Needs assessment of older people in Lebanon after the Israel-Lebanon cross-border escalation of September-November 2024

Data collected February 2025

مؤسسة عامل الدولية amelassociation International

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HelpAge International

Contents

Introduction

Older people's right to humanitarian assistance

HelpAge International's vision is of a world where older people lead active, dignified, healthy and secure lives. This applies to all older people, including those affected by humanitarian emergencies. The four principles of humanitarian action – humanity, neutrality, impartiality and operational independence – afford everyone the right to safe and dignified access to humanitarian assistance and protection without discrimination and on an equal basis with others. Commitment to international humanitarian law and these principles means everyone responding to a humanitarian crisis has a responsibility to ensure all those affected, including older people, have their rights upheld.

We want older people to be able to access humanitarian aid with dignity and in safety. Older people are not inherently vulnerable to disasters. However, when disasters strike, they are at risk of having their rights denied.

Purpose of this assessment

The purpose of this assessment is to better understand the situation and needs of older people during and after the cross-border escalation that took place between Lebanon and Israel from September to October 2024, which was part of the broader regional impact of the Gaza conflict. The escalation affected Lebanese and other communities, including Syrians, Palestinians, and others residing in Lebanon. Prior to September 2024, the conflict was largely confined to Lebanon's southern border areas, with limited impact on other regions. However, the escalation that began in September 2024 marked a significant shift, resulting in widespread hostilities that affected multiple regions across the country.

The primary objective of this assessment is to inform the work of the humanitarian sector in Lebanon, enabling HelpAge International and other humanitarian actors to adapt and implement more inclusive aid interventions tailored to the specific needs of older people.

Additionally, the report will serve as a valuable resource for government bodies and donors operating in Lebanon, supporting them in developing and implementing age-inclusive programmes and strengthening advocacy for the rights of older people.

This report was developed by HelpAge International, with significant contributions from our partner-organisations IDRAAC and Amel at all stages of the assessment.

Context

Lebanon has been in a state of economic collapse since 2019. A 90 per cent fall in the value of the Lebanese pound, soaring inflation and escalating unemployment have left a significant portion of the population unable to meet their basic needs. According to the United Nations, approximately 82 per cent of Lebanon's 6.7 million people now live in multidimensional poverty, whereby access to the basics such as healthcare, education, employment and basic services is lacking.[1] The situation has been further exacerbated by the COVID-19 pandemic, the Beirut port explosion in 2020, and ongoing political instability.

The current humanitarian crisis in Lebanon stems from the escalation of hostilities along the southern border, which intensified significantly in October 2023 following the outbreak of the conflict between Hamas and Israel. This escalation triggered months of cross-border attacks between Hezbollah and Israeli forces, culminating in a full-scale conflict in September 2024. As a result, over 4,000 people in Lebanon were killed, more than 17,000 injured, and around 1 million individuals displaced or directly affected. As of April 2025, the United Nations and the Government of Lebanon had raised approximately US$88.8 million in response to the Lebanon Flash Appeal, which had a total funding requirement of US$371.4 million. Between October 2023 and April 2025, approximately 1,058,666 people were displaced in Lebanon due to the cross-border conflict. As of April 2025, an estimated 965,360 individuals had returned, while 93,306 remained displaced.

[1] United Nations Economic and Social Commission for Western Asia. *Multidimensional poverty in Lebanon (2019-2021) Painful reality and uncertain prospects* (Policy Brief), Beirut, United Nations Economic and Social Commission for Western Asia. 2021.

The conflict has also had profound economic implications. Key sectors such as tourism, agriculture, and manufacturing have been severely impacted, with rising unemployment affecting approximately 1.2 million workers across the country.

Lebanon hosts a significant number of refugees, primarily from Syria. The recent conflict has prompted a reverse flow of refugees, with hundreds of thousands attempting to return to Syria despite the risks. Reports indicate that over 300,000 people crossed back into Syria within two weeks, facing challenges such as impassable routes due to bombings and exploitation by profiteers.

In Lebanon, older people account for 11 per cent of the population – the highest proportion of all Arab states – but social protection for them is limited. A state pension exists only for civil servants and security forces, covering just 10 per cent of the labour force. The economic crisis has eroded their savings, plunging many into poverty and forcing them to skip meals and forego essential medications.

The compounded crises have severely strained Lebanon's infrastructure and resources, leaving vulnerable populations, particularly older people, in desperate circumstances. Immediate and sustained international support is crucial to address humanitarian needs and to work towards long-term recovery and stability.

Methodology

Data were collected by data collectors and Amel and IDRAAC staff members between 23 January and 3 February 2025. The data collectors undertook needs-assessment training (led by HelpAge International) on the purpose of the assessment and how to use the survey, and participants conducted a pilot test to review and strengthen the tool and its application.

The assessment was conducted in Mount Lebanon, Nabatieh, West Bekaa, South Lebanon, and Beirut. Allocation of data collectors to specific locations was determined by presence of ongoing IDRAAC or Amel operations. These locations were identified by HelpAge's local partners (Amel, IDRAAC) in Lebanon, with input from local municipalities.

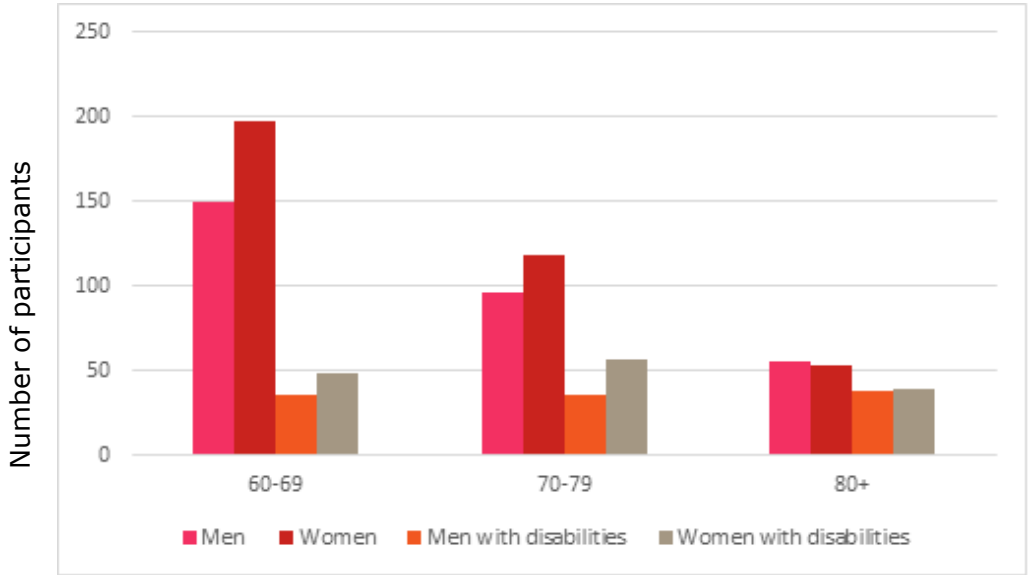
The data collectors used a structured survey developed by HelpAge and translated into Arabic. Interviews were conducted by phone or through face-to-face, one-to-one interviews at people's homes or at community centres. Data were collected either directly using the KoboCollect app, or on paper and then entered on KoboCollect digital needs-assessment forms for ease of analysis. The local partners' field coordinator / team leads oversaw the data collection process to ensure accuracy, consistency, and adherence to the training provided. A spot check was conducted in the field by HelpAge's Age Inclusion Advisor.

