



GENDER AND DISABILITY ALERT

DISPLACEMENT, DISABILITY AND GENDER IN LEBANON'S 2026 CRISIS

May 2026



SUOMI
FINLAND



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Front cover photo: The escalation of hostilities in Lebanon last year resulted in widespread displacement, reinforcing the need for sustained support for Syrian refugees alongside affected communities across the country. Photo: © 2026 LUPD

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UN Women

Lebanon, May 2026



**SUOMI
FINLAND**



Trocaire
TOGETHER FOR A JUST WORLD



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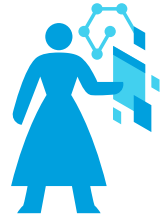
EXECUTIVE SUMMARY

Lebanon's renewed conflict and large-scale displacement in 2026 have generated a complex humanitarian crisis, with more than one million people displaced, many of them multiple times. Within this context, persons with disabilities face disproportionate barriers to safety, protection, humanitarian assistance and recovery. Yet they remain insufficiently visible in displacement data, inconsistently considered in humanitarian planning, and unevenly reached by response efforts. Women and girls with disabilities experience compounded discrimination arising from the intersection of gender, disability and forced displacement, resulting in heightened protection risks and reduced access to essential services and decision-making processes.

This alert examines the situation of displaced persons with disabilities in Lebanon, with particular attention to the differentiated experiences of women and girls with disabilities. Drawing on available humanitarian data, government sources, rapid assessments and evidence from Organizations of Persons with Disabilities (OPDs), it highlights persistent gaps in disability-inclusive humanitarian action and identifies priority measures to strengthen protection, inclusion and accountability.

Available data capture only part of the picture. As of 14 April 2026, the Shelter Monitoring Dashboard recorded 2,867 internally displaced persons with disabilities residing in collective shelters. Separately, a Ministry of Social Affairs (MoSA) presentation dated

ACCORDING TO MOSA DATA
28,754 INTERNALLY
DISPLACED PERSONS HOLD
DISABILITY CARDS.



16 April 2026 indicated that 28,754 internally displaced persons (approximately 2 per cent of those included in the presentation) held disability cards. This figure should not be interpreted as representing the total number of displaced persons with disabilities, as it appears to reflect administrative registration rather than identification based on functional limitations. Applying the globally recognized disability prevalence estimate of 15 per cent to the 1,049,000 self-registered internally displaced persons suggests that as many as 157,000 displaced people may be living with disabilities. While these estimates are not directly comparable, together they underscore a critical evidence gap: Lebanon currently lacks comprehensive, disability-disaggregated data capable of informing an inclusive humanitarian response, particularly for persons displaced outside collective shelters.

AS MANY AS 157,000
INTERNALLY DISPLACED PERSONS
MAY BE LIVING WITH DISABILITIES
- WHEN APPLYING THE 15% GLOBAL
DISABILITY PREVALENCE ESTIMATE.



This information gap has significant operational consequences. An estimated 87 per cent of displaced people are living outside formal shelter systems, yet little systematic information is available on persons with disabilities residing in host communities, rented accommodation, informal settlements, unfinished buildings or public spaces. Although MoSA's displacement registration platform includes a disability-related question, disability-disaggregated data were not available at the time this alert was prepared. OPDs continue to generate valuable information through outreach and case management, but these efforts remain geographically limited and cannot substitute for a comprehensive national evidence base. The absence of reliable disability-disaggregated data limits the ability of humanitarian actors to identify needs, prioritize assistance, monitor inclusion and ensure equitable access to services.

The findings further demonstrate that collective shelters have frequently failed to provide accessible, safe and dignified accommodation for persons with disabilities. A rapid accessibility assessment conducted by the Lebanese Union for People with Physical Disabilities (LUPD) across 77 collective shelters found that only 14 per cent were fully accessible. Key barriers included inaccessible sanitation facilities, the absence of functioning elevators, inadequate sleeping arrangements, and limited prioritization of accessible or ground-floor

accommodation. In addition to physical barriers, shelter management practices contributed to exclusion, with documented cases of persons with disabilities being denied admission, relocated to inappropriate spaces or left without effective referral pathways. Persons with intellectual, psychosocial, cognitive and communication disabilities encountered additional barriers due to limited awareness and capacity among shelter personnel and residents.

Outside collective shelters, persons with disabilities often face even greater risks that remain largely invisible within humanitarian reporting. Many have relocated to inaccessible housing or informal settings where they encounter significant barriers to mobility, healthcare, assistive devices, electricity, communication, transportation and essential services. Others have remained in areas affected by hostilities because inaccessible evacuation procedures, dependence on caregivers, inaccessible information and the absence of disability-inclusive preparedness measures prevented safe evacuation. These circumstances expose persons with disabilities to heightened protection risks while reducing their access to humanitarian assistance.

Despite important efforts by government institutions, humanitarian actors and OPDs, disability inclusion remains uneven across the response. Disability-sensitive guidance, coordination mechanisms and technical tools have expanded, but implementation remains inconsistent across sectors and geographic locations. Referral pathways are often fragmented, and many persons with disabilities continue to depend on OPDs and informal community networks to access specialized assistance, accessible information,

**OUT OF 77 COLLECTIVE
SHELTERS ASSESSED
ONLY 14% WERE
FULLY ACCESSIBLE.**



suitable accommodation and disability-related services. This demonstrates the need to move beyond ad hoc accommodations towards systematically integrating disability inclusion across humanitarian planning, implementation and monitoring.

Across multiple rapid assessments, financial assistance and food emerged as the most consistently identified priorities for persons with disabilities. Cash assistance is particularly important because disability-related expenditures vary considerably and frequently extend beyond the scope of standard humanitarian assistance packages. Reported needs include assistive devices, hearing aid maintenance, colostomy supplies, adapted hygiene items, specialized nutrition, transportation, communication support, medication and accessible household items. These findings reinforce the importance of flexible, individualized assistance that recognizes the additional costs associated with disability and enables persons with disabilities to exercise choice, dignity and autonomy.

Women and girls with disabilities experience multiple and intersecting forms of discrimination that intensify during displacement. The loss of accessible environments, support networks, assistive devices and familiar routines increases their exposure to gender-based violence, exploitation and abuse, while limiting access to sexual and reproductive health services, protection mechanisms and complaint systems. Menstrual hygiene management remains insufficiently addressed, particularly for women and girls with physical, intellectual and multiple disabilities. At the same time, unpaid caregiving responsibilities—performed predominantly by women—have intensified considerably, with

