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PARTICIPATE: a rights-based framework to include older people's health-care needs in humanitarian crises

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The present paper concludes *The Lancet Healthy Longevity* Series on the health-care rights and needs of older people in humanitarian crises and outlines a rights-based framework for age-inclusive humanitarian public health approaches. The framework was shaped by an iterative process of consultation with key stakeholders and emphasises five fundamental rights that should guide humanitarian action. The fundamental rights include the rights to visibility and meaningful participation; non-discrimination; health; social care and protection from violence, exploitation, and neglect; and autonomy. We translate these fundamental rights into a concrete framework of actions, adopting the acronym PARTICIPATE, which aims to ensure inclusion and reduce excess mortality, morbidity, disability, exclusion, and care dependence among older people, while upholding their dignity, autonomy, and inherent worth in humanitarian crises. An accelerated commitment from humanitarian actors is urgently needed to meet the growing and diverse health-care rights and needs of older people, close gaps in health-care access, and embed accountability mechanisms for equitable, age-inclusive care. With consistent, rights-based engagement, genuine participation, and accountable systems, the humanitarian sector can uphold the rights and meet the health-care needs of older people, acknowledge their crucial roles and contributions, strengthen community resilience, and ensure justice across generations, thus remaining true to the core principles of humanitarian action.

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Background

This Series paper, which concludes *The Lancet Healthy Longevity* Series on the health-care rights and needs of older people in humanitarian crises, outlines a rights-based framework for age-inclusive humanitarian public health approaches. The present paper builds on the first paper of the Series, which provides an overview of the current policy landscape and factors contributing to the exclusion of older people,[1] and the second paper, which provides an overview of the health-care needs of older people.[2]

Despite repeated calls for action, older people (ie, those who self-identify or are recognised as older within their specific social and cultural contexts; this classification allows accounting for different life expectancies and changes in social roles across settings.[3–5]) remain overlooked in humanitarian settings and their diverse rights and needs remain unmet.[6–13] This situation is expected to worsen in the current shrinking, underfunded, and overstretched humanitarian landscape. Humanitarian crises are projected to become more complex, compounded, and protracted over the coming years and decades, further exacerbated by the climate emergency.[14,15] Currently, middle-income countries with rapidly ageing populations account for the majority of population affected by conflict.[16] It is projected that by 2050, 80% of population older than 60 years will live in low-income and middle-income countries, where humanitarian emergencies (ie, conflict, environmental disaster, and displacement) are most likely to occur.[17] The growing scale and complexity of humanitarian crises, combined with rapid global demographic shifts, demand urgent and sustained attention to the specific needs and rights of older people. Yet ageism, compounded by intersecting forms of bias, continues to result in their exclusion.[18] Without intentional, intersectoral, and rights-based inclusion, humanitarian action risks reinforcing existing structural inequalities, leading to excess mortality, morbidity, disability, and care dependence among older people, and also undermining their autonomy and dignity.

We propose a comprehensive rights-based framework that outlines key actions for humanitarian and health actors to include older people in humanitarian preparedness, response, and recovery. This framework was shaped by an iterative process of consultation with key stakeholders, including humanitarian responders, researchers, policy makers, and advocates, ensuring that the rights of older people remain central to its design. Drawing on lessons from established standards such as the Minimum Initial Service Package for sexual and reproductive health in crises (an internationally recognised, non-negotiable, and mandatory set of priority activities endorsed by the Inter-Agency Standing Committee and embedded within the SPHERE standards[19,20]), our framework brings similar clarity, ambition, and normative weight to the inclusion of older people's health and care.

This framework emphasises five fundamental rights that should guide humanitarian action. These are (1) the right to visibility and meaningful participation, ensuring older people's voices are elevated in programming, advocacy, research, data collection and analysis, and policy development; (2) the right to non-discrimination, addressing intersecting biases, including those based on age, gender, ethnicity, disability, and displacement; (3) the right to