A purposive sampling approach was used to select women and men aged 60 and over, complemented by snowball sampling to reach marginalised older people who might otherwise be hard to find, for example because of mobility issues. The aim of this sampling approach was not to represent the age demographics in the targeted areas, but to obtain a sufficiently large sample size to understand the needs of older people in different older age groups. A significant portion of those interviewed were beneficiaries of Amel and IDRAAC programmes at the time of interview.

The sample size is 670 older people from four age cohorts: 60–69 years;70–79 years; 80-89 years; and 90 years and above (representing 2 per cent of the total sample). As the oldest cohort sample is small (15 people), they have been included in the overall results within the age cohort 80+ years and are not accounted for separately.

In total, 670 older people were interviewed, of whom 368 (55 per cent) were women and 301 (45 per cent) were men. This was a large enough sample to disaggregate the data into smaller subgroups to show results by age, sex and disability. However, where there is no large disparity (more than 5 per cent) in sex-disaggregated data, the findings for women and men are not given separately. A breakdown of participants by sex, age and disability is given in Figure 1.

Figure 1: Demographic breakdown of survey participants by gender and disability

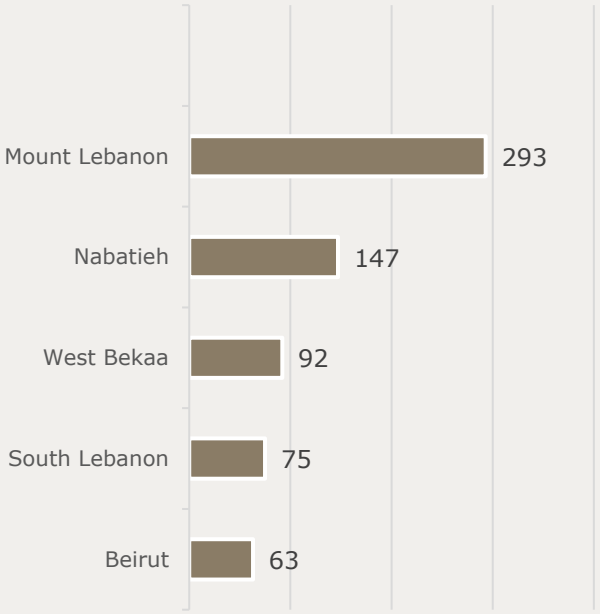


More details in the dashboard.

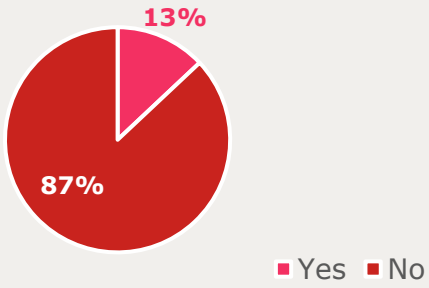
Needs assessment demographics

670 older people interviewed

Interviews by location



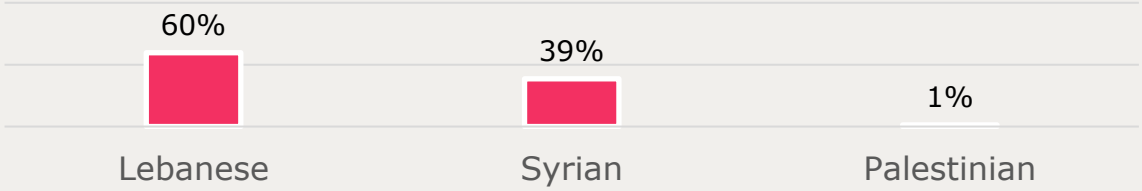
Older people living alone



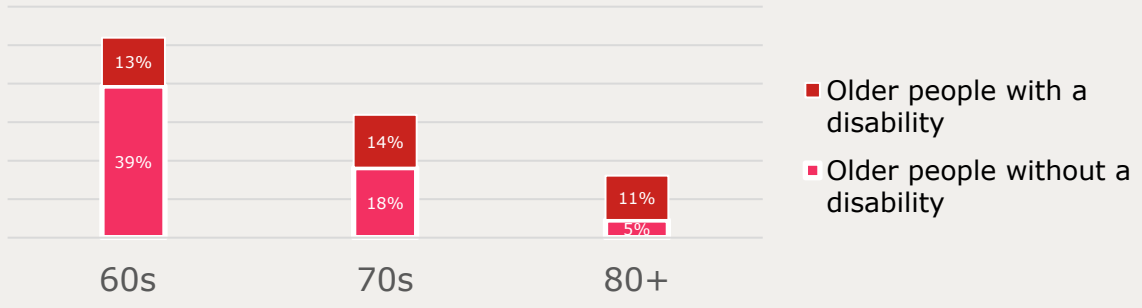
38% of older people have at least one disability

Walking: 61%
Sight: 36%
Hearing: 19%
Self-care: 28%
Remembering: 12%
Communicating: 4%

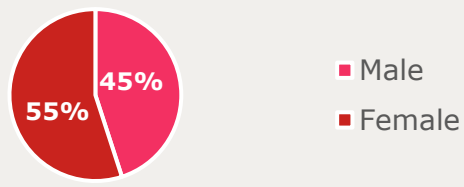
Nationality



Age and disability



Sex



Key findings

Protection

55% of older respondents depend on others to meet their basic needs, a percentage that increased to **72%** among those with disabilities. Additionally, **13%** of older respondents reported living alone, potentially heightening their vulnerability.

68% of older respondents reported their main concerns during the conflict as safety risks, specifically bombing, shelling, and exposure to violence.

Health

48% reported infrequent access to healthcare services, while **17%** could not access them at all. Current health needs include general healthcare (**49%**), medications (**39%**), and dental care (**24%**).

Mental health and wellbeing

39% of older respondents described their mental health as either poor (**32%**) or very poor (**7%**). **59%** of older respondents reported not receiving or having access to psychosocial services.

Income and livelihood

50% of older people rely on family remittances, while **18%** have no regular income. **39%** partially lost income due to the conflict, and **25%** lost it entirely. Over half (**55%**) depend on others to meet their basic needs.