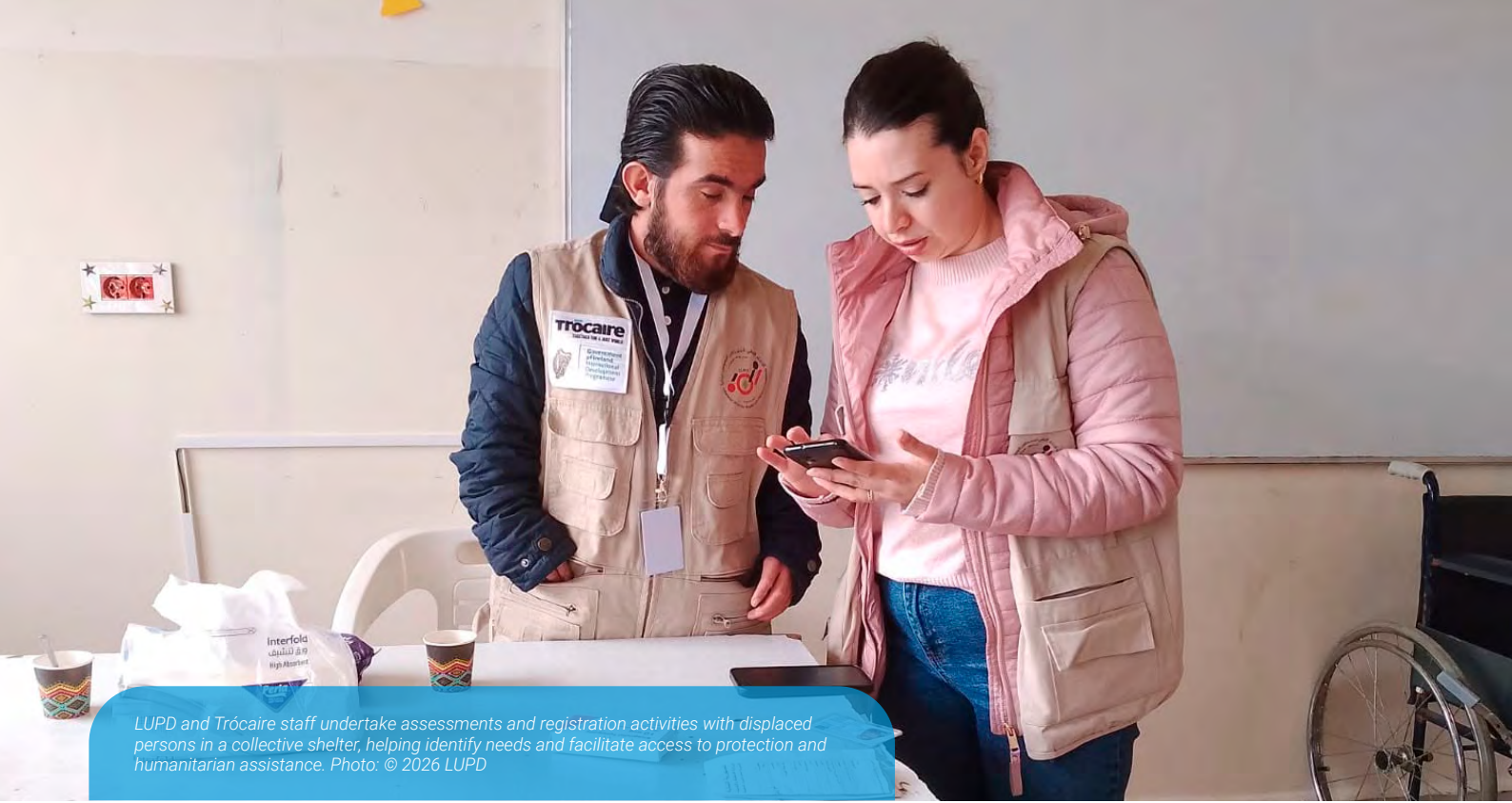
caregivers providing continuous support in overcrowded and inaccessible environments while receiving limited psychosocial, financial or respite support. These intersecting challenges highlight the need for humanitarian responses that integrate disability inclusion and gender equality rather than addressing them separately.

The findings call for a transition from fragmented disability-specific interventions to a predictable, adequately resourced and fully disability-inclusive humanitarian response grounded in human rights and the principle of leaving no one behind.

Priority actions include:

- strengthening disability-disaggregated data collection and information-sharing;
- ensuring accessible shelter, evacuation, registration and referral systems;
- expanding flexible cash assistance alongside disability-specific support;
- and systematically integrating accessibility across health, rehabilitation, protection, gender-based violence, sexual and reproductive health, mental health and psychosocial support, education and accountability mechanisms.

Organizations of Persons with Disabilities should be recognized and adequately resourced as strategic partners in humanitarian coordination, outreach, monitoring and preparedness. Embedding these measures within preparedness, response and early recovery efforts will be essential to ensuring that future humanitarian action protects the rights, dignity, participation and leadership of persons with disabilities, particularly women and girls with disabilities.



LUPD and Trocaire staff undertake assessments and registration activities with displaced persons in a collective shelter, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD

OVERVIEW

The escalation of hostilities in March 2026 triggered a large-scale humanitarian crisis characterized by widespread aerial bombardment, destruction of civilian infrastructure and repeated waves of displacement, particularly from South Lebanon, the Bekaa Valley and Beirut's southern suburbs (Dahiyeh). The crisis has significantly affected the protection, safety and human rights of civilians across Lebanon. Many families were forced to flee multiple times with little or no advance warning, leaving insufficient time to gather essential belongings, documentation and other necessities. For many persons with disabilities, inaccessible evacuation procedures, disrupted support networks, and the loss of assistive devices, essential medication, communication support and caregiving arrangements created life-threatening barriers during displacement. Women and girls with disabilities faced compounded risks arising

from the intersection of gender inequality, disability and forced displacement, further limiting their access to protection, humanitarian assistance and essential services.

A ceasefire agreement initially established for a 10-day period took effect on 16–17 April 2026 and was subsequently extended. Despite this, military activity has continued, including airstrikes, shelling and exchanges of fire in parts of southern Lebanon, alongside ongoing insecurity and restrictions on civilian movement in affected areas. As a result, safe, voluntary and sustainable returns have remained limited, with many displaced people unable to return despite the extended ceasefire. This instability has also resulted in repeated cycles of displacement, with some families fleeing, returning home and then being displaced again, compounding humanitarian needs and creating significant challenges for data collection, referral follow-up, humanitarian planning and service delivery.

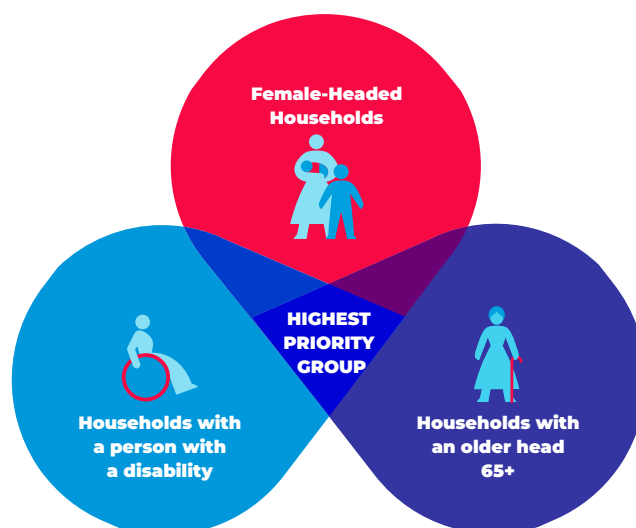


1 million+ people DISPLACED SINCE 2 MARCH 2026 - ROUGHLY ONE IN FIVE RESIDENTS.

At the peak of the crisis, more than one million people were displaced, many of them multiple times. Collective shelters, primarily schools and public buildings, were rapidly overwhelmed. By 10 April 2026, more than 684 sites were hosting approximately 140,447 individuals. The majority of displaced people - estimated at 87 per cent - were living outside collective shelters, including with host families, in overcrowded rented accommodation, informal settings and public spaces such as streets, parks and unfinished buildings.

Within the displaced population, information on persons with disabilities remains limited, particularly for those living outside collective shelters. Evidence gathered by Organizations of Persons with Disabilities (OPDs) indicates that some persons with disabilities, particularly persons with physical disabilities, were unable to evacuate safely because of inaccessible transport, damaged infrastructure, safety risks, limited assistance and inaccessible information. This not only increased their exposure to hostilities but also reduced their access to humanitarian assistance and protection services. For those who were able to flee, displacement disrupted essential support systems, including access to caregivers, medication, communication support, assistive devices, rehabilitation and routine healthcare services.

Consistent with the Convention on the Rights of Persons with Disabilities (CRPD), disability inclusion in humanitarian action should not be treated as a stand-alone or disability-specific intervention. Rather, it requires coordinated action across national authorities, humanitarian actors, municipalities, OPDs and sectoral coordination mechanisms to ensure that persons with disabilities are identified, meaningfully consulted, appropriately prioritized according to identified needs, and able to access protection, assistance and services on an equal basis with others. An intersectional approach is essential to understanding how multiple and intersecting forms of discrimination shape humanitarian needs and access to assistance. Gender, disability, age, nationality, displacement status, caregiving responsibilities and shelter status interact to influence exposure to risk, access to services and the type of support required. For women and girls with disabilities, these intersecting factors affect their ability to exercise their rights, access humanitarian assistance, participate in decision-making, maintain autonomy and live in safety and dignity throughout displacement.



The convergence of female headship, disability and older age defines the subgroup facing the most severe and compounded deprivation.

The 2026 crisis reflects and amplifies patterns documented during Lebanon's previous emergencies, including the COVID-19 pandemic, the 2020 Beirut Port explosion and the 2024 conflict. Across these crises, systemic barriers affecting persons with disabilities have been repeatedly documented, including limited shelter accessibility, exclusion from humanitarian planning and information systems, inadequate disability-disaggregated data, shortages of assistive devices, and insufficient capacity among humanitarian

personnel to deliver disability-inclusive assistance. Law No. 220/2000 on the Rights of Persons with Disabilities, which guarantees accessibility in public spaces and services, continues to face significant implementation challenges. The current crisis has further exposed these longstanding structural barriers, compounded by Lebanon's protracted economic crisis, reduced operational capacity of OPDs and an increasingly constrained humanitarian funding environment.