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Key messages

- Older people are consistently overlooked in humanitarian crises: despite growing numbers and vulnerability, their diverse health-care needs and rights remain unmet and their contributions often go unrecognised due to ageism, intersecting biases, and systemic neglect.
- A rights-based, age-inclusive approach is essential: humanitarian responses should be grounded in principles of participation, equity, autonomy, accountability, and impartiality, driven by an inclusive approach, to ensure older people are visible and included.
- We translate these fundamental rights into a concrete framework of actions, adopting the acronym PARTICIPATE, which aims to ensure inclusion and reduce excess mortality, morbidity, disability, exclusion, and care dependence among older people, while upholding their dignity, autonomy, and inherent worth in humanitarian crises.
- An accelerated commitment from humanitarian actors is urgently needed to meet the growing and diverse health-care rights and needs of older people, close gaps in health-care access, and embed accountability mechanisms for equitable, age-inclusive care.
- With consistent, rights-based engagement, genuine participation, and accountable systems, the humanitarian sector can uphold the rights and meet the health-care needs of older people, acknowledge their crucial roles and contributions, strengthen community resilience, and ensure justice across generations, thus remaining true to the core principles of humanitarian action.

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.

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health, guaranteeing access to affordable, appropriate, quality health-care services that are acceptable and culturally relevant for older people; (4) the right to social care and protection from violence, exploitation, and neglect, including sexual violence and trafficking; and (5) the right to autonomy, recognising the freedom of older people to make informed decisions about their lives. We translate these fundamental rights into a concrete framework of actions, adopting the acronym PARTICIPATE, which aims to ensure inclusion and reduce excess mortality, morbidity, disability, exclusion, and care dependence among older people, while upholding their dignity, autonomy, and inherent worth in humanitarian crises. Accountability underpins this framework and requires that humanitarian systems are responsive to and uphold older people's rights.

Methods

We used a stepwise approach to develop this framework. First, we conducted a literature review, published elsewhere,[21] to map the existing evidence base. Then, in Feb 13–March 7, 2025, we administered an online questionnaire (appendix pp 2–4) to gather insights from practitioners working on the health-care rights and needs of older people in humanitarian crises. The questionnaire was sent to 40 prospective participants, who were purposively selected based on their experience working on the topic and were identified through the authors' network. Prospective participants had to have experience working in health, or a closely related field such as protection; food security and nutrition; or water, sanitation, and hygiene, in humanitarian crises. When identifying prospective participants, we considered a balance of affiliation types (eg, academia, non-governmental organisations [NGOs], and UN agencies), and geographical area of work. Thirty-seven participants completed the questionnaire (appendix p 5). One prospective participant declined to participate, and two prospective participants did not respond. 35 participants chose to join the Collaboration Group for the *Lancet* Series on Older Persons in Humanitarian Crises, whereas two participants chose to remain anonymous key informants. Two authors (EvB and FE) inductively grouped the data into themes.

See Online for appendix

A rights-based framework of actions towards age-inclusive humanitarian health action: PARTICIPATE

Through a stepwise approach, we conceptualise a rights-based framework of actions to ensure inclusion and reduce excess mortality, morbidity, disability, and care dependence in older people and uphold their dignity, autonomy, and inherent worth (figure, panel 1).

P – Prepare for humanitarian crises to include older people

Preparedness plans that account for the rights and needs of older people require the combined action of older people, families, communities, organisations, and governments.[22] During the preparedness phase, assessments should evaluate the capacity of health and social care systems, NGOs, community-based organisations (CBOs), and communities to deliver inclusive humanitarian responses that respect the rights and needs of older people.

Resilience-building programmes are typically integrated in preparedness frameworks, covering a wide range of sectors including health, livelihoods, and social protection, and should be designed and implemented to ensure the inclusion of older people.[23] Resilience-building includes supporting communities to be better prepared to withstand and recover from economic, social, and environmental shocks and stresses (eg, extreme climate-related events including heat waves) and recognises that communities have expert knowledge of their local environment and are best positioned to observe, learn, experiment, innovate, and respond to the risks they face.[23] Local government bodies and CBOs should work closely with older people including older people's associations (OPAs), in preparedness efforts, utilising older people's skills and experiences to enable them to provide locally led solutions.[23]