Disability

38% of older people reported having at least one disability. Glasses (**51%**), crutches (**25%**), and hearing aids (**17%**) were the most needed assistive devices.

Humanitarian assistance

Almost **40%** of older people reported that they did not receive any humanitarian assistance during the conflict and this increased to **61%** since the conflict ended. **32%** of older people said that the aid they are currently receiving does not meet their needs.

WASH

57.7% of older people reported regular access to clean water, while **31%** had occasional access and **11%** had none. Although **61%** had enough water to meet daily needs, **39%** reported inconsistent or insufficient supply.

Shelter

49% of older people reported their current shelter is only partially appropriate, while **9%** said it is not appropriate at all.

Accountability to affected populations

51% of respondents said they were not consulted by humanitarian actors regarding their needs, and **45%** said they felt their views were not considered in the design of assistance programmes. **44%** cited inaccessible registration or feedback mechanisms as a barrier to participation. Despite this, **65%** expressed interest in being involved in future activities.

Findings and recommendations

Protection

Levels of dependency among older people in Lebanon are high, with over half (55 per cent) of older respondents reporting relying on others to meet their basic needs, rising to 72 per cent among older people with disabilities. Additionally, 13 per cent of older respondents reported living alone, a factor which may further increase their risk of neglect and isolation.

Safety risks were the most reported concern during the conflict, with 68 per cent of older respondents fearing threats such as bombing, shelling, and exposure to violence. Other serious concerns included lack of access to healthcare or medication (37 per cent), financial difficulties (37 per cent), limited access to food and water (35 per cent), and lack of shelter (25 per cent). Among displaced populations, safety risks were even more prominent, cited as the main concern by 71 per cent of internally displaced older people (IDPs) and 79 per cent of returnees.

While 42 per cent of older respondents reported not experiencing specific protection risks during the conflict, many still faced significant challenges. Of the 58% that did report specific protection risks, psychological distress was reported by around one third of responses (31 per cent), denial of resources, opportunities, or services by around a quarter (24 per cent), and forced relocation or evacuation by around a fifth (19 per cent).

When asked about the specific protection risks facing older women, respondents (women and men) identified neglect (42 per cent) as the most common, followed by isolation (36 per cent), denial of resources, opportunities, or services (27 per cent), emotional abuse (27 per cent), and financial abuse (24 per cent). Among older women who responded, 46 per cent identified neglect as the primary protection risk facing older women, compared to 37 per cent of older men. Similarly, 40 per cent of older women surveyed identified isolation as a key concern for older women, compared to 30 per cent of older men.

The top five protection risks for older men were neglect (31 per cent), denial of resources (29 per cent), financial abuse (29 per cent), isolation (28 per cent), and lack of a safe place in the community (21 per cent).

Social isolation also emerged as a significant concern. More than half of older respondents (52 per cent) – and rising to 58 per cent of older people with disabilities – reported not being involved in any community or social activities. When asked what would help them feel less isolated and more connected, 47 per cent said peer support, 39 per cent suggested community gatherings or events, and 30 per cent highlighted the need for outreach support and opportunities to connect with others.

These findings highlight the protection challenges facing older people, especially those with disabilities and those living alone. They also point to the critical importance of strengthening social support, peer engagement, and community participation to reduce isolation and promote wellbeing. Despite their vulnerability, older people remain largely excluded from community activities and decision-making. Their inclusion in protection and recovery efforts must be a priority.

Recommendations

- Strengthen community volunteers and/or outreach teams to identify and support older people at risk, particularly those living alone, with disabilities, or unable to access aid or services independently.
- Develop targeted protection responses (e.g. home visits, information sharing, referrals) for older women and men facing specific risks such as neglect, financial abuse, and emotional abuse – especially those with disabilities or aged 70 and above.
- Establish safe, age-friendly community spaces where older people can connect, access information, and receive psychosocial or protection support.
- Engage older people in community protection efforts, especially those coping well, by involving them in peer support roles, outreach activities, or community committees.
- Promote awareness and enable reporting of protection risks such as financial exploitation, denial of services, and emotional abuse through accessible and age-friendly feedback and complaint mechanisms, including for people with hearing or mobility impairments or other difficulties.
- Work with religious leaders and community leaders to develop culturally appropriate activities that reduce isolation and promote inclusion, particularly for older people at risk of neglect and emotional abuse.
- Work with local leaders, organisations, and older people to make sure their needs are included in programme planning, with better access to services and participation in decisions.

Health

The needs assessment sought to understand the current health status of older people in the aftermath of the conflict in 2024 in Lebanon, with a particular focus on access to services and emerging health concerns.

When asked about their overall health status, more than half of respondents (56 per cent) rated their health as fair, while 23 per cent reported it as poor. Only 16 per cent described their health as good, indicating that the majority of older people perceive their health as suboptimal.

Regarding health deterioration since the onset of the conflict, 29 per cent of respondents reported having experienced new or worsening health conditions. The most commonly cited issues were non-communicable diseases (17 per cent), such as hypertension, diabetes, and cardiovascular illnesses, and mental health challenges (15 per cent), including anxiety. This aligns with global findings that older people are disproportionately affected by both chronic health conditions and the mental health consequences of displacement and crisis.

In terms of access to healthcare since the conflict, only 32. per cent of respondents reported being able to access services regularly, while nearly half (48 per cent) said they accessed services infrequently. Alarmingly, 17 per cent said they could not access healthcare services at all. The main barriers to access identified by older people included:

- Financial barriers (8. per cent)
- Lack of nearby healthcare facilities (7. per cent)
- High cost of transport (7. per cent in a previous related question)
- Lack of health insurance or coverage (6. per cent)

These barriers highlight how socio-economic and geographic constraints – exacerbated by the conflict and Lebanon's ongoing economic crisis – continue to hinder older people's ability to receive timely and adequate medical care.

When asked about their current healthcare needs, the most frequently cited services needed included:

- General healthcare (49 per cent)
- Access to medications, particularly for non-communicable diseases (39 per cent)

- Dental care (2 per cent)
- Diagnostic tests (23 per cent)
- Specialist consultations (15 per cent)
- Clear information on available services (14 per cent)
- Mental health support (10 per cent)
- Rehabilitation services (5 per cent)

The challenges faced by older people in Lebanon's post-conflict setting demand a shift from disease-centric care to a patient-centred approach that prioritises dignity, quality of life, and holistic wellbeing.

Addressing these issues requires active community involvement, enhanced professional training, and collaboration with the Ministry of Health and the World Health Organization (WHO) to create sustainable solutions that include long-term and palliative care, alongside effective management of non-communicable diseases.

