH contributed to the case studies and review of the manuscript. All co-authors reviewed the manuscript before submission. 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

JM received support from HelpAge International to attend WHO high-level technical meeting on non-communicable diseases in humanitarian settings in Denmark in February, 2024. JM serves as Chair of the Steering Committee of the Healthy Aging Platform (HelpAge International), President of the Board of Fundación Convite Colombia, and Board Member of Convite AC Venezuela. All other authors declare no competing interests.

Acknowledgments

We are grateful to the Collaboration Group for *The Lancet* Series on Older Persons in Humanitarian Crises for their invaluable contributions through the expert consultation survey: Mohana Amirtharajah, Rachel Coghlan, Kathryn Falb, Diana Hiscock, Sari Mutiatimur, Jason Nickerson, Etwal Bou Raad, Basem Shaher, Sunita Sharma, Yuka Sumi, Mahmoud Tharwat, Antonio Vargas, Mija Ververs, and Tanit Iglesias Zayas. We would also like to thank the one anonymous key informant who completed the survey.

Editorial note: The Lancet Group takes a neutral position with respect to territorial claims in text.

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