A – Address ageism in humanitarian health systems

Reasons for the exclusion of older people in humanitarian crises are complex and multifaceted and include ageism at the institutional, interpersonal, and individual levels, as discussed in the first paper of this Series.[1,24,25] Typically, humanitarian crises strain societies and systems, which can exacerbate ageism and other forms of bias and oppression.[26–28] Ageism is associated with a shorter life span (of up to 7·5 years), poorer physical and mental health, slower recovery from disability, and cognitive decline.[5] Addressing ageism in humanitarian action requires adopting and adapting three actions that have proven to be effective for addressing ageism.[5] The first action requires creating legal and institutional frameworks that protect older people from discrimination and ensure their rights are upheld. The development and adoption of a UN convention on the rights of older people that explicitly includes provisions related to humanitarian crises and that establishes monitoring systems to ensure compliance in ratifying countries, is long overdue and urgently needed. The second action includes mandatory training for humanitarian workers on ageism, aimed at improving knowledge and dispelling existing misconceptions about ageing and older people. For example, service providers should receive training to help them identify and challenge common misconceptions and harmful narratives about older people and ageing (eg, depression and loneliness are normal in older people, and older people are not sexually active and will not have sexually transmitted infections) that can hinder access to needed health and care services.[29,30] The third action requires actively seeking intergenerational interventions. This approach could be implemented by creating spaces where different age groups can learn from one another, thereby helping to reduce ageist attitudes.

Finally, indicators to measure experiences of ageism and its intersection with other forms of bias should be used,[5,31,32] such as the WHO ageism scale, which is undergoing testing in selected humanitarian crises.[29,33]

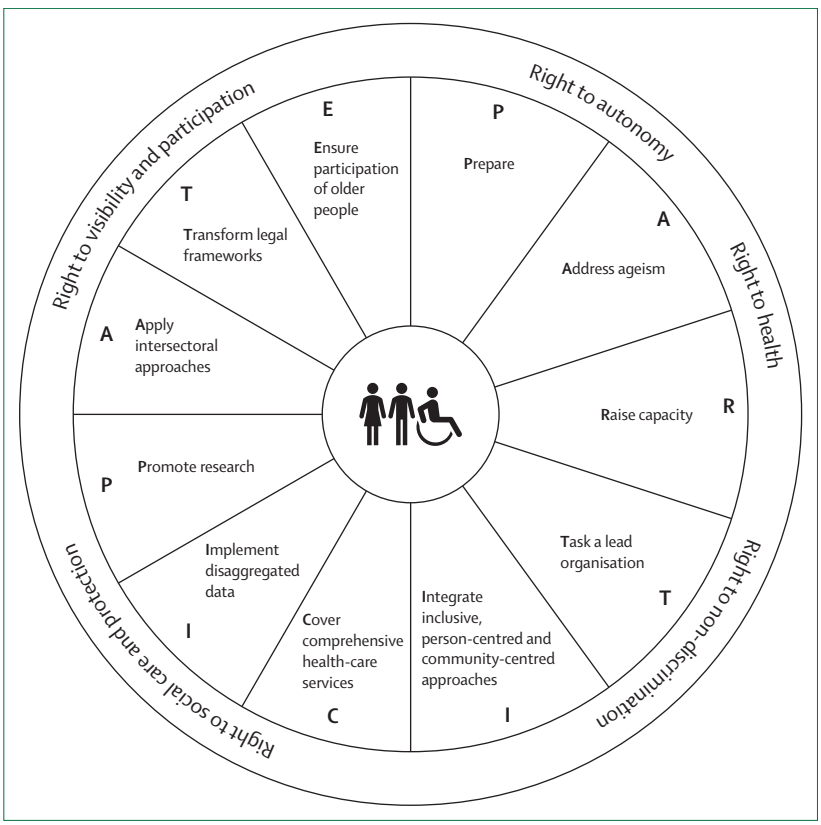


Figure: **Rights-based framework of actions to ensure inclusion and reduce excess mortality, morbidity, disability, and care dependence in older people and uphold their dignity, autonomy, and inherent worth**

R – Raise capacity of stakeholders for age-inclusive humanitarian health responses

Various guidelines and toolkits partly address the health-care rights and needs of older people, including the Humanitarian Inclusion Standards and national policies and guidelines in countries affected by humanitarian crises.[34] HelpAge International developed a Rapid Needs Assessment toolkit,[35] and WHO provides technical resources to implement the integrated care for older people approach, referred to as ICOPE, which aims to facilitate the reorientation of health and social services towards more person-centred and coordinated care that supports the optimisation of intrinsic capacity and functional ability for older people.[30] However, these resources are not systematically used or completely adapted for humanitarian response. Survey participants identified the following barriers to the systematic use of these guidelines and toolkits: absence of awareness among humanitarian actors, competing priorities, insufficient training and capacity, inadequate policy integration, perceived complexity, insufficient accountability and monitoring, and insufficient pressure from donors to use the guidelines and toolkits (appendix pp 6–7).