Recommendations

- Strengthen families, caregivers and local organizations to provide healthcare and social support that reflects older people's lived experiences and preferences.
- Develop community-based initiatives that combine health education, peer support and access to healthcare to combat isolation and promote social inclusion.
- Create individualized care plans that integrate physical, emotional and social needs through person-centered approaches.
- Expand local healthcare infrastructure to ensure older people can access quality care without extensive travel requirements.
- Remove financial and logistical barriers by subsidizing healthcare services, covering medication costs and providing affordable transport options.
- Ensure consistent access to medications, diagnostics and consultations for chronic conditions like hypertension and diabetes that drive global mortality.
- Shift from disease management to functional independence by integrating holistic services that support overall wellbeing.
- Establish long-term care systems to address growing needs of older adults with chronic, disabling or degenerative conditions.
- Integrate palliative care as core health services to ensure dignified end-of-life care for those with advanced illnesses.
- Train healthcare providers in geriatric-specific care, focusing on person-centered, compassionate and age-sensitive approaches.
- Equip professionals with tools to challenge ageist attitudes and deliver care that values older people's societal contributions.
- Advocate with ministries and WHO to develop national policies that include older people in healthcare planning using ICOPE[2] frameworks.
- Partner with researchers and organizations to assess needs and design evidence-based interventions for older populations.
- Systematically incorporate older people in all response stages, from data collection to service delivery, through age-inclusive policies.
- Develop monitoring mechanisms to continuously refine programmes based on older people's feedback and evolving needs.

[2] This is the World Health Organization's Integrated care for older people approach.

Mental health and wellbeing

Older people in Lebanon reported a range of psychological and emotional challenges, with 39 per cent describing their mental health as either poor, and 7 per cent describing it as very poor. In the previous month, 29 per cent reported feeling depressed or upset on most days and 14 per cent said they felt this way every day. Similarly, 32 per cent felt worried or anxious most days, and 13 per cent experienced these feelings daily.

While levels of distress were high, some older people reported emotional resilience – 11 per cent said they had not felt depressed and 5 per cent had not felt worried in the past month. This group may represent a potential source of peer support within the community.

Feelings of loneliness were also reported. Just under a quarter (22 per cent) of older respondents described feeling lonely most days, and 12 per cent felt lonely every day. Among older people with disabilities, 21 per cent reported feeling lonely every day. However, 14 per cent of older women and 10 per cent of older men said they never felt lonely, further highlighting a potential resource of peer support from within the older population itself.

When asked whether they took part in any community or social activities, 52 per cent of older people said no – a figure that rose to 58 per cent among older people with disabilities. However, 47 per cent said they were involved either occasionally (39 per cent) or regularly (8 per cent), rising to 41 per cent among those with disabilities. This is a positive finding, and it is important to continue engaging older people with and without disabilities in community activities that recognise their skills, experience and capacities. Doing so can have a strong positive effect on their wellbeing, sense of belonging, and help reduce isolation and loneliness.

Sleep difficulties were another major concern, with 40 per cent of older respondents reporting trouble sleeping since the conflict. When asked about their ability to cope, 14 per cent said they were unable to manage their situation, 51 per cent said they could cope with support, and 35 per cent stated they could manage on their own. This reflects a degree of resilience but also points to the significant support needs among older people in crisis contexts.

Access to psychosocial support remained a critical gap, with 59 per cent of respondents reporting no access to mental health or psychosocial services. This figure rose to 65 per cent among older people with disabilities and returnees. In addition, 45 per cent of older people overall – and 53 per cent of older people with disabilities – were unaware of any available support services for people experiencing stress.

When asked about the types of psychosocial support they needed, 47 per cent of older respondents identified group support sessions, 24 per cent preferred recreational activities, while 34 per cent reported not needing any psychosocial support at the time of the survey. Older people were also asked what would help them feel more engaged or less isolated: 47 per cent said peer support groups, 39 per cent community gatherings, 30 per cent outreach connections, and 14 per cent mentioned more opportunities to volunteer. These findings reinforce the importance of inclusive, age-friendly and disability-inclusive mental health and psychosocial support (MHPSS) programming that actively involves older people in designing and leading activities.

These findings highlight the urgent need for accessible, community-based and age-friendly MHPSS services that not only address the emotional and psychological needs of older people but also engage and mobilise those with the capacity to support others. Strengthening peer support, ensuring access to group-based and recreational activities, and raising awareness of available services are essential steps towards improving the wellbeing of older people in Lebanon.

Recommendations

- Mobilise and support local partner organisations and community volunteers to provide basic psychosocial support to older people – particularly those with disabilities, those living alone, and those reporting distress – through group activities, home visits, befriending, and sharing information.
- Develop and train a network of community volunteers, including opportunities for older people to volunteer, to deliver age-friendly psychosocial activities such as peer-led groups, recreational events, and intergenerational exchanges, tailored to local and cultural contexts.
- Increase access to psychosocial support through community-based activities that encourage social connection, help manage anxiety and reduce loneliness. Create safe, comfortable spaces where older women and men can participate in support groups, peer groups, intergenerational groups and community gatherings.
- Provide targeted outreach to older people with disabilities and those feeling isolated, offering personalised support such as befriending, listening, peer support and practical home-based care where possible and needed.
- Ensure communication about available services is accessible and appropriate, especially for older people with disabilities, by using clear messaging and engaging trusted community members.
- Work with local religious and community leaders to incorporate spiritual and culturally relevant forms of support that can strengthen wellbeing and community bonds.
- Train staff and volunteers in respectful, age-sensitive communication, including with older people who have hearing, vision, or cognitive impairments, to ensure all psychosocial support is inclusive.
- Establish or strengthen referral pathways to connect older people with more specialised services where needed, such as mental health care, palliative care, or disability support.

Income and livelihood

The economic consequences of the recent conflict have had a profound impact on older people's financial stability, especially for those displaced or living in already precarious conditions. With Lebanon's economy continuing to deteriorate, compounded by high inflation and limited job opportunities, older people are dependent on external support to meet their basic needs. The assessment findings reveal that many older people are struggling to secure stable sources of income, with the majority relying on family assistance or humanitarian aid.

Current sources of income

When asked about their current sources of income or financial support, half of respondents (50 per cent) reported depending on family remittances as their primary or only source. This underscores the critical role played by family members, particularly in a context where formal state support remains limited. It is important to recognise that in Lebanon, family support for older adults is deeply rooted in cultural norms. Many older individuals live with their adult children, a practice that is both traditional and widely accepted. Therefore, distinguishing between situations where older people are dependent due to recent changes such as displacement from conflict and those where co-residence is a longstanding family arrangement requires further investigation. Only 27 per cent of older people reported having any income from employment, indicating both the limited availability of age-friendly livelihood opportunities and the physical or health barriers many older people face in maintaining employment. Alarmingly, 18 per cent said they had no regular income source, highlighting the risk of extreme vulnerability and deprivation.

