The invisible gap: sexual and reproductive health and rights for older people in humanitarian emergencies

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By 2050, more than one in five people will be considered older persons, aged 60 years or older, accounting for more than 2·1 billion people.[1] Simultaneous to this demographic evolution is the intensification of sudden-onset and protracted humanitarian crises. Despite these parallel trends, older people are often overlooked within the humanitarian architecture, even as their needs become compounded by disability, cognitive decline, limited mobility, and other comorbidities that have accumulated and compounded across the life course.[2] This neglect is particularly pronounced within sexual and reproductive health and rights (SRHR) programming and research, which typically only receives a fraction of humanitarian health funding. The chronic underfunding of this sector has become even more dire since 2025, with the targeted defunding of SRHR by the US Trump administration, which had previously accounted for 54% of global SRHR funding, resulting in increased morbidity and mortality of women, especially in humanitarian settings.[3] Within SRHR, older people are nearly invisible in programming and research, as the humanitarian field has largely focused on women and adolescent girls of reproductive age. For example, a 2025 systematic review on the implementation of the Minimum Initial Services Package for SRHR in humanitarian settings was unable to draw conclusions about older persons' health, given the paucity of representation in studies.[4] This insufficient consideration for older adults in research efforts is underscored in a 2025 frontline practitioner-guided SRHR research agenda exercise that contained no research questions regarding this population throughout the article despite one reference in a visual diagram.[5]

Efforts to improve the SRHR needs of older people are hampered by a paucity of sex, age, and disability disaggregated data, discriminatory attitudinal barriers among humanitarian practitioners and policy makers, and an inadequate clinical understanding of the health needs of older people. These challenges exist in nearly all health systems globally as the world faces a rapidly ageing population, yet are even more challenging to address in humanitarian settings that are typified by constrained resources, forced displacement, and ongoing security threats. Consequently, a foundational recommendation is to improve data-monitoring systems that enable targeted age categories across the life course. Beyond demographic disaggregation, meaningful progress would also require the inclusion of older people in planning and collecting data and ensuring their inclusion in SRHR priority-setting processes.

Moreover, in the domain of reproductive health, screening, and treatment for the reproductive system, health concerns are often overlooked within humanitarian health programming, wherein the focus is rightly on emergency lifesaving care needs. However, as crises become protracted, the capacity to address or refer (or both) these concerns to host population health systems is increasing. When health system capacity permits, this capacity should encompass the detection and management of reproductive cancers, including ovarian, cervical, breast, or prostate cancers. Cross-sectoral collaboration between health and water, sanitation and hygiene sectors is also essential to invest in and deliver new gender-appropriate and sex-appropriate solutions for urinary and faecal incontinence, which transcend medical concerns to affect individual dignity, protection, and survival.[6] Efforts could include improved screening of population needs and barriers to toileting and hygiene facility access, odour control, or other assistive products should be mainstreamed into water, sanitation and hygiene protocols. The provision of age-inclusive home-based services and infrastructure modifications could also serve as a key protective mechanism, reducing both individual vulnerability and familial care burdens while mitigating social exclusion for older persons with incontinence.

Within the domain of sexual health, stigma and ageist attitudes assume that older people are no longer sexually active and desire pleasure, and are no longer in need of services. This invisibility is notable in HIV and sexually transmitted infection prevention and response services, which frequently exclude older people in prevention messaging, condom distribution programmes, and testing services,[7] and in the insufficient recognition that many people with HIV are entering older ages globally. These access challenges are exacerbated by missed opportunities for age-appropriate sexual health information.

Although both men and women face ageism, older women face its impacts differently due to evolving

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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gender-based discrimination and inequalities compounded within older ages. For instance, although sexual violence can affect people regardless of sex, older women face considerable risks of sexual violence, abuse, and neglect.[8,9] They could be specifically targeted due to perceived vulnerability, including physical weakness, social isolation, or disability. However, multiple barriers impede older women's ability to report such violence and access justice, health, and protection services, including ageist attitudes that diminish their credibility, stigma surrounding sexuality in later life, and ableist discrimination, particularly affecting those with cognitive impairments in later years.[10] These factors are compounded as women's societal value transforms beyond reproductive years. For example, older women experiencing sudden widowhood face acute economic deprivation and social marginalisation, which contributes to aid exclusion and heightens the risk for exploitation, particularly when they are denied property or inheritance rights, or both. Structural barriers rooted in patriarchal norms further restrict their access to health care and SRHR services through low economic independence, restricted household decision-making power, and pervasive stigma surrounding older women's sexuality. Moreover, menopause and its associated conditions remain crucially neglected across research, clinical management, and health professional training. Women and girls' safe spaces in humanitarian settings could also benefit from programming directly targeted towards older women, to provide social support and health information for their specific needs.

The ability to make decisions about one's body, relationships, and sexuality are fundamental rights regardless of age. Yet, the SRHR needs of older people, especially women, have been systematically denied within humanitarian crises through underfunding and omission. As global population ageing converges with escalating natural disasters, armed conflict, and climate-related migration, integrating older persons' SRHR into humanitarian health; water, sanitation, and hygiene; and protection systems, and proactively embedding older persons' needs into systems preparedness planning and funding mechanisms is imperative.

We declare no competing interests.

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