To raise capacity, survey participants made the following suggestions. First, humanitarian actors and national authorities need to increase knowledge and capacity to

Panel 1: **The PARTICIPATE framework**

The PARTICIPATE framework includes the following actions:

- P – Prepare for humanitarian crises to include older people
- A – Address ageism in humanitarian health systems
- R – Raise capacity of stakeholders for age-inclusive humanitarian health responses
- T – Task a lead organisations to coordinate and ensure the inclusion of older people in humanitarian health responses
- I – Integrate inclusive, person-centred and community-centred approaches into humanitarian health responses
- C – Cover comprehensive health-care services including older people's health and care needs
- I – Implement disaggregated data collection and analysis by age, sex, and disability
- P – Promote research with older people on their health-care needs using participatory, adaptive, and inclusive methods
- A – Apply intersectoral approaches to address the diverse needs of older people
- T – Transform current legal frameworks for age-inclusive humanitarian health response
- E – Ensure participation of older people to guarantee accountability of humanitarian actors towards more inclusive humanitarian health responses

implement guidelines and integrate them into national and organisational policies.

Second, health and care staff, policy makers, and health authorities need training on health challenges that demand tailored responses across the continuum of care, including the integration of long-term and palliative care for chronic, degenerative, and life-threatening conditions, and protection from neglect and abuse—whether physical, psychological, sexual, or financial.

Third, a Community of Practice should be formed to foster knowledge sharing, learning, and collaboration among humanitarian stakeholders, including national authorities, NGOs, CBOs, OPAs, and communities, to improve practices and advance knowledge and skills on the inclusion of older people in humanitarian preparedness, response, and recovery.

T – Task a lead organisation to coordinate and ensure the inclusion of older people in humanitarian health responses

Humanitarian actors should identify a lead organisation at the beginning of each crisis response, with the explicit mandate to coordinate and ensure the inclusion of older people in the response. The choice of lead organisation is highly context-dependent ranging from national authorities to UN agencies, NGOs, CBOs, or OPAs, depending on who has the required technical expertise, capacities, and resources. Preference should always be given to the national health authority, unless there are valid reasons why this is not possible. A similar approach is taken for sexual and reproductive health care in humanitarian crises, where a lead organisation is appointed for the implementation of the Minimum Initial Service Package for sexual and reproductive health services.[36]

Various crises have tested the appointment of Age Inclusion Specialists.[37] These specialists are embedded in humanitarian coordination systems and work with national authorities, UN agencies, NGOs, CBOs, and OPAs to increase the visibility of older people in needs assessments, planning meetings, and response activities and to amplify their voices and ensure their perspectives are given due consideration. This approach should be explored further in health and related clusters in other humanitarian crises.

I – Integrate inclusive, person-centred and community-centred approaches into humanitarian health responses

Older people are a heterogenous group with different needs, capacities, and preferences.[2] Survey participants identified the following social factors that can affect older people's health-care needs and access to services: being a woman, identifying as LGBTQ+, absence of a support network, being displaced, living alone, being a caregiver themselves, remaining behind when family members flee, living in poverty, being of more advanced age, having a low level of education, or belonging to a minority ethnic or religious group. However, it is equally important to recognise their capacities and contributions. Many older people actively participate in their communities as caregivers, knowledge holders, and leaders, among other roles, and offer invaluable social support and strengthen community resilience.[38]

As set out in the second paper of this Series, humanitarian responders should apply person-centred and community-centred approaches to ensure age-inclusive service provision.[2] Grounded in the right to autonomy, co-methodologies should inform the design of person-centred and community-centred health-care services in humanitarian crises.[39] Co-methodologies include different versions of co-working, such as co-design, co-production, co-creation, participatory research, or participatory design.[39] Through these approaches, older people can design, implement, and evaluate health-care services that are accessible, affordable, appropriate, and acceptable to them, thereby improving uptake, health outcomes, and ultimately health equity.[39] Survey participants identified various barriers to consulting and involving older people in the design, implementation, and evaluation of humanitarian programmes, including ageism, lack of physical access, lack of accessible information about consultation or participation avenues, prioritisation of other groups, and poor representation in those

Panel 2: **Integrative approaches to care**

An integrative approach to care should include the following:

Functional assessments: Standardise evaluations of mobility, sensory impairments, cognitive decline, and malnutrition using tools adapted for humanitarian contexts, such as WHO's ICOPE framework. Access to assistive products, rehabilitation services, and interventions that promote functional independence should be ensured.