Additionally, 17 per cent of older people reported receiving humanitarian cash assistance, while just 8 per cent indicated they benefit from social assistance or state-provided benefits. These low figures reflect longstanding gaps in social protection coverage for older people in Lebanon, particularly in rural or conflict-affected areas. Given the financial constraints facing both the Lebanese government and the humanitarian sector, strengthening community-level resilience and informal support networks may offer a more sustainable approach to supporting older people in the current context.

Impact of conflict on income

The conflict and subsequent displacement further disrupted the fragile financial security of older people. When asked whether they lost any source of income due to the conflict or displacement, 39 per cent reported partially losing their income, 25 per cent said they lost it completely, and only 17 per cent indicated their income had remained unchanged

These losses not only diminish older people's ability to meet their daily needs but can also lead to increased dependency and psychological distress due to the perceived loss of dignity or self-sufficiency.

Access to livelihood opportunities

In terms of livelihood opportunities, the picture is mixed, with 41 per cent of those surveyed stating that there were ways to be employed and earn an income, but a smaller number (33 per cent) indicating that they could not access livelihood opportunities. This could indicate some barriers facing older people who want to work.

However, a significant number of older people (24 per cent) told us they did not want to work, which we correlate to the high number of older people who were being supported by close relatives.

Dependence on others

More than half of respondents (54 per cent) acknowledged that they rely on others to meet their basic needs. As an accepted cultural practice for extended families to care for older relatives, this practice does not necessarily imply dependency, but the risk of controlling behaviour, in relation to financial resources, as well as the possibility of violence, abuse and neglect, still exist and should be investigated further. This highlights the need to expand accessible and sustainable income-generation or cash-assistance mechanisms tailored to older people.

Recommendations

- Focus on building community-based support that is adapted to the local culture and situations.
- Map the capacities and knowledge of older people, especially in relation to coping mechanisms and knowledge about specific livelihoods.
- Invest in intergenerational work that utilises the knowledge and capacities of older people and links them with younger generations.
- Analyse barriers that prevent older people from accessing livelihood opportunities.
- Map the potential impact of large numbers of older people relying on others for income and support – work with communities to understand how protection issues arising from this reliance can be overcome.

Disability

The assessment also aimed to better understand the prevalence and nature of functional difficulties among older people, as well as the availability and gaps in assistive devices essential to maintaining their independence and dignity.

Using the Washington Group Short Set of Questions, 38 per cent of the older people interviewed reported at least one form of disability. Among those, 60 per cent were women and 43per cent men, revealing a higher prevalence of disability among older women. Disaggregated by age group, 13 per cent of respondents aged 60–69 years reported having disabilities, while 39 per cent in the same age group did not. Among those aged 70–79 years, 14 per cent had disabilities compared to 18 per cent without. In the 80+ age group, 11 per cent had disabilities, while 5 per cent did not.

The most-reported functional limitation was mobility difficulty, affecting 60 per cent of older people. This was followed by pain impacting daily activities (41 per cent), visual difficulties (36 per cent), self-care limitations with activities such as washing and dressing (28 per cent), and hearing impairments (18 per cent). These findings are consistent with global evidence showing that mobility and sensory impairments are among the most prevalent challenges for older people, often exacerbated during crises. Older people reported a lot of difficulty or inability to do any daily activities due to pain – this closely correlated with findings on

difficulty in walking or climbing stairs, and with the difficulties experienced with self-care. The high number of older people reporting difficulty in daily activities due to pain or other reasons is of concern and needs further investigation (see Table 1 for breakdown of key difficulties experienced by age and gender).

Table 1: Difficulties with daily activities by age and gender

Age range	Women reporting difficulty in daily activities due to pain	Men reporting difficulty in daily activities due to pain
60–69	7%	5%
70–79	20%	14%
80–89	41%	41%
90	54%	54%

Age range	Women reporting difficulty in walking or climbing stairs	Men reporting difficulty in walking or climbing stairs
60–69	11%	11%
70–79	34%	20%
80–89	60%	43%
90	75	64%

Age range	Women reporting difficulty in self-care	Men reporting difficulty in self-care
60–69	3%	3%
70–79	16%	9%
80–89	31%	25%
90	75%	64%

Compared to the 60–69 years age group, the reported incidence of pain increased significantly in the 70–79 years age group, and older woman in this age group reported higher levels of pain than men. In the age groups 80–90+, the reported incidence of pain more than doubled, with similar findings for women and men.

The levels of difficulty in climbing stairs and walking also increased significantly among older women and men in the 70–79 years age group compared to the 60–69 years age group, and more than doubled in the 80–90+ age groups. It is useful to consider how pain can be a limiting factor on their mobility.

The levels of difficulty in self-care also increased in older women and men between the 60–69 and 70–79 years age groups, and more than doubled in the 80–90+ age groups. It is useful to consider how pain can be a limiting factor to reduce older people's level of independence.

In terms of assistive needs, the most commonly mentioned supportive devices were:

- Spectacles (51 per cent)
- Crutches (25 per cent)
- Hearing aids (17 per cent)
- Pill organisers (12 per cent)
- Wheelchairs (11 per cent)

- Canes or walking sticks (9 per cent)
- Walking frames (7 per cent)
- Toilet chairs (5 per cent)
- Waterproof mattresses (5 per cent)

These aids are critical for daily functioning, particularly for those with visual, mobility, or cognitive challenges. However, 38 per cent of those who needed assistive devices reported not having access to them. The most frequently missing items were:

- Spectacles (18 per cent)
- Hearing aids (12 per cent)
- Crutches (9 per cent)
- Pill organisers (7 per cent)

The data highlights a significant gap in the provision of assistive technologies, which can severely limit the independence and quality of life of older people. The lack of these items not only increases dependence on caregivers but also raises protection risks, particularly in emergencies when support systems are stretched.

Recommendations

- Use the data to inform future programmes, ensuring that humanitarian assistance is provided without discrimination and that older people and people with disabilities have safe and equitable access to services, recognising their diverse needs and capacities.
- Ensure older people with and without disabilities are informed about their rights and entitlements in accessible formats and actively participate in decisions that affect their lives.
- Advise humanitarian organisations to include strengthening the capacities of older people with and without disabilities in their work, enabling them to better respond to emergencies, rebuild their lives and leave no one behind.
- Consider new approaches to service delivery, such as mobile aid and cash-based assistance to ensure no one is left behind.
- Carry out follow up visits to better understand the underlying causes of older people's pain and look at solutions related to healthcare and rehabilitation, and access to assistive products and services.
- Ensure better integration of assistive technology services is available through local production and repair, if no other services are available. Develop practical tools and guidance for humanitarians on how to assess, measure and use different assistive products.
- Develop practical tools and guidance on how to communicate with older people with disability.
- Develop practical tools and guidance on how to prevent falls and provide rehabilitation to support older people to keep active and mobile.