Lebanon's National Strategy for the Rights and Inclusion of Persons with Disabilities (2023–2030) recognizes the structural barriers affecting persons with disabilities, including accessibility gaps, limited disability-disaggregated data, and challenges related to inclusive protection and service delivery. The current escalation underscores the urgency of translating these commitments into concrete action across emergency preparedness, humanitarian response, early recovery and longer-term resilience efforts.

This gender and disability alert is jointly issued by UN Women, the Lebanese Union for People with Physical Disabilities (LUPD) and Trócaire. It examines the impact of displacement on persons with disabilities during Lebanon's 2026 conflict, with particular attention to the experiences of women and girls with disabilities, who face intersecting forms of discrimination related to gender, disability and forced displacement. Drawing on available humanitarian data, government sources, rapid assessments and evidence generated by OPDs, the alert identifies priority actions to strengthen disability-inclusive, gender-responsive and rights-based humanitarian preparedness, response and recovery in Lebanon.



A woman participates in an advocacy action organized by LUPD, highlighting the barriers faced by persons with disabilities during displacement and calling for inclusive humanitarian assistance. Photo © 2026 LUPD

METHODOLOGY

This alert adopts a mixed-methods approach, combining qualitative evidence, operational monitoring and secondary data analysis to examine the impact of displacement on persons with disabilities during the acute phase of Lebanon's 2026 humanitarian crisis. The analysis covers the period from March to April 2026 and draws on data and testimonies collected during the emergency response. Where relevant, comparisons are made with the 2024 conflict to identify recurring patterns affecting persons with disabilities and assess the extent to which lessons identified during previous emergencies have been reflected in the current response.

The analysis is informed by a human rights-based, gender-responsive and intersectional approach, recognizing that disability intersects with gender, age, nationality, displacement status, caregiving responsibilities and other characteristics to shape humanitarian needs, protection risks and access to assistance. Findings were triangulated across multiple qualitative and secondary sources to strengthen the consistency and credibility of the analysis. The methodology was designed to capture the experiences of persons with disabilities through multiple sources of evidence, with particular attention to the differentiated experiences of women and girls with disabilities.

Primary data

Primary data sources include:

- **Focus group discussion (FGD) with representatives of five Organizations of Persons with Disabilities (OPDs)** actively engaged in the emergency response and working with persons with different types of disabilities, including physical, intellectual, hearing, visual and communication-related disabilities: the Lebanese Union for People with Physical Disabilities (LUPD), the Ecumenical Disability Advocates Network, the Lebanese Association for Self-Advocacy, the Learning Center for the Deaf, and the Lebanese Universities League for the Blind.
- **FGD with LUPD field staff across multiple field bases**, drawing on their direct monitoring, outreach and case documentation during the emergency response.
- **LUPD field monitoring and documentation**, including rapid accessibility assessments of 77 collective shelters across Beirut and Mount Lebanon, Bekaa, North Lebanon, Beirut and South Lebanon.
- **LUPD outreach assessments with displaced persons with disabilities living in private housing**: 125 individuals in Beirut and Mount Lebanon, 89 in Saida and 104 in Bekaa.
- **Key informant interview** with representatives of the **Disability Inclusion Working Group**, conducted in May 2026.
- **Key informant interview** with representatives of the **Lebanese Red Cross Disaster Risk Reduction Unit**, conducted in May 2026.
- **Technical consultations with ShareQ and Arcenciel**, non-governmental organizations and members of the Emergency Task Force providing specialized services to persons with disabilities.
- **Interviews conducted by UN Women** with displaced women and girls with disabilities for the 2026 Rapid Gender Assessment, cited throughout the alert as UN Women interviews, 2026.

- **Selected interviews, testimonies and documentation** collected by LUPD from displaced persons with disabilities during the 2024 conflict. These materials are used as supplementary qualitative evidence where they illustrate displacement-related barriers that have reappeared during the 2026 crisis, particularly in relation to shelter accessibility, protection risks, caregiving, discrimination and access to services. They are not used as a substitute for 2026 data.

Secondary data

Secondary sources reviewed for this alert include OPD position papers, field reports and assessments produced during the 2024 and 2026 emergencies; official government administrative data, primarily from the Ministry of Social Affairs (MoSA) and the Disaster Risk Management (DRM) Unit at the Presidency of the Council of Ministers; and publications from international organizations, including UN Women, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Food Programme (WFP), the International Labour Organization (ILO) and Humanity & Inclusion.

Methodology notes and limitations

This alert is an evidence-informed analytical assessment rather than a statistically representative survey. Its purpose is not to produce a prevalence estimate of disability among displaced populations, but to analyse available evidence on how persons with disabilities are being identified, reached, prioritized and supported within the current humanitarian response. The following limitations should be considered when interpreting the findings:

- **The data are not population representative.** LUPD assessments and outreach data reflect the organization's registered caseload, operational access and geographic coverage.
- **The shelter accessibility assessment is indicative rather than representative.** It covered 77 shelters out of 684 active sites, selected on the basis of operational criteria rather than representative sampling.
- **Comprehensive disability-disaggregated data were not available for this alert, particularly for persons living outside collective shelters.** MoSA's self-registration platform and OPD outreach provide partial information, but the available figures remain incomplete.
- **Some groups are underrepresented in the available data,** including children with disabilities, older persons with disabilities, non-Lebanese persons with disabilities and persons living outside formal shelter systems.
- **Case studies and testimonies are illustrative.** They are used to demonstrate documented patterns identified through field monitoring, interviews and consultations and should not be interpreted as prevalence estimates. Names are pseudonyms unless explicit consent for identification was provided.
- **The research team was unable to meet with representatives of the Ministry of Social Affairs** during the drafting period. This limited opportunities to directly triangulate findings relating to shelter registration, disability data, referral pathways, coordination arrangements and the methodology underpinning available disability-related figures.
- **The alert was prepared under rapidly evolving emergency conditions.** Data collection and verification were constrained by access limitations, security conditions and the rapidly changing operational context.

DISABILITY ANALYSIS



THE DATA GAP: WHERE ARE DISPLACED PERSONS WITH DISABILITIES?

Reliable information on displaced persons with disabilities remains limited, particularly for those living outside collective shelters. Existing administrative and operational data provide only a partial picture of the scale and characteristics of disability among displaced populations, limiting the ability of humanitarian actors to identify persons with disabilities, prioritize assistance, monitor equitable access to services and assess whether humanitarian assistance is reaching those most at risk.

According to the Shelter Monitoring Dashboard, 2,867 internally displaced persons (IDPs) residing in collective shelters were recorded as having a disability as of 14 April 2026¹. This figure reflects only persons identified within collective shelters and should be interpreted as a partial count rather than an estimate of the total number of displaced persons with disabilities in Lebanon. Shelter Monitoring Dashboard figures are updated regularly and may change on a daily basis as people move between shelters, leave shelters or are newly identified.

A Ministry of Social Affairs (MoSA) response presentation dated 16 April 2026 provides another official reference point, indicating that 28,754 displaced people - around 2 per cent of the displaced population covered in the presentation - were persons holding disability cards. The presentation does not

specify how this figure was calculated. Based on the wording used, it appears likely that this is an administrative estimate drawing on MoSA's disability-card database and the geographic areas affected by displacement, rather than a count generated through disability identification during the IDP registration process. Consequently, this figure should not be interpreted as representing the total number of displaced persons with disabilities. It is likely to exclude persons with disabilities who do not hold disability cards, including persons with newly acquired disabilities, older persons with functional limitations, non-Lebanese persons with disabilities, and persons with less visible or underregistered disabilities.

When the standard global disability prevalence estimate of 15 per cent is applied to the 1,049,000 self-registered internally displaced persons, it suggests that up to approximately 157,000 displaced persons may have disabilities. This estimate is used solely to illustrate the possible scale of disability among the displaced population and should not be treated as a verified caseload, planning figure or substitute for crisis-specific disability-disaggregated data. OPD representatives consulted through focus group discussions emphasized that the actual number of displaced persons with disabilities remains unknown. The difference between the MoSA

1. WHO (World Health Organization). 2026. [Lebanon Health Emergency Situation Update #19 – 14 April 2026](#). Accessed 10 May.