Geriatric syndromes: Provide comprehensive early detection and management of frailty, falls, dementia, polypharmacy, osteoporosis, fractures, chronic pain, and urinary and faecal incontinence.

Mental health and psychosocial support services: Address mental health challenges, including depression, anxiety, sleep disorders, and substance abuse; mitigate suicide risk and social isolation; and manage grief and trauma effectively.

Non-communicable diseases: Ensure continuity of care for non-communicable diseases, which often require long-term management. In humanitarian crises, these needs are amplified by disrupted access to medication, inadequate diagnostic and treatment options, and insufficient access to integrated services, including palliative and end-of-life care, to preserve quality of life and dignity.

Infectious diseases: Prioritise prevention strategies such as vaccination alongside timely diagnosis and treatment, especially for older people with comorbidities. Address the unique challenges faced by older people living with HIV by ensuring comprehensive care plans that integrate both HIV management and broader geriatric care needs.

Nutrition: Develop age-specific nutritional interventions with regular screenings to identify malnutrition. Adapt food programmes to meet the unique dietary needs of older people and implement targeted supplementation to address micronutrient deficiencies. Incorporate routine oral health assessments and support, as conditions such as tooth loss, dry mouth, and gum disease can negatively affect chewing, dietary intake, and overall nutritional status.

Trauma care: Tailor trauma care to older people by addressing age-related factors such as falls that can complicate treatment and recovery, thereby improving outcomes and preserving functional independence.

Sexual and reproductive health: Ensure that the Minimum Initial Service Package incorporates specific interventions for older women, including management of genitourinary syndrome of menopause, screening and treatment for reproductive cancers, and prevention and treatment of sexually transmitted infections, for men and women.

Sexual and gender-based violence: Provide age-inclusive risk mitigation and interventions for older survivors, including access to clinical, psychosocial, protection, and legal support.

processes in which it could be decided to consult older people (appendix pp 8–9). To encourage humanitarian actors to consult older people, participants suggested increasing awareness of the benefits of consulting and involving older people; increasing the capacity and skills of humanitarian actors in co-methodologies through training and availability of funding and resources; embedding accountability mechanisms including donor enforcement; and proactively reaching out to older people through adapted communication channels, such as existing CBOs and OPAs.

C – Cover comprehensive health-care services including older people's health and care needs

From a person-centred approach, humanitarian responders should integrate the diverse health needs of older people within existing services provided by the national health system or by complementary humanitarian responses. As set out in WHO's ICOPE framework, an integrative approach promotes holistic care by addressing health conditions, incorporating functional assessments, and managing geriatric syndromes to safeguard older people's health, dignity, and wellbeing (panel 2).[40]

To deliver these services, a person-centred approach is essential and should integrate the following modalities: (1) adapted service delivery strategies: make services flexible and accessible through outreach programmes, mobile clinics, home-based care, and community-level initiatives to overcome logistical and physical barriers;[41] (2) community engagement and mobilisation: actively involve community groups in caregiving, social support, and disability assistance to ensure culturally sensitive and sustainable care delivery; (3) personalised care plans: care should focus on maximising intrinsic capacity and functional ability, promoting autonomy, and addressing psychosocial needs, with emphasis on fostering self-care and self-management; (4) a robust continuum of care: prioritise often-overlooked services such as prevention, rehabilitation, long-term care support, and palliative and end-of-life care to address the evolving health needs of older people. As the global population ages, serious health-related suffering is projected to rise sharply, underscoring the need to prioritise palliative and end-of-life care in humanitarian crises—ensuring dignity and reducing suffering for older people;[42–44] (5) access to medicines and technologies without financial burden: ensure timely provision of essential medicines, medical supplies, and assistive technologies to enhance health outcomes and independence; (6) support for caregivers: equip caregivers with training, resources, respite care, and psychosocial support to reduce burnout and improve the quality of care provided; (7) empowering older community volunteers: engage older people as community volunteers to foster inclusion, empowerment, and peer-led support mechanisms.[2]

I – Implement disaggregated data collection and analysis by sex, age, and disability

The Inter-Agency Standing Committee recommends sex, age, and disability disaggregated data collection and

Panel 3: Examples of age-inclusive health care in humanitarian settings

This panel presents examples from Médecins Sans Frontières illustrating how health-care services have been adapted across diverse humanitarian contexts to better respond to the needs of older people, showing how the PARTICIPATE framework can be applied in practice.