Humanitarian assistance

Despite a strong initial emergency response by humanitarian actors to the crisis, findings from this assessment show that large numbers of older people, especially internally displaced people (IDPs) and returnees, were and remain excluded from life-saving humanitarian assistance.

Post-conflict humanitarian assistance

Since the cessation of hostilities, 61 per cent of older people surveyed reported that they had not received any humanitarian assistance, while only 38 per cent said they had. The gap was even more pronounced among displaced populations, with 54 per cent of surveyed older IDPs and 51 per cent of surveyed older returnees stating that they had received no support since returning or being displaced. This exclusion raises serious concerns about the equity and reach of the post-conflict humanitarian response.

Alarmingly, only 12 per cent of people surveyed felt that the assistance provided was fully sufficient, and while 57 per cent said it was partially sufficient, almost a third of all

respondents (32 per cent) said it was insufficient, demonstrating the significant investment needed in the recovery stage of the crisis.

Those who did receive support reported that the types of assistance provided were food distributions (29 per cent), cash or voucher assistance (15 per cent), mental health and psychosocial support (7 per cent) and medical care or medications (5 per cent). This contrasts with the priority needs identified by those surveyed for this assessment, which were financial assistance / cash (91 per cent), followed by access to healthcare and medication (56 per cent). This highlights a critical issue: while some humanitarian support reached older people, it was often inadequate, poorly coordinated, and failed to meet their priority needs.

It is important to note that assistance was primarily delivered by local NGOs (26 per cent), followed by international NGOs (6 per cent), and government organisations (6 per cent). This highlights the value of locally led action and underscores the need for coordination bodies, government, international agencies and donors to create space, equitable partnerships and capacity recognition for local NGOs in emergency responses in Lebanon.

Humanitarian assistance during the conflict

During the conflict, many older people were left without consistent access to aid. Only 16 per cent of respondents said they received humanitarian support regularly. While 45 per cent reported that they received assistance infrequently, a striking 39 per cent reported not receiving any assistance at all. Given the impact the conflict had on older people, this is an alarmingly high percentage of older people who were excluded from assistance, reflecting the need for a systematic age-inclusive review of assistance allocation during crises in Lebanon.

Reflecting the types of assistance reported following the conflict, the majority of support provided was reported to be food (62 per cent), followed by hygiene kits (36 per cent), bedding items (25 per cent), cash or voucher assistance (24 per cent), and health services or medication (10 per cent). Given the widespread displacement of people to collective centres, it is understood that this resulted in more frequent distribution of items versus cash assistance. However, it is disappointing to see such low levels of health service support, as well as an absence of mental health, assistive devices, and protection support.

Older people interviewed identified clear gaps in the humanitarian response during the conflict (see Table 2).

Table 2: Gaps in humanitarian assistance during the conflict, by surveyed participant group

Gap	All respondents	IDPs	Returnees	Non-displaced people
Limited or no food distributions	57%	61%	52%	57%
Inadequate healthcare services	42%	36%	45%	46%
Inadequate shelter conditions	15%	17%	27%	3%
Absence of mental health support	6%	7%	6%	7%

While there were no significant differences of note between men and women, there was a notable difference based on displacement status, whereby a higher percentage of IDPs identified limited or no food distributions, inadequate shelter and a lack of mental health support compared to returnees and non-displaced older people who had a higher percentage who identified inadequate healthcare services and no tailored assistance for people with disability. Notably, a much higher percentage of returnees cited inadequate shelter conditions than IDPs and non-displaced people. This reflects the dire need for shelter support for this community.

Accessibility of humanitarian assistance

Given the low percentage of respondents who reported receiving sufficient assistance during and after the live conflict, it is essential to understand the barriers as identified by those trying to access humanitarian assistance. The most significant barriers identified in both periods are set out in Table 3.

Table 3: Barriers to humanitarian assistance during and post-conflict

Barrier	During conflict	Post-conflict
Lack of information	30%	41%
Inability to travel to aid sites	7%	13%
Older people not being prioritised in aid distribution	6%	10%
Discrimination due to age or disability	5%	7%
Complex or inaccessible registration procedures	5%	7%

These barriers reveal serious shortcomings in how humanitarian assistance is designed and communicated – issues that are particularly harmful to older people with mobility limitations, sensory impairments, or those living alone.

It should also be noted that when asked whether they could reach aid sites independently, 41 per cent said that they could not, reflecting the likely marginalisation of people with mobility or health challenges. When explored further, it was reported that in order to access assistance, 26 per cent of responding older people said that they relied on others (family, friends, etc.) to bring items to them, while 21 per cent said their family, friends or volunteers assisted them in getting to aid sites, and 9 per cent said that they pay for their own transport to distribution sites. These findings emphasise the need for community-based distribution mechanisms and door-to-door outreach, especially for homebound or mobility-impaired older individuals.

Current humanitarian priorities

When asked about their current priorities, older people overwhelmingly identified a need for financial and medical support, as well as basic services. This did not vary significantly between gender, age, or disability, except to note a higher prioritisation of assistive devices by people with disabilities (19 per cent). Table 4 sets out older people's priorities.

Table 4: Older people's post-conflict humanitarian priorities

Financial support	91%
Access to healthcare and medication	56%
Access to sufficient and nutritious food	43%
Hygiene products and sanitation	23%
Mental health and psychosocial support	16%
Clean drinking water	16%
Recreational activities	16%
Mobility or assistive devices	12%
Safe and secure shelter	10%
Community engagement	8%

Recommendations

- Hold reflection meetings with coordination bodies and representative local NGOs and government, where older people can voice and gain recognition of the barriers to assistance and make practical suggestions for an age-inclusive emergency preparedness, response and recovery plan per sector.
- Provide regular age, gender and disability inclusion training and guidance to local NGOs, government agencies, community leaders, religious leaders and coordination bodies to promote understanding of age-inclusive emergency preparedness and response, with a focus on needs assessments, communication sharing, and a community feedback and response mechanism.
- Support community-based organizations (CBOs), and local / community organisations to map vulnerable people in their communities, set up outreach or peer-to-peer support groups to ensure the most marginalised have a support network that can share information and access aid sites on their behalf.
- Conduct an ageism audit or WHO ageism scale to determine the key drivers of ageism in Lebanon and develop community-focused, age-inclusion champion organisations or agencies to drive the anti-ageism movement in Lebanon.
- Work with older people and their communities to map information-sharing or communication methods and how best to ensure older people can access vital information during a humanitarian crisis.