KEY FIGURES AT A GLANCE



1M+

**TOTAL DISPLACED
POPULATION**



87%

**ESTIMATED SHARE OF
DISPLACED PEOPLE OUTSIDE
FORMAL SHELTERS**



140K

**DISPLACED PEOPLE IN
COLLECTIVE SHELTERS**



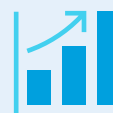
2,867

**PERSONS WITH DISABILITIES
RECORDED IN COLLECTIVE
SHELTERS ONLY
(AS OF 14 APRIL 2026)**



28,754

**DISPLACED PEOPLE HOLDING
DISABILITY CARDS, BASED ON
MOSA ESTIMATION
(METHODOLOGY NOT SPECIFIED)**



150K

**INTERNALLY DISPLACED PERSONS
MAY BE LIVING WITH DISABILITIES
(WHEN APPLYING THE 15% GLOBAL DISABILITY
PREVALENCE ESTIMATE.)**

disability-card figure and the prevalence-based estimate reflects different methodologies and definitions: one appears to be based on administrative disability-card registration, while the other is derived from a globally recognized prevalence benchmark.

No comprehensive disability-disaggregated data are currently available for persons with disabilities living outside collective shelters, including those residing in host communities, rented accommodation, informal settings, public spaces or unfinished buildings. The official IDP registration platform managed by MoSA includes a disability-related question; however, disability-disaggregated data from this platform were not available for this alert at the time of drafting. In parallel, OPDs collect disability-related information through their outreach and operational work, but these data are limited to their respective caseloads, geographic coverage and operational access. As a result, available sources do not yet

indicate how many persons with disabilities are displaced outside shelters, where they are located, the types of disabilities and support needs they have, or whether they are being reached through referral mechanisms and humanitarian assistance. The absence of comprehensive disability-disaggregated data also limits analysis of the differentiated experiences of women, men, girls and boys with disabilities, constraining the design of gender-responsive and disability-inclusive humanitarian interventions.

Because the available data are incomplete and highly time-sensitive, shelter-level figures should be interpreted as a snapshot rather than a stable caseload. Interviewed OPD representatives noted that the shelter figures available for this alert may not reflect the most recent situation. Numbers can change rapidly as displacement patterns evolve and as some persons with disabilities leave collective shelters because conditions



LUPD and Trócaire staff undertake Focus Group Discussions (FDGs) with displaced persons in a collective shelter, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD

are inaccessible or unsuitable, including difficulties accessing toilets, water, food or appropriate accommodation. Consequently, a decrease in the number of persons with disabilities recorded in a shelter should not be interpreted as evidence that needs have been resolved. Instead, it may indicate that individuals have moved into less visible and less supported settings.

Taken together, the available figures demonstrate that disability-related data exist but remain fragmented across data sources, definitions and displacement settings. This fragmentation is particularly significant because an estimated 87 per cent of displaced people are living outside formal shelter systems, where disability-related needs are less visible to registration, outreach, referral and aid distribution systems. At the same time, OPD representatives consulted for this alert expressed concerns regarding the consistency of disability identification within collective shelters, noting that the Washington Group Questions are not systematically applied and that persons with disabilities may therefore be under-identified or misclassified in shelter records. Together, these findings highlight

the importance of strengthening disability identification and improving the availability of disability-disaggregated data to support a more inclusive and evidence-informed humanitarian response.

These limitations mean that the available data do not provide a sufficiently intersectional picture of disability within the displaced population. While shelter figures indicate the number of persons recorded as having a disability, they do not include sufficient publicly available information on sex, age, disability type, nationality, household composition, displacement setting or support needs. This is significant because gender, disability, age, nationality, displacement status and other intersecting factors shape exposure to risk, access to services and the type of assistance required. Without such data, humanitarian actors face greater challenges in identifying and responding to the differentiated needs of women and girls with disabilities, older persons with disabilities, non-Lebanese persons with disabilities, and persons living outside collective shelters, increasing the risk that these groups are overlooked in needs assessments, referrals and humanitarian assistance².

2. UN Women. 2022. [Intersectionality Resource Guide and Toolkit: An Intersectional Approach to Leave No One Behind](#).



IN COLLECTIVE SHELTERS: NUMBERS AND DISABILITY TYPES

Collective shelter data provide the clearest available information on displaced persons with disabilities. However, they capture only persons identified within collective shelters and should be interpreted as a time-sensitive snapshot rather than a stable caseload. Shelter Monitoring Dashboard figures are updated regularly and may change as people move between shelters, leave shelters or are newly identified. Accordingly, all figures should be interpreted within the context of their reporting date, data source and methodology.

In addition to the individual-level figures presented earlier, Humanity & Inclusion reported an earlier household-level estimate. As of 14 March 2026, more than 1,600 households headed by a person with a disability had been recorded in collective shelters. This figure complements, rather than replaces, individual-level data, as the two datasets measure different units of analysis³.

LUPD operational data and field assessments indicate that persons with disabilities identified or reached while residing in collective shelters were concentrated primarily in Mount Lebanon, followed by South Lebanon and Beirut. This distribution appears to reflect displacement from Beirut's southern suburbs (Dahiyeh) and South Lebanon towards areas perceived as relatively safer.

WHO Situation Update No. 19, drawing on data extracted from the Shelter Monitoring Dashboard, provides a general indication of the types of disabilities recorded among internally displaced persons residing in collective shelters.

According to these figures, 1,300 persons were recorded as having physical disabilities, 760 as having mental disabilities, 419 as having hearing impairments, and 388 as having visual impairments⁴. The category of "mental disabilities" reflects the terminology used in the Shelter Monitoring Dashboard. Throughout this alert, the analysis uses broader and more precise terminology, referring, where relevant, to persons with intellectual, developmental, psychosocial or communication-related disabilities.

1,300 people
WERE RECORDED AS HAVING
PHYSICAL DISABILITIES;



760 AS HAVING
MENTAL DISABILITIES;



419 AS HAVING
HEARING IMPAIRMENTS;



388 AS HAVING
VISUAL IMPAIRMENTS.

3. Humanity & Inclusion. 2026. [Lebanon: People with disabilities, forgotten victims of the crisis](#). 4 May.

4. WHO 2026.

The relatively high number of persons recorded under the category of “mental disabilities” warrants particular attention. OPDs and LUPD field staff reported that persons with intellectual, developmental, psychosocial or communication-related disabilities may experience heightened exclusion within collective shelters because of stigma, discrimination, limited awareness among shelter managers and residents, and insufficient capacity to provide appropriate support. These barriers may discourage some families from accessing collective shelters, lead others to leave after experiencing rejection or inadequate accommodation, or result in persons with disabilities remaining outside formal shelter systems, where they are less visible to humanitarian registration, referral and assistance mechanisms.

A case documented by LUPD during the 2024 conflict illustrates how these barriers can result in exclusion and secondary displacement:

During the 2024 conflict, a mother of a 17-year-old child with autism from Tyre was initially admitted to a collective shelter in Ghaziyeh. She was subsequently asked to leave because of her child’s behaviour. She then sought refuge with a host family, who were only able to accommodate them for four days. After leaving the host family, the mother and her child were left without accommodation and were forced to stay on the street.

**FOCUS GROUP DISCUSSION
WITH LUPD FIELD STAFF, 2026**



SHELTER ACCESSIBILITY

Collective shelters remain largely inaccessible for persons with disabilities. LUPD’s shelter accessibility assessment indicates that, even where accessibility features are present, they are not consistently functional, prioritized or usable in practice. As a result, physical accessibility alone does not guarantee equitable access to safe, dignified and inclusive shelter.

As part of its emergency disability inclusion response, LUPD field teams conducted rapid accessibility assessments of 77 collective shelters between March and April 2026. The assessments sought to identify physical accessibility barriers, document conditions affecting displaced persons with disabilities, and support advocacy with shelter management and humanitarian actors.

The assessed shelters were located across Mount Lebanon (37), Bekaa (17), North Lebanon (9), Beirut (9) and South Lebanon (5). Shelters were selected according to operational criteria, including their location outside active danger zones, the presence of relief teams, available information on the number of displaced persons with disabilities at each site, complaints received from persons with disabilities or their families, and proximity to LUPD community kitchens.

Although the assessment is not representative of all collective shelters in Lebanon, it highlights significant accessibility gaps across the sites assessed. Of the 77 shelters assessed, only 14 per cent - approximately 11 shelters - were fully equipped to welcome persons with disabilities. The most significant gaps related to accessible toilets and bathing facilities, functioning elevators, and the prioritization of ground-floor

**OUT OF 77 COLLECTIVE
SHELTERS ASSESSED
ONLY 14% WERE
FULLY ACCESSIBLE.**



or private rooms for persons with disabilities. These gaps are particularly significant given that Mount Lebanon and Bekaa were among the principal receiving areas for people displaced from Dahiyeh, South Lebanon and conflict-affected areas of the Bekaa.