Cox's Bazar refugee camps, Bangladesh

In Cox's Bazar, Bangladesh, around 1·1 million Rohingya refugees are hosted in large camp settings, including an estimated 4·4% of people aged 60 years or older. Older adults frequently face compounded barriers to accessing care, including physical limitations, dependency on caregivers, and multiple chronic conditions.

Médecins Sans Frontières has integrated age-inclusive adaptations into primary health-care services. Older people are prioritised during triage to reduce waiting times and improve access. Health facilities are designed with accessibility features such as wheelchair-friendly and stretcher-friendly infrastructure; improved internal pathways; and designated sanitation facilities for older people, people with disabilities, and pregnant women.

Patient navigators support older adults, especially those without family accompaniment, by assisting them with navigating services and ensuring continuity of care. Future adaptations include introducing palliative care, strengthening transport support, improving staff training in geriatric care, and expanding targeted health promotion through mobile and outreach services.

Key lesson: Embedding accessibility, navigation support, and continuity mechanisms into routine primary care substantially reduces structural barriers for older people.

Key actions:

- A – Address ageism in humanitarian health systems
- R – Raise capacity of stakeholders for age-inclusive humanitarian health responses
- I – Integrate inclusive, person-centred and community-centred approaches into humanitarian health responses
- C – Cover comprehensive health-care services including older people's health and care needs
- E – Ensure participation of older people to guarantee accountability of humanitarian actors towards more inclusive humanitarian health responses

Niono, Mali

In conflict-affected central Mali, particularly in the remote K2 village within Niono district, older residents identified ophthalmological care as their most pressing health need during community assessments, revealing gaps in conventional humanitarian needs assessments.

The context is marked by armed conflict, displacement, food insecurity, epidemics, and a weakened health system. Non-communicable disease services such as hypertension and diabetes management are available, although vision and hearing care are often excluded from standard humanitarian packages despite their substantial impact on independence and wellbeing.

Access to eye care is severely constrained: Mali has only two ophthalmic surgeons per million people, with rural areas most affected. Sightsavers conducts two annual cataract surgery campaigns at Niono Referral Hospital, treating approximately 200 older patients per campaign. However, geographical isolation, insecurity, and unavailability of transport continue to limit access for many older people.

Key lesson: Humanitarian health responses should better integrate sensory health care and strengthen outreach and referral systems to reach remote older populations.

Key actions:

- I – Integrate inclusive, person-centred and community-centred approaches into humanitarian health responses
- C – Cover comprehensive health-care services including older people's health and care needs
- E – Ensure participation of older people to guarantee accountability of humanitarian actors towards more inclusive humanitarian health responses

Eastern Ukraine

In frontline areas of eastern Ukraine, older people, predominantly women, form the majority of those remaining in conflict-affected communities. Many remain because of strong attachment to place, limited mobility, chronic illness, or absence of viable displacement options.

Health-care access is constrained by destroyed infrastructure, shortages of health-care staff, poor transport, and ongoing insecurity. Médecins Sans Frontières data show that most patients are older than 65 years, with high rates of non-communicable diseases, multimorbidity, and psychological distress.

Médecins Sans Frontières has adapted its model by delivering primary health care through mobile clinics to frontline communities. When access is restricted, local nurses provide remote consultations to maintain continuity of care. Additional measures include 3-month medication supplies for stable patients, mental health support, community engagement initiatives, and tailored health promotion activities such as the Babushka Newsletter.

Key lesson: Flexible, decentralised models that maintain continuity of care are essential to sustain health care for older people in conflict-affected settings.

Key actions:

- I – Integrate inclusive, person-centred and community-centred approaches into humanitarian health responses
- C – Cover comprehensive health-care services including older people's health and care needs
- A – Apply intersectoral approaches to address the diverse needs of older people
- E – Ensure participation of older people to guarantee accountability of humanitarian actors towards more inclusive humanitarian health responses

analysis in humanitarian crises to guide operational decision making and ensure the needs of older people are seen and met.[45] However, disaggregation is not systematically applied.[46] For example, only one in three humanitarian agencies collect age-inclusive data during their emergency response and only one in four needs assessment reports

mention older people, leaving their voices unheard and their needs likely largely unaccounted for.[3] Typically, older people are represented in statistics as a single age cohort (eg, aged 50 years or older).[47,48] Identified reasons for data gaps include shortcomings in current humanitarian guidance, which does not mandate comprehensive, intersectional analyses; inconsistent methodologies for defining older people;[31] insufficient awareness and prioritisation; operational and logistical challenges; weak or inconsistent data systems; insufficient technical capacity; ethical and cultural barriers; insufficient funding and low prioritisation by donors; and coordination and data sharing issues (appendix pp 10–11).