Water, sanitation, and hygiene (WASH)

Access to clean water and appropriate sanitation is a fundamental determinant of health and dignity, yet many older people in Lebanon continue to face challenges in meeting their daily WASH needs—challenges that have been exacerbated by the conflict and displacement.

When asked about access to clean water, just over half of older people surveyed (58 per cent) reported having regular access, while 31 per cent said they only had access occasionally, and 11 per cent reported no access at all. This intermittent availability of safe water raises concerns about older people's ability to maintain basic hygiene and prevent illness, particularly in displacement settings or underserved rural areas.

In terms of quantity, only 61 per cent of respondents said they had enough water to meet their daily personal needs, while 33 per cent reported inconsistent access, and 7 per cent said they did not have enough water. These gaps point to both supply issues and possible barriers in collection and distribution – barriers that are especially difficult for older people with limited mobility or those living alone.

When asked about sanitation facilities, 79 per cent reported regular access, and 16 per cent had occasional access. However, 5 per cent reported there was no access to appropriate sanitation facilities at all. While this may seem like a small percentage, even short-term deprivation of hygiene facilities can lead to health complications, increased risk of disease, and indignity for vulnerable older individuals (Table 5 shows access to clean water by region surveyed).

Table 5: Older people's access to clean water, by region

Location	Access to clean water for all older people
West Beqaa	18%
Beirut	18%
Mount Lebanon	15%
South Lebanon	13%

Over 20 per cent of older men and women have limited or no access to sanitation facilities, with the most commonly reported problems being poor hygiene conditions (58 per cent),

living a long distance from sanitation facilities (48 per cent), and facilities not being age friendly and accessible (31 per cent).

Recommendations

- Use community data with questions identifying types of access to water to better understand where older people source water to meet their basic daily needs.
- Engage with local community members of all ages, recognising their gender and disability, to Identify and address barriers to water supply in underserved areas.
- Develop programmes or infrastructure to reduce any gaps by including older people in the planning to create local solutions.
- Conduct participatory assessments to better understand older people's specific sanitation needs and challenges to inform adaptable programme activities.

Shelter

Escalation of the cross-border conflict since September 2024 has profoundly impacted the living conditions of older people, particularly of IDPs and returnees. A comprehensive needs assessment reveals significant challenges related to shelter appropriateness, safety, and accessibility for this vulnerable group.

Current shelter appropriateness

Only 35 per cent of IDPs reported their current shelter as fully appropriate for their needs, while 48 per cent found it partially appropriate with some issues, and 17 per cent deemed it not appropriate at all. The primary challenges identified include poor ventilation and temperature control (38 per cent), overcrowding (35 per cent), and lack of privacy (30 per cent). Additionally, 18 per cent reported inadequate or unsafe sleeping arrangements, 9 per cent cited lack of accessible facilities, and 8 per cent noted the long distance from essential services.

For returnees, 42 per cent considered their current shelter fully appropriate, 53 per cent partially appropriate, and 5 per cent not appropriate at all. The main issues faced by returnees include poor ventilation and temperature control (22 per cent), lack of accessible facilities (17 per cent), inadequate or unsafe sleeping arrangements (16 per cent), lack of privacy (16 per cent), overcrowding (13 per cent), and distance to essential services (12 per cent). Notably, returnees reported inadequate shelter conditions at a significantly higher rate compared to IDPs and non-displaced individuals, underscoring the urgent need for targeted shelter assistance for this group.

Older people who were not displaced reported that 50 per cent found their current shelter fully appropriate, 44 per cent partially appropriate, and 5 per cent not appropriate at all. Their primary challenges encompass poor ventilation and temperature control (21 per cent), overcrowding (15 per cent), lack of privacy (10 per cent), inadequate or unsafe sleeping arrangements (10 per cent), distance to essential services (9 per cent), and lack of accessible facilities (6 per cent).

Shelter conditions during the conflict

During the active conflict, both IDPs and returnees faced severe shelter inadequacies. Only 15 per cent reported their shelters as fully appropriate, while 45 per cent found them partially appropriate, and 40 per cent deemed them not appropriate at all. The predominant challenges during this period included lack of privacy (29 per cent), overcrowding (29 per cent), poor ventilation and temperature control (24 per cent), inadequate or unsafe sleeping arrangements (20 per cent), lack of accessible facilities (13 per cent), and distance to essential services (13 per cent).

Support for housing repair and rebuilding

A significant proportion of IDPs and returnees have not received adequate support for housing repair or rebuilding. Specifically, 58 per cent reported receiving no support, 20 per cent received partial support, 15 per cent did not require any support, and only 6 per cent received full support. This lack of assistance has left many older people in precarious living conditions, unable to undertake necessary repairs due to financial constraints.

Security of housing

When asked about their sense of security in their current housing, 57 per cent of IDPs and returnees felt secure, 27 per cent felt somewhat secure but feared eviction or displacement, and 16 per cent did not feel secure at all. Among IDPs, concerns about returning to their place of origin were prevalent: 47 per cent could not return as their homes may have been fully destroyed, 17 per cent had security concerns, 13 per cent cited lack of services and shelter, 5 per cent did not wish to return. Overall, only 19 per cent felt safe to return.

Recommendations

- Improve shelter conditions for older people in Lebanon using a multi-faceted approach that addresses accessibility, safety, and long-term sustainability.
- Improve shelter infrastructure by upgrading basic living conditions in shelters, finding practical ways to improve temperature control, installing privacy measures in shelters so they meet the needs of older people
- Ensure older people are consulted throughout the process of improving shelter design and modification.
- Improve accessibility by, for example, installing ramps, handrails, and accessible facilities to accommodate mobility challenges, and provide assistive products to support older people in maintaining their independence
- Provide direct financial aid or construction materials to assist older people in repairing or rebuilding their homes and identify volunteer networks to provide skilled support.
- Coordinate with community volunteers to support older people who cannot build, repair or manage their shelters alone.
- Strengthen community-based support programmes – local initiatives that offer temporary housing, legal assistance, and psychosocial support for older people.
- Link shelter support with MHPSS and protection services to respond to distress, loss and displacement experienced by older people.
- Advocate for the inclusion of older people's needs in shelter coordination platforms and across sectors.

Refer to the National Strategy on Ageing in Lebanon and Shelter working group.

Accountability to affected populations

To be accountable to the communities affected by the 2024 attacks in Lebanon, responding agencies, government, and coordination bodies need to use power responsibly by giving communities influence over decisions that affect them (taking account of), being transparent and effective at information sharing (giving account to), and giving communities the opportunity to assess responding agencies (being held to account). Key to this is engaging, listening, acting on information, and ensuring meaningful participation of communities in the response. In this regard, based on the data collected, the response during and after the crisis failed to be accountable to the affected communities.

