Malnutrition in humanitarian emergencies has no age limit

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We welcome the opportunity to focus attention on the nutrition of a long neglected, yet highly vulnerable population group. Older adults (aged 60 years or older) are disproportionately affected by humanitarian emergencies. In these settings, malnutrition among older adults is often hidden in plain sight—overshadowed by chronic disease, mistaken for normal ageing—and its effects on health, wellbeing, and independence are underestimated.

The Series, Older adults in humanitarian settings, highlights the current policy environment for protection of older adults, describes barriers to their inclusion in emergency response, and provides a framework for action. Paper 2 of this Series recognises the importance of nutrition; however, this aspect is not specifically addressed. Therefore, in this Comment, we focus on existing nutritional guidance, gaps caused by structural issues in the humanitarian architecture, and recommended actions.

Malnutrition in older adults is driven by a combination of physiological, health, and social factors. Age-related changes include appetite loss, reduced ability to taste and smell, dental problems, swallowing difficulties, low mobility, and cognitive or mental health impairment. These issues might be compounded by chronic illness, pain, side-effects of medication, and restrictive diets, alongside social isolation, poverty, lack of support, and limited access to nutritious food.[1] These factors can result in undernutrition, obesity, and micronutrient deficiencies, contributing to excess morbidity and mortality.

Although the average global prevalence of undernutrition in community-dwelling older adults is approximately 3%, large geographical variations exist, with much higher prevalences in low-income and middle-income countries such as Iran (12·2%), India (16·3%), Nepal (24·0%), and Ethiopia (26·6%).[2–4] A meta-analysis from African contexts found a prevalence of malnutrition ranging from 2% to 77% among older adults, with an overall pooled prevalence of 18%.[5] Many of these estimates possibly under-represent the true burden of malnutrition, as they do not capture micronutrient deficiencies, overweight, or obesity.

To avoid malnutrition, older adults require a nutrient-dense, calorie-conscious diet to manage changing metabolism and reduce the risk of chronic disease. Older adults have relatively higher requirements for some micronutrients, such as vitamins D and B12, and fibre than younger people. Adequate hydration is also crucial, as the sense of thirst diminishes with age.

Pre-existing nutritional risks for older adults are often heightened in humanitarian contexts, with disrupted access to food, compounded by scarcity of safe drinking water, increased risk of infectious diseases, physical and psychological stress, disruptions to livelihoods, and reduced access to health and social protection services. The relative importance of food-related and non-food-related causes of malnutrition varies according to the nature of the crisis and degree of food insecurity.

The global population is ageing, yet emergency nutrition programmes have not kept pace with this demographic reality. An analysis of humanitarian financing, which examined 16 221 global humanitarian initiatives implemented between 2011 and 2014, showed that projects specifically targeting older adults accounted for less than 1% of programmes funded.[6]

Often, the reality is that what gets measured gets treated and in most humanitarian nutrition responses, older adults are simply not measured. This issue is exacerbated by the lack of consensus on the definition of malnutrition in this age group and complexity of assessment protocols. For example, only 7% of hospitals in Lebanon were found to use a nutritional screening tool for older adults.[7] In Gaza, during 2025, high rates of malnutrition were suspected and deaths were frequently reported among older adults, although little data on nutritional status were collected.

Numerous screening and assessment tools have been validated for identifying malnutrition in older adults, yet these tools are not often being used.[7–10] For humanitarian contexts, further simplification of existing tools is needed, along with the inclusion of other common nutritional issues beyond undernutrition, such as anaemia and obesity.

Guidance on suitable interventions for older adults in humanitarian contexts is also available, such as the 2018 Humanitarian Inclusion Standards for Older People and People with Disabilities, mentioned in paper 1 of this Series; however, uptake of this guidance into practice within the nutrition sector appears to be low. We found only few published examples of malnutrition interventions for older adults in emergencies.

Although the aetiology of malnutrition in older adults is undoubtedly complex, in humanitarian contexts, intervention design should be simple if programmes are to be successfully implemented at scale. The management of wasting in children (6–59 months of age) has been successfully implemented in emergencies, partly because this approach follows a relatively simple protocol and does not require specialist knowledge for decision making. Integrating nutritional care for older adults into other services, such as dental care and non-communicable disease support, wherever available, might also increase nutrition service coverage.

We argue that in addition to simple, consensus-based guidelines on assessment and intervention, some adjustments to organisational structures are required if older adults are to receive the required level of attention. The Global Nutrition Cluster (GNC) is tasked with coordinating nutritional responses in humanitarian crisis and is led by UNICEF, which has a specific mandate to address the needs of children and their mothers. The GNC, therefore, has no institutional mandate to address malnutrition in older adults or other population groups. Mandate gaps also appear to exist between WHO and UNICEF for nutritional support in hospitals and care homes, with neither UN agency taking responsibility. The World Food Programme also tends to ignore this age group when designing food assistance programmes, even though many of the products designed for children could also be distributed to older adults. These structural issues contribute to the current situation in which older adults are not routinely included in baseline nutrition assessments or the nutrition sections of humanitarian response plans.

Despite major cuts in funding in the last 2 years, older adults have a right to good nutrition, which is currently being neglected, especially in emergency contexts. Drawing on the PARTICIPATE framework, we recommend some urgent actions. First, *prepare* by ensuring harmonisation and updating of the nutrition aspects of existing guidelines, to achieve consensus on the needs and ways to include older adults in humanitarian response. Second, *raise* the capacity of stakeholders for age-inclusive humanitarian health responses by adapting and applying the UNICEF conceptual framework for understanding the multilayered causes of malnutrition in populations ranging from children to older adults. Third, *task* a lead organisation to coordinate and ensure the inclusion of older people in humanitarian nutrition responses. Fourth, *integrate* older adults within the nutrition assessment and treatment models already used for other age groups, to facilitate wider scale uptake.

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
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We declare no competing interests.

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