Consultations also demonstrated that identifying accessible shelters does not necessarily translate into effective access. Some families were referred to accessible schools in Jal el Dib and Keserwan but were unable to relocate because the sites were too far from their current location or support networks. In addition, accessible shelters were not reserved exclusively for persons with disabilities, meaning that they competed for available space alongside the wider displaced population. These findings underscore the importance of early identification of persons with disabilities and timely referral to appropriate and accessible accommodation before available capacity is exhausted.

Building on LUPD's assessment findings, OPD representatives emphasized that shelter accessibility extends beyond the presence of physical infrastructure. Accessibility should also be understood in terms of usability, safety, distance, privacy, allocation procedures and the availability of appropriate support. A shelter equipped with ramps, ground-floor rooms or accessible toilets may nevertheless remain inaccessible in practice if facilities are located too far away, lack privacy,

are not allocated to those who need them, or are situated within an unsafe or unsuitable environment. Participants further noted that shelters considered physically accessible may still be unsafe or unsuitable for women with disabilities and persons with intellectual disabilities, underscoring the need to consider accessibility alongside protection, dignity and the specific support requirements of different groups of persons with disabilities.



A woman with a physical disability in a shelter could not access the bathroom. A bath chair was provided, but in the absence of private and accessible space, the device alone was not sufficient.

— ARCENCIEL CONSULTATION, 2026

LUPD field documentation further indicates that many shelters lacked the minimum conditions necessary to ensure a safe and dignified stay for persons with disabilities. Common gaps included inaccessible accommodation, limited disability-sensitive communication, insufficient personal assistance, inaccessible toilets and bathing facilities, inadequate privacy, and unclear referral pathways. In some documented cases, persons with disabilities were carried up stairwells to upper-floor rooms instead of being allocated accessible ground-floor accommodation. Where elevators were available, they were frequently non-functional, restricting movement within shelters and limiting access to essential services, communal areas and daily activities. In some instances, the absence of suitable accessible accommodation led persons with disabilities to leave collective shelters or return to unsafe areas.

Even where ground-floor or private rooms were available, no consistent procedures existed to prioritize their allocation to persons with disabilities. OPDs and LUPD field teams negotiated individually with shelter management to secure more appropriate accommodation, but these arrangements remained ad hoc and inconsistent.

Access to toilets and bathing facilities emerged as one of the most significant barriers. Toilets were frequently inaccessible, located on different floors or unsuitable for persons with physical disabilities. Bathing facilities presented even greater challenges, with barriers reported to be particularly severe for women with disabilities. Inadequate privacy, non-functioning locks in some facilities, and insufficient arrangements to ensure safe and dignified assistance for women and girls with disabilities further heightened protection concerns, including exposure to harassment and additional distress for survivors of gender-based violence (GBV).

Overall, overcrowding, poor shelter organization, limited protection services and inaccessible facilities meant that many collective shelters were unsuitable for persons with disabilities documented by LUPD and participating service providers. Consultations indicated that some persons with disabilities visited collective shelters, assessed the conditions and chose to return to unsafe areas because they considered the shelters inaccessible, unsafe or undignified. Others avoided collective shelters altogether, left prematurely, or remained in unsafe or informal settings because accessible and dignified accommodation was unavailable.



A participant engages during a Focus Group Discussions (FDGs) in a collective shelter, led by LUPD and Trócaire, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD



SHELTER ADMISSION, PRIORITIZATION AND MANAGEMENT

Despite some shelters being designated or referred to as accessible, LUPD documented cases in which persons with disabilities and their families were turned away as sites filled rapidly. There was no consistent mechanism to reserve or prioritize places for persons with disabilities in accessible shelters, including for those with urgent mobility, personal assistance or medical support needs.

Some shelters were also reported to have refused persons with disabilities or asked them to leave after initial admission, particularly when staff and residents were not equipped to respond to disability-related support needs. LUPD documented cases in which unaccompanied persons with disabilities who required assistance were refused admission, a potentially life-threatening practice, given that many displaced persons with disabilities do not have consistent caregiver support. This is particularly concerning given that UN Women's Rapid Gender Analysis reports that 55 per cent of older people and 73 per cent of persons with disabilities relied on others to meet basic needs⁵.

Persons with intellectual, developmental, psychosocial or cognitive disabilities faced particularly severe barriers. OPDs documented cases when persons with intellectual disabilities and autistic persons were refused entry or were unable to remain in shelters because staff and co-residents lacked the knowledge, support or willingness to accommodate their needs.



A 70-year-old woman with Alzheimer's disease in Baalbek remained at home with her son after being refused admission to several shelters, and no clear referral pathway was identified between relevant authorities and service providers.

—FGD WITH LUPD FIELD STAFF, 2026

Shelter-level capacity and procedures also shaped whether persons with disabilities could access and remain in shelters safely and with dignity. Shelter managers, focal points and staff were often not trained to identify disability-related needs, communicate appropriately with persons with disabilities or make reasonable accommodation decisions. This contributed to inappropriate room allocations, exclusion from services and missed referrals to relevant support.

LUPD assessors also noted that inconsistent disability identification at shelter level affected both data quality and referrals, as some persons with disabilities were not identified or were not referred to appropriate support. Staff also lacked guidance on how to distinguish between disability, chronic illness and age-related support needs, and had limited capacity to communicate with persons with disabilities, particularly persons with intellectual, developmental, psychosocial or communication-related disabilities.

5. UN Women. 2026. [Rapid Gender Analysis: Gendered impacts of displacement outside collective shelters in Lebanon](#). March 2026.

OPDs documented repeated instances of discrimination by both co-residents and shelter staff. Persons with disabilities reported being made to feel unwelcome, being placed at shelter entrances or in hallways rather than assigned appropriate rooms and, in some cases, being pressured to leave after initial admission. Fear, stigma or lack of awareness among co-residents contributed to hostility towards persons with disabilities. Designated shelter focal points and staff also failed in some cases to identify older persons as persons with disabilities, treating them solely as older adults and overlooking disability-specific support needs. This reflects a broader lack of awareness of the intersection between age, disability, dependency and protection risks.



A family from Dahiye with a 10-year-old son with a physical disability was forced to return home under bombardment after being subjected to abuse by shelter co-residents, with an inadequate management response.

—FGD WITH LUPD FIELD STAFF, 2026

A 2024 testimony collected by LUPD illustrates how discrimination in displacement settings affects dignity, belonging and psychosocial well-being:



Society does not accept us. There is discrimination against us, especially in displacement settings, alongside enormous difficulties with movement – like accessing the bathroom. They look at me as if I am a stranger to them, as if I am nothing like them. Their gaze towards me is inhuman and abnormal. I have become unable to sit among them.

—DANA (PSEUDONYM), A WOMAN WITH A DISABILITY, DISPLACED FROM SOUTHERN LEBANON (LUPD TESTIMONY COLLECTION, 2024)

Exclusion note: Non-Lebanese persons with disabilities

Non-Lebanese persons with disabilities – including Syrian refugees, Palestinian refugees and migrant domestic workers – face additional barriers to admission, registration, referral and assistance. Field evidence indicates that some non-Lebanese persons with disabilities are not welcomed or admitted into Lebanese collective shelters and are largely absent from disability-disaggregated data. Their exclusion from formal registration and referral systems makes their needs less visible and increases reliance on informal or community-based support.



OUTSIDE COLLECTIVE SHELTERS AND IN HARD-TO-REACH AREAS

The majority of displaced people in Lebanon are living outside collective shelters, yet persons with disabilities residing in private housing, host communities, informal settings, public spaces and hard-to-reach or high-risk areas remain considerably less visible within the humanitarian response. As noted above, the Ministry of Social Affairs (MoSA) official IDP registration platform includes a disability-related question; however, disability-disaggregated data from this platform were not available for this alert at the time of drafting. Organizations of Persons with Disabilities (OPDs) continue to conduct outreach within their operational capacity, but these efforts are limited by their caseloads, geographic access and operational reach.