Over half of older people interviewed (51 per cent) reported that they had not been consulted by humanitarian actors regarding their needs, and while just over a third (36 per cent) said they had occasionally been contacted, only 12 per cent said they were regularly consulted. This did not vary significantly based on gender, age and disability. However, it should be noted that while only 15 people over the age of 90 were interviewed (which is too small a number to reflect a trend), it is alarming to note that 80 per cent of them said that they had not been consulted at all during or after the crisis. This requires further investigation but may indicate that the older a person is the more likely they are to be excluded. In terms of location, very high percentages reported a lack of consultation in Bekaa, and Mount Lebanon (averaging 65 per cent) compared to an average of 33 per cent across Beirut, Nabatieh, and South Lebanon, reflecting significant variation of engagement with communities based on location alone.

A key component in accountability is giving communities influence over decisions that affect them, such as the design of humanitarian programmes. When asked whether they felt that their views were considered in the design of assistance programmes, almost half (45 per

cent) said no. Only 12 per cent felt positively in this regard and this dropped to 9 per cent amongst older men interviewed.

A higher percentage of non-displaced people reported feeling a lack of consideration of their views (52 per cent), which should be noted as this could create tensions between communities based on displacement status and responding agencies' prioritisation of those displaced. In line with the overall findings described above, responses in locations varied significantly, with very high percentages in Bekaa and Mount Lebanon (averaging 59 per cent) reporting not feeling their views were being considered in the design of assistance programmes, compared to an average of just 25 per cent across Beirut, Nabatieh, and South Lebanon. Overall, this reflects a lack of engagement and therefore participation of older people during and after the response, removing their ability to hold agencies to account or provide input in the humanitarian response which directly impacted their lives.

Given the low levels of participation and engagement reported by older people interviewed, it was important to explore the barriers identified by those affected (see Table 6). In line with data above, there was no significant difference according to sex or disability, but there was in terms of displacement status and location. Issues relating to inaccessible registration or feedback mechanisms and age discrimination were particularly pronounced in Nabatieh (64 per cent reporting inaccessible feedback mechanisms and 60 per cent reporting age discrimination), and South Lebanon (47 per cent reporting inaccessible feedback mechanisms and 60 per cent reporting age discrimination), which needs further investigation.

Table 6: Barriers to accountability to older people during the crisis

Barrier	All respondents	IDPs	Returnees	Non-displaced
Inaccessible registration or feedback mechanisms	44%	43%	51%	38%
Age discrimination	43%	46%	49%	37%
Lack of outreach to older people	40%	37%	43%	40%
Language or communication barriers	24%	28%	26%	19%

Respondents highlighted language or communication challenges as barriers to inclusion, alongside inaccessible feedback mechanisms. As such, a deeper analysis was needed on how older people prefer to be reached for information-sharing and feedback. The needs assessment explored this by asking respondents about their preferred information method. Telephone calls or text messages were the most preferred option (71 per cent) across gender/sex, age, disability, displacement status and location, followed by face-to-face meetings or community gatherings (41 per cent), and word of mouth from family, friends or community members (25 per cent). While social media ranked in fourth place (16 per cent), it was a popular choice among returnees (28 per cent), and among respondents in Nabatieh (43 per cent), and South Lebanon (35 per cent).

In line with commitments to accountability to affected communities, it is important to ensure that communities are involved in designing and leading adaptations required for humanitarian responses. Older people interviewed were asked what humanitarian actors could do to improve their inclusion and the key improvement was a stronger focus on age-specific programmes (see Table 7 for the highest-ranked improvements).

It is evident from the findings that more age-specific programmes are required. While this may be due to the fact that general response programmes are not sufficiently mainstreaming age-inclusion (resulting in older people feeling excluded or marginalised from the response), it is also vital to recognise older people's preferences, which in this case are stand-alone, age-focused programmes. With regard to displacement status, it is important to note that returnees report a higher percentage in almost all categories of suggested improvements while non-displaced respondents reported lower levels. There was no significant difference between men and women.

Table 7: Key accountability improvements for older people

Improvement	All respondents	OP with disabilities	IDP	Returnee	Non-displaced
Age-specific programmes	76%	74%	74%	88%	67%
More home visits or outreach	47%	41%	47%	59%	36%
Older people in leadership roles	37%	32%	34%	43%	35%
Tailor information and communications to older people	35%	30%	39%	40%	37%
Invite older people to volunteer or lead	23%	15%	21%	31%	18%

Despite the lack of meaningful participation of the affected communities within the humanitarian and recovery response so far, almost two-thirds of all interviewed older people (65 per cent) said that they are interested in being involved in future planning. This was particularly high among returnee communities in Bekaa (83 per cent), South Lebanon (81 per cent), and Nabatieh (98 per cent). Fostering a willingness to participate is important in population groups and locations where this has scored low (i.e. among IDPs, people with disabilities; and in Beirut and Mount Lebanon). However, it is vital to ensure that moving forward, in recognition of this data, older people are invited to meaningfully participate in the response, through decision-making, ideas generation, feedback and monitoring and evaluation mechanisms, and programme design, implementation and reporting.

Ensuring accountability to the affected communities should be at the heart of all responses. Where this is not in place, it risks a response that does not effectively consider and meet the needs of the communities, and further alienating or marginalising under-represented members of the community.

Recommendations

- Ensure inclusive accountability frameworks by reviewing and revising information-sharing and feedback mechanisms with older people, to align with their preferences (eg telephone, face-to-face, community gatherings, etc) and open a dialogue on the barriers they have raised on inaccessible feedback mechanisms.
- Proactively seek feedback when reviewing feedback mechanisms by building in regular outreach through community groups or focus group discussions with older people to ensure that they understand the feedback process, mechanisms, and the organisation's commitment to respond.
- Increase older people representation and participation by reviewing programmatic and MEAL teams to determine whether there is sufficient representation of older people in the organisation. If there is not, encourage hiring older people as staff and/or facilitate regular engagement with older people to inform decision and reflections on the quality and effectiveness of the response.
- Conduct additional exploration with older people and stakeholders on the barriers to an inclusive response, such as age discrimination and a lack of outreach to older people. Potentially conduct an ageism audit and seek solutions.
- Explore location-related issues by working with coordination bodies, responding agencies and communities to further understand issues faced in locations that reported higher levels of marginalisation (Bekaa, and Mount Lebanon) and ways to address these.

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

The Institute for Development, Research, Advocacy, and Applied Care (IDRAAC) is one of the first national non-governmental organisations (NGOs) fully dedicated to mental health in Lebanon. Its vision is to promote mental wellbeing and reduce stigma by advancing research, raising awareness and improving access to quality mental health care for all.

Amel Association International (Amel) is a secular Lebanese NGO set up in 1979. The association is a social movement for reform, which aims to promote human dignity for all, ensure access to fundamental human rights and build a state of social justice based on citizenship.

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