P – Promote research with older people on their health-care needs using participatory, adaptive, and inclusive methods

Over the past decade, systematic reviews have assessed the available evidence on health-care needs of older people in humanitarian crises, highlighting substantial knowledge gaps.[21,49,50] Survey participants identified 131 research questions (appendix pp 14–21). Most research questions addressed the health-care needs of older people in humanitarian crises. Specific research questions were suggested in the domains of non-communicable diseases, mental health and psychosocial support services, rehabilitation and disability support, nutrition and food security, infectious diseases, climate change, incontinence, sexual and reproductive health, traumatic injury, and vaccination. Additionally, research questions related to health-care service delivery were identified on: models of care; access to care; drivers of inclusion and exclusion of older people; consultation and participation of older people in the design, implementation, and evaluation of health-care programmes; data collection; and the skills and capacity of health and social care workers. Research questions on models of care were most frequently suggested, exploring how different approaches—such as mobile clinics, telemedicine, digital health solutions, community-based approaches, and other innovative models—could improve access to health-care services for older people. Finally, survey participants suggested research questions related to intersectionality, social determinants of health, and intersectoral approaches in humanitarian response, such as age-inclusive approaches to shelter and water, sanitation, and hygiene services.

Older people are often under-represented in research, particularly those with multimorbidity, frailty, limited mobility, or cognitive decline, including dementia.[51] When asked to identify barriers and enablers of health research related to older people, survey participants suggested many factors that function as barriers when absent and enablers when present (eg, funding, prioritisation of older people by humanitarian actors, consultation with or participation of older people in health research, and research skills of staff). The most frequently mentioned barriers were absence of earmarked funding and no prioritisation of older people by national and humanitarian actors, typically underpinned by ageism. Various challenges in accessing older people in humanitarian crises were identified as barriers to their inclusion in health research, including restricted access during conflict or environmental disaster because of insecurity and displacement, and older people's reduced ability to travel to central community locations where interviews or surveys often take place, due to limited mobility, disability, other health conditions, or social isolation.

Conducting research with older people in humanitarian crises is uniquely challenging, although effective approaches exist. To facilitate the inclusion of older people in health research, survey participants suggested improved coordination among humanitarian actors, adaptive research design and methods, and partnerships with older people and local communities. Standard data collection methods such as surveys, interviews, and focus groups can exclude older people from studies if used without adaptation.[52] To ensure inclusion of older people, especially those at even higher risk of being overlooked due to disability including auditive or visual impairment or cognitive decline, alternative and adapted participatory research methodologies should be considered.[53] Arts-based methods are participatory approaches that use varied art forms to collect, analyse, interpret, and disseminate research data, incorporating music, poetry, visual arts, theatre, and dance to understand human experiences.[54] Arts-based approaches can empower communities that experience systemic barriers to meaningful engagement and inclusion by capturing older people's lived experiences and identifying knowledge gaps in the understanding of ageing in humanitarian crises and its related support needs.[54] Alternatively, participatory action research is increasingly used in humanitarian crises and has the potential to facilitate meaningful participation of affected people in research from inception and design, through implementation and formulation of recommendations.[53]

A – Apply intersectoral approaches to address the diverse needs of older people

The health-care needs of older people are embedded within a complex ecosystem involving health, protection, and social care. Poor nutrition can worsen chronic conditions, yet food aid often lacks nutrients suited for older adults. Inadequate water, sanitation, and hygiene services increase infection risks and complicate incontinence care, threatening health and dignity. Social isolation and weak protection services also increase risks of neglect and abuse, affecting mental wellbeing and access to care.

Intersectoral approaches should coordinate across clusters and actors to provide age-inclusive non-food items (eg, bedding, hygiene kits, and winter supplies); ensure accessible shelter and age-friendly home modifications; integrate protection services with age-adapted measures;

and establish community-led support systems, including caregiver networks, to prevent and address neglect, abuse, exploitation, and social isolation among older people.