Private housing and host communities: For many persons with disabilities, displacement into private housing or host communities has meant relocating to environments that are inaccessible, overcrowded and poorly adapted to their needs. Consultations indicated that, for some persons with disabilities, conditions in private accommodation were generally better than those in collective shelters. However, overcrowding continued to present significant challenges related to privacy, dignity and daily living. Families reported urgent needs for cash assistance, assistive devices adapted to new living arrangements, reliable electricity to operate medical equipment, and financial support to reduce the risk of eviction.

At the same time, humanitarian assistance was often directed primarily through collective shelters, leaving many persons with disabilities living in private accommodation with more

limited access to support. In some cases, the need for ground-floor accommodation, continuous water access or proximity to essential services increased households' exposure to rising rents and other housing-related pressures. One documented case in Saida involved monthly rent increasing from USD 1,200 to USD 1,700, leaving the family with no viable alternative.

A case documented by Arcenciel illustrates the compounded barriers that persons with disabilities may face during displacement:

An older man with tetraplegia in Aley, who had lost two family members during the conflict, was found sleeping on a mattress without a wheelchair or medical bed. Unable to access the bathroom and without adequate assistance, he had reduced his food intake to avoid needing to use the toilet. Following a referral, Arcenciel provided him with a wheelchair and a medical bed, enabling him to access the bathroom with greater dignity and improving his living conditions.

— ARCENCIEL CONSULTATION, 2026

Communication barriers further restrict access to humanitarian assistance, particularly for persons with hearing or speech disabilities. In the absence of sign language interpretation, accessible communication tools and trusted community networks, persons with sensory disabilities face significant challenges communicating with landlords, service

providers, municipalities and humanitarian actors, limiting their ability to access information, services and assistance.

LUPD outreach to its registered caseload identified 125 displaced persons with disabilities living in private housing in Beirut and Mount Lebanon, 89 in Saida and 104 in Bekaa. Approximately 40 per cent of those reached were women, and around 60 per cent had physical disabilities. These figures reflect LUPD's operational outreach and should not be interpreted as population-level estimates. While municipalities have registered displaced people arriving in their areas, available municipal records do not consistently capture disability status or disability type, limiting the ability of local authorities and humanitarian actors to identify persons with disabilities and respond to disability-related needs.

Hard-to-reach areas: A particularly serious concern is the number of persons with disabilities who remain in high-risk or hard-to-reach areas because they have been unable to evacuate safely. Reported barriers include mobility limitations, reliance on caregivers, the absence of disability-inclusive evacuation planning, limited accessible shelter options and inaccessible information. LUPD identified 192 individuals still residing in hard-to-reach areas in South Lebanon. In Bekaa, 78 of the 93 individuals contacted through municipalities were confirmed to still be living in hard-to-reach areas. The actual number is likely to be higher. LUPD has also documented two deaths among persons with disabilities in its database resulting directly from explosions.

A case documented by LUPD illustrates how inaccessible evacuation arrangements can prevent families from reaching safety:

A family from South Lebanon with two children with physical disabilities was unable to evacuate. The father, who also had limited physical capacity, was unable to carry both children or navigate the stairs of a collective shelter on his own.

— FOCUS GROUP DISCUSSION
WITH LUPD FIELD STAFF, 2026

Streets and public spaces: Persons with disabilities who are unable to access collective shelters or host community support are also living in streets and public spaces, where they face heightened protection risks, inadequate access to water and sanitation, and limited access to humanitarian assistance. Interviewed OPD representatives noted that this is linked, in part, to the shortage of accessible and appropriate shelter options. Some persons with disabilities are unable to access collective shelters, while others leave because conditions are inaccessible, unsafe or undignified.

OPDs have used their existing networks and hotlines to identify and support persons with disabilities living outside collective shelters. For example, the Learning Center for the Deaf reported that 70 families with members with hearing disabilities had contacted its hotline while living outside shelters. Although

these efforts have played an important role in identifying and supporting persons with disabilities, they remain dependent on the operational capacity of individual OPDs and cannot substitute for a coordinated system to identify, refer and support persons with disabilities living outside collective shelters.

A case documented by LUPD illustrates the barriers that some displaced families with disabilities faced in securing safe and affordable accommodation:

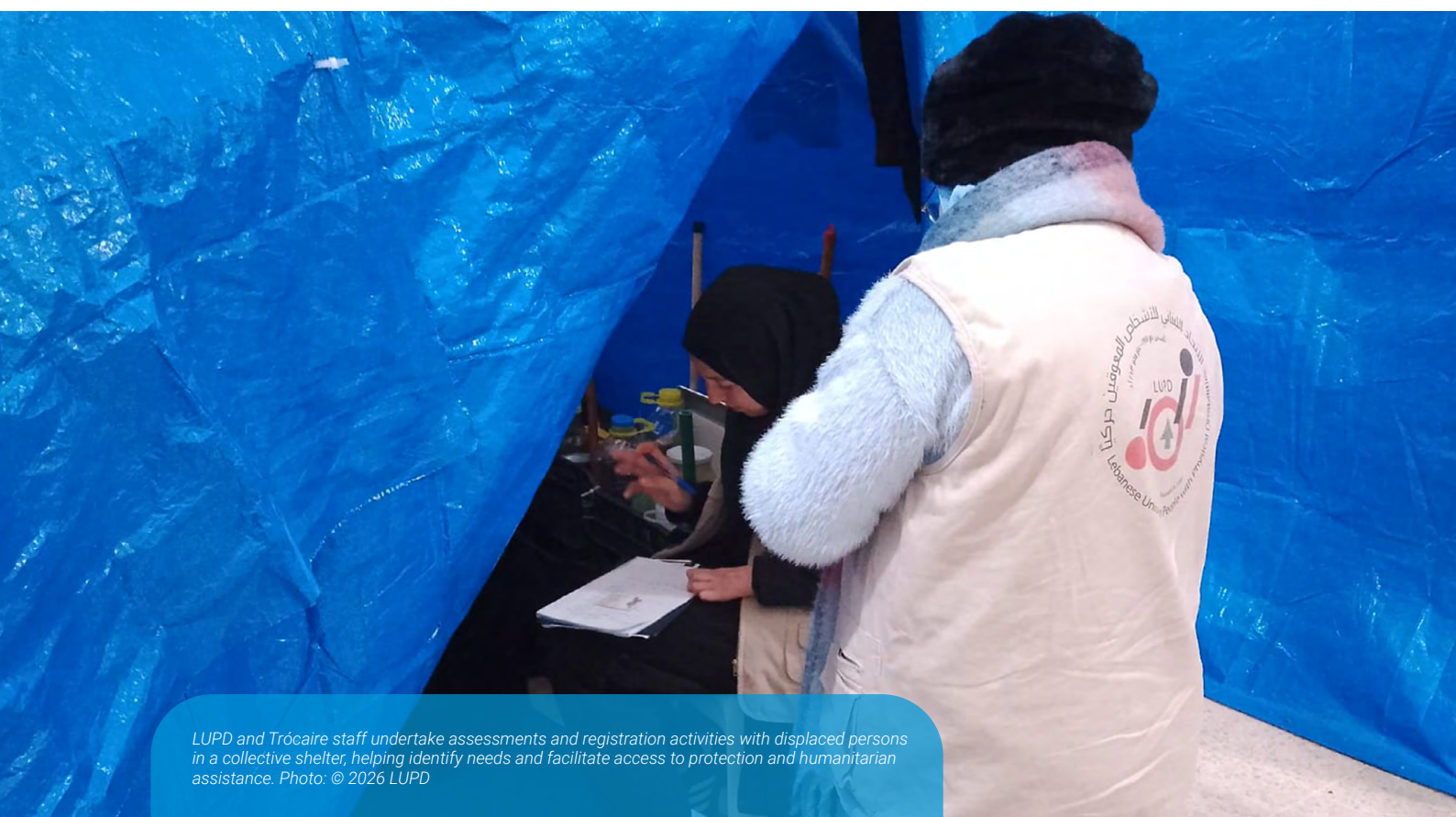
A Syrian family, a woman travelling from Nabatieh with her two daughters, both with visual impairments, and an older relative who had acquired a physical disability following a fall during displacement—was unable to afford the increased rent in Bar Elias. As a result, the family spent 10 days living in their car, with no organization able to reach them during that period.

— FOCUS GROUP DISCUSSION
WITH LUPD FIELD STAFF, 2026

A case documented by LUPD illustrates that referral to an accessible facility does not necessarily guarantee accessible accommodation:

A family in Sidon with two women, aged 25 and 32, with multiple disabilities—including physical, intellectual and speech disabilities—was referred to a facility described as accessible in Sidon. However, the family left after finding that it was not equipped to accommodate wheelchair users. They subsequently rented an unfurnished apartment in Hilaliyeh, where they were sleeping on the floor.

— FOCUS GROUP DISCUSSION
WITH LUPD FIELD STAFF, 2026



LUPD and Trócaire staff undertake assessments and registration activities with displaced persons in a collective shelter, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD

CURRENT RESPONSE



The barriers documented in the preceding sections—including inaccessible shelters, inconsistent prioritization, limited disability-disaggregated data and gaps in outreach beyond collective shelters—demonstrate that disability inclusion depends not only on accessible infrastructure and targeted assistance, but also on how humanitarian coordination, referral systems and institutional responsibilities are organized and implemented in practice. While consultations point to important progress since the 2024 response, they also indicate that disability inclusion remains uneven across coordination structures and operational sectors. This section examines the coordination mechanisms established during the emergency, identifies areas of progress, and highlights the principal gaps that remain.

The national emergency response is led through government structures, with the Ministry of Social Affairs (MoSA) designated as the lead ministry and the national Disaster Risk Management (DRM) Unit playing a central role in emergency coordination. In principle, disability inclusion should be mainstreamed throughout this broader response architecture, including across relevant ministries, DRM structures, municipalities, humanitarian sectors, humanitarian actors and Organizations of Persons with Disabilities (OPDs).

Evidence from consultations indicates, however, that this objective has not yet been implemented consistently in practice. Participants emphasized that persons with disabilities should not require a separate or

parallel response, but that disability inclusion has yet to be systematically embedded across sectors, collective shelters, referral systems and emergency coordination mechanisms. OPD representatives also reported that OPDs were not directly represented within DRM coordination structures at the time of the interviews. Although a representative had reportedly been proposed to support disability inclusion, no formal invitation to participate had been issued. According to participants, this limited opportunities for OPDs to contribute directly to real-time coordination and operational decision-making.

Despite these limitations, consultations identified several encouraging developments. Disability-specific coordination mechanisms, including the Emergency Task Force for Persons with Disabilities and the Disability Inclusion Working Group, have provided important platforms for OPDs, specialized service providers, UN agencies and humanitarian actors to coordinate referrals, health services, assistive devices, shelter assessments, technical guidance and advocacy. Participants noted that these mechanisms were not functioning in the same way during the 2024 response and appeared to have strengthened the visibility of disability inclusion within parts of the humanitarian coordination system. At the same time, consultations suggest that stronger technical coordination has not yet translated consistently into operational practice across the wider humanitarian response.

Preparedness activities undertaken before the escalation also appear to have strengthened elements of the response. Consultations highlighted disability inclusion and disaster risk reduction training delivered to Lebanese Red Cross (LRC) and DRM actors in January 2026, together with the Emergency Task Force's ongoing work on referral pathways, assistive devices, health needs and shelter accessibility. While it is not possible to directly attribute improvements in the response to these initiatives, they demonstrate the value of investing in disability-inclusive preparedness before emergencies occur.

Coordination with the Lebanese Red Cross was consistently identified as one of the more proactive examples of disability inclusion during the current response. Participants described regular communication between the LRC and OPDs, enabling faster information exchange, referrals and follow-up than during previous emergencies. In some collective shelters, OPD engagement also facilitated practical accommodations, including relocating persons with disabilities from upper floors to ground-floor rooms.

Consultations further highlighted municipalities as an underutilized resource for disability-inclusive emergency response. Their contribution was described as uneven, reflecting differences in local capacity, resources and commitment. Where municipalities had participated in disaster risk reduction and disability inclusion training, participants observed more inclusive treatment of persons with disabilities and older persons, greater attention to disability-related data, and more strategic approaches to emergency management. These experiences suggest that strengthening municipal capacity could improve disability-inclusive preparedness, identification, referrals and local response.

Despite these positive developments, consultations consistently pointed to a gap between coordination structures and operational implementation. Disability-related policies, guidance and technical tools are increasingly visible but have not yet been translated consistently into practice across sectors, collective shelters and geographic locations. This implementation gap is reflected in the issues documented throughout this alert, including inaccessible shelters, inconsistent prioritization, unclear referral pathways, limited disability-disaggregated data and gaps in outreach beyond collective shelters.

Referral pathways also remain uneven. Persons with disabilities and their families may continue to face difficulties identifying where to seek assistance, report concerns or request services. This has particular implications for women and girls with disabilities, whose access to protection services, gender-based violence (GBV) referrals, sexual and reproductive health services, caregiving support and other specialized assistance often depends on timely identification and effective coordination across multiple actors. OPDs frequently verify needs directly with individuals before providing support—a necessary safeguard to ensure dignity, appropriateness and accuracy, particularly for assistive devices—but one that can add time to an already delayed response. OPDs also reported that access procedures and administrative approvals may slow their ability to assess needs and provide assistance within collective shelters.

The most responsive component of the disability response continues to be OPD-led coordination, often relying on direct follow-up and informal communication channels. This has enabled timely support, including referrals, assistive devices, accessible accommodation,

communication support and disability-related items not covered through standard humanitarian distributions (see Box 1).

Participants emphasized that persons with disabilities and their representative organizations should be recognized not only as recipients of assistance but also as technical experts with first-hand knowledge of what makes services accessible, safe and usable in practice. Consistent with UN Women's intersectional approach, this also requires the meaningful participation of women and girls with disabilities in the design, implementation and monitoring of humanitarian services, particularly where decisions affect shelter safety, privacy, GBV risk mitigation, sexual and reproductive health, caregiving support, and accessible complaints and feedback mechanisms⁶.

Taken together, these findings suggest that disability inclusion has become more visible within humanitarian coordination structures but remains insufficiently institutionalized across the wider response. Progress continues to depend heavily on the initiative, technical expertise and operational capacity of OPDs rather than on systematically accessible systems and procedures. Moving from ad hoc accommodation to a more predictable disability-inclusive response will require clearer institutional responsibilities, accessible referral pathways, systematic use of OPD expertise, disability-inclusive communication and dedicated resources across sectors.

Across LUPD assessments, financial support and food emerged as the most consistently reported needs, identified by all persons with disabilities assessed. However, these were only part of a broader range of unmet needs. Findings presented throughout this alert also



PRIORITY NEEDS AND SECTORAL GAPS

highlight urgent requirements for medication, assistive devices, rehabilitation services, medical assistive materials, accessible accommodation, hygiene items and other disability-specific support that cannot be adequately addressed through standard humanitarian distributions. Together, these findings reflect both the immediate loss of income associated with displacement and the additional costs linked to disability. For many persons with disabilities, displacement disrupted livelihoods and deepened pre-existing barriers to employment, increasing reliance on humanitarian assistance within an already constrained funding environment.

Cash assistance is particularly important because disability-related costs are highly individualized and frequently extend beyond the scope of standard humanitarian assistance packages. LUPD documented needs including blended food, oversized adhesive pads, colostomy kits, hearing aid repairs, assistive devices, medication, appropriate beds and other disability-specific items that are rarely available through generic relief distributions. OPD representatives similarly emphasized that standardized assistance packages do not always respond to individual disability-related needs, particularly where assistance requires assessment, adaptation, fitting, medical supervision, repair or ongoing follow-up. These findings highlight the importance of flexible and individualized assistance that can respond to the diverse needs of persons with disabilities while preserving dignity, choice and equitable access to humanitarian support.

6. UN Women. 2025. [30 years of Beijing Platform for Action: An intersectional approach to gender and disability inclusion](#).

BOX 1

Examples of disability-related response initiatives underway

Several disability-related initiatives are underway and provide important entry points for support. While these efforts represent important progress, consultations and field evidence indicate that they do not yet address the full scale or diversity of needs documented by LUPD, OPDs and other disability actors consulted for this alert.