T – Transform current legal frameworks for age-inclusive humanitarian health response

On April 3, 2025, the Human Rights Council in Geneva agreed on a resolution initiating the drafting process for an international legally binding instrument that should include provisions similar to those in Article 11 of the Convention on the Rights of Persons with Disabilities,[55] establishing that people with disabilities have an equal right to humanitarian relief. A legally binding instrument dedicated to the human rights of older people will further re-affirm existing provisions under international law. Such a convention should provide guidance to national and humanitarian actors, to ensure that older people are included in humanitarian preparedness, response, and recovery, and that older people in all their diversity are not overlooked with regard to their right to health care in humanitarian crises.

E – Ensure participation of older people to guarantee accountability of humanitarian actors towards more inclusive humanitarian health responses

Participation is a fundamental right and a precondition for equitable and effective health and humanitarian action. Meaningful engagement with older people—throughout planning, decision making, implementation, and evaluation—is essential to recognise and affirm older people's agency, uphold their dignity and autonomy, and ensure that responses reflect their lived experiences and diverse needs. The humanitarian sector should be accountable to older people as rights-holders and active contributors to the systems and services that affect their lives. An accountable humanitarian system—where the rights and dignity of people affected by crises are protected and preserved, no one is left behind, and humanitarian principles are upheld—is central to effective and ethical humanitarian response.[56] To enable this approach, older people affected by crises should be included in all research and policy-making efforts that seek to rethink and reimagine the strategies, architectures, and delivery modes of humanitarian response.[57] We have illustrated the practical applications of the PARTICIPATE framework in panel 3.

Strengths and limitations

This framework was developed through consultation with 37 experts, including humanitarian responders, researchers, policy makers, and advocates. Participants were purposively selected based on their experience working with older people in humanitarian crises and were recruited through the authors' network. This recruitment strategy might have introduced selection bias by privileging the perspectives of individuals with experience working with older people or those within authors' networks. A limitation of this study is the absence of direct consultation with older people themselves. Although experts provided valuable perspectives, incorporating the voices of older people affected by humanitarian crises would strengthen the relevance and applicability of the framework. Future work should prioritise participatory approaches to capture the lived experiences and priorities of older people. However, the selected participants came from diverse geographical and humanitarian backgrounds and had extensive experience working with older people, which mitigates this limitation and supports the robustness of the framework. The objective of this study was to develop a rights-based framework that articulates concrete actions. Developing detailed implementation guidance was beyond the scope of this work. Further development of such guidance, addressing practical application and potential challenges, is recommended for the Community of Practice.

Conclusion

This final paper in *The Lancet Healthy Longevity* Series calls for a fundamental shift in how the humanitarian system understands, engages with, and responds to the health-care rights and diverse needs of older people.

We propose a rights-based framework grounded in participation, equity, autonomy, and accountability that places the health-care needs of older people at the centre of all phases of a humanitarian crisis. Informed by consultations with key stakeholders, the framework offers concrete actions for humanitarian actors to uphold older people's rights, recognise their agency, and respond to their health-care needs with a focus on dignity and justice.

Marking the midpoint of the UN Decade of Healthy Ageing (2021–30),[58,59] an accelerated commitment from humanitarian actors—including governments, donors, UN agencies, NGOs, CBOs, and local communities—is urgently needed to meet the growing and diverse health-care needs of older people, close gaps in health-care access, and embed accountability mechanisms for equitable, age-inclusive care. Humanitarian actors should embrace age inclusion as a core system-wide responsibility, ensure earmarked funding, build inclusive evidence through participatory research, and challenge ageist assumptions and narratives. Theoretical commitments should be transformed into tangible actions; for example, by establishing a Community of Practice on ageing in humanitarian crises, which would unite stakeholders, foster innovation, and further develop this rights-based framework and corresponding actions.

Without urgent and sustained commitment, the rights and health-care needs of older people will continue to be overlooked in humanitarian crises, further exacerbated by unprecedented challenges to global humanitarian response capacity, including political barriers and funding constraints. However, with consistent, rights-based engagement, genuine participation, and accountable systems, the humanitarian sector can uphold the rights and meet the health-care needs of older people, acknowledge their crucial roles and contributions, strengthen community resilience,

and ensure justice across generations, thus remaining true to the core principles of humanitarian action.

Contributors

EvB and FE conceptualised the manuscript. EvB and FE designed the methodology. EvB conducted the data analysis and wrote the original draft. GC, MAC, VdlF-N, JM, DH, KB, BS, JS, AYB, CM, YS, and FE reviewed and edited the 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

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