- **Emergency social protection through the National Disability Allowance:** MoSA, UNICEF and the ILO announced emergency financial support through the National Disability Allowance on 12 March 2026. The support includes a one-off USD 100 payment for approximately 6,000 families of children with disabilities aged 0–19 already enrolled in the NDA, benefiting around 24,000 individuals. Scheduled regular NDA payments for all 34,000 enrolled persons with disabilities were also advanced. This is an important use of national social protection systems during the emergency, while remaining limited to persons and families already enrolled in the programme.⁷
- **Assistive devices and essential services:** Humanity & Inclusion reported that, under the leadership of the Ministry of Public Health, it was providing emergency response and essential services – including assistive devices – to displaced persons with disabilities and older persons at Bir Hassan Shelter in Beirut as of 22 April 2026.⁸
- **Assistive devices through Arcenciel:** Arcenciel's disability response includes wheelchairs, crutches, hearing aids, prosthetics and other assistive devices, with assessments, custom fittings and training for displaced and war-affected persons, including children and older persons. Public reporting notes that these services are provided through centres in Beirut, Bekaa, the South and other regions.⁹
- **OPD-led food assistance and inclusive livelihoods:** LUPD's Access Kitchen initiative, supported by UN Women through the generous funding of the Government of Australia, together with CBM and other partners, provides an example of an OPD-led humanitarian response that combines food assistance with inclusive livelihood opportunities. According to LUPD, the Access Kitchen has remained operational throughout the current emergency in Zahle, Beirut and South Lebanon, providing hot meals to displaced families, including persons with disabilities, while creating livelihood opportunities through the active participation and leadership of women and persons with disabilities. The initiative demonstrates how disability-inclusive humanitarian action can simultaneously address immediate humanitarian needs and promote economic inclusion.
- **Accessible communication:** The Learning Centre for the Deaf produced sign-language video messages explaining how to complete the MoSA registration process. This OPD-led initiative, helped reach displaced persons with hearing disabilities who were not adequately served by standard written or verbal communication channels.

These initiatives demonstrate that disability-related support is being delivered through national systems, humanitarian programmes, OPD-led initiatives and specialized disability actors. However, consultations and field evidence indicate that coverage remains uneven and does not yet match the scale and diversity of needs identified through this alert. Many persons with disabilities, particularly those living outside collective shelters, those not enrolled in formal assistance systems, non-Lebanese persons with disabilities, and those requiring individualized support, remain difficult to identify, refer and reach.

7. UNICEF. 2026. "Ministry of Social Affairs, UNICEF and ILO Announce Emergency Cash Support for Children and Persons with Disabilities Affected by the Conflict." 11 March. <https://www.unicef.org/lebanon/press-releases/ministry-social-affairs-unicef-and-ilo-announce-emergency-cash-support-children-and->

8. Humanity & Inclusion. 2026. "HI thanks the Ministry of Health for its leadership and support." 24 April. <https://www.hi.org/en/news/hi-thanks-the-ministry-of-health-for-its-leadership-and-support->

9. Arcenciel. 2026. "Supporting displaced persons with disabilities with assistive devices," Instagram post, 11 March. <https://www.instagram.com/p/DVvRQfICg9S/>

The table below summarizes the principal sectoral gaps identified through the data collection and analysis undertaken for this alert.

TABLE 1

Sectoral gaps snapshot

Sector	Key disability gap
Assistive devices and evacuation	Assistive devices were often left behind during flight. Generic devices are not fitted to individual needs, limiting mobility, communication, autonomy and access to information. Support often requires individual assessment, fitting, adaptation and follow-up.
Health and rehabilitation	Access to specialist medication, appropriate beds, wound care, rehabilitation, pressure sore prevention and post-surgical follow-up remains limited. Interviewed OPD representatives specifically raised gaps in medication and beds in shelters. New conflict-related disabilities are not systematically identified or linked to rehabilitation pathways.
Water, sanitation, hygiene (WASH) and dignity	Toilets and bathing facilities are often inaccessible, lack privacy or are located far from where persons with disabilities are staying. Limited water access increases risks of urinary tract infections, dermatitis, pressure sores and other health complications.
Livelihoods and economic security	Displacement has disrupted income sources for many persons with disabilities, deepening pre-existing barriers to employment and increasing reliance on humanitarian assistance. Cash and livelihood responses do not consistently account for additional disability-related costs.
Food security	Persons with disabilities may be unable to queue, reach distributions or carry food parcels. Standard food packages do not consistently address disability-specific nutritional needs, including blended or soft foods.
Mental health and psychosocial support	MHPSS is not consistently adapted for persons with intellectual, psychosocial or communication-related disabilities, older persons, children with disabilities or caregivers. Displacement, loss of routine, repeated exposure to conflict and inaccessible shelters may further heighten distress, particularly for persons with intellectual or psychosocial disabilities and children who require stability, explanation and support.
Protection and complaints	Persons with disabilities may not know where to seek support, report concerns or request services. Complaint and referral mechanisms are not consistently accessible, and persons with disabilities are not systematically prioritized in shelters, aid distribution or protection services.
Accessible communication and information	Information on registration, assistance, safety and referrals is not consistently available in accessible formats, including sign language, visual formats, easy-read materials, audio or supported communication. Limited Internet and phone access further restrict communication, especially for persons outside shelters and persons with hearing, visual, intellectual or communication-related disabilities.
Sexual and reproductive health	Menstrual hygiene products are inconsistently distributed, and SRH information and services are not adapted for women and girls with disabilities.



Displaced from the South and Southern Suburbs of Beirut taking refuge in the streets in Ain Al Mraiseh, Beirut. Photo: UN Women Lebanon / Georges Roukoz

WOMEN AND GIRLS WITH DISABILITIES



INTERSECTING RISKS OF GENDER, DISABILITY AND DISPLACEMENT

Since 2 March 2026, an estimated 620,000 women and girls have been displaced, representing more than half of the total displaced population. Conflict and displacement do not affect all displaced people equally; rather, they tend to deepen pre-existing inequalities and create new forms of exclusion. For women and girls with disabilities, the intersection of gender, disability and forced displacement gives rise to multiple and overlapping barriers that shape their exposure to risk, access to humanitarian assistance and ability to exercise their rights. These intersecting factors increase exposure to gender-based violence (GBV), restrict access to sexual and reproductive health (SRH) services, limit access to information, humanitarian

assistance and protection mechanisms, and increase dependence on caregivers, relatives, landlords or service providers. Risks are further compounded by physical barriers that may prevent women and girls with disabilities from moving away from unsafe situations, communication barriers that can impede reporting abuse or requesting assistance, and discriminatory social norms and stigma that may discourage or prevent them from seeking support safely, independently and confidentially.

One of the most immediate, yet often under documented, consequences of displacement is the loss of the familiar and adapted environments that many women and girls with disabilities depend on to live safely

and independently. Prior to displacement, many had established physical, social and psychological support systems that enabled greater autonomy, privacy, communication and participation in daily life. These included familiar layouts within the home, trusted caregivers or neighbours, established relationships with service providers, accessible sleeping and bathing arrangements, and well-established ways of communicating needs. Displacement can dismantle these support systems almost immediately, particularly when women and girls move into overcrowded collective shelters, unfamiliar host arrangements or inaccessible housing.

The consequences extend well beyond the loss of physical space. When familiar environments and support networks are disrupted, everyday activities that were previously manageable—including using the bathroom, changing clothes, requesting assistance, moving around safely, managing menstruation and avoiding unwanted attention—may become difficult, unsafe or undignified. These changes can reduce privacy, independence and personal autonomy while increasing dependence on others for routine daily activities. They may also heighten exposure to protection risks and further limit access to essential services and

humanitarian assistance, particularly where shelters, referral pathways and communication systems are not designed to be accessible or responsive to the needs of women and girls with disabilities.



From the moment we were displaced, I have not felt safe. In my home, I knew every corner and every path and felt comfortable sleeping. Here, we live in the unknown, in a place I know nothing about. When I hear any sound I become frightened. I live with strangers. I cannot change my clothes. Getting to the bathroom is very difficult, and sleeping here is hard. I feel as if I am losing a part of myself. I am afraid of being harassed or attacked. I remain afraid and cautious of everything, and every day my anxiety grows.

—JUMANA (PSEUDONYM), WOMAN WITH A PHYSICAL DISABILITY, DISPLACED FROM HER HOME (LUPD TESTIMONY COLLECTION, 2024)



LUPD and Trócaire staff and volunteers package hygiene kits for distribution to displaced women and girls, supporting access to essential hygiene supplies during the humanitarian response. Photo: © 2026 LUPD



The displacement has affected me a great deal. The place is somewhat safe, but I cannot get what I need, and the people around me do not know how to deal with me. Before, I was integrated into society, I worked and volunteered and people around me knew me. But everything has changed because of the war. I have also been affected physically because I am confined among people and the density of the space.

—SUHA (PSEUDONYM), WOMAN WITH A DISABILITY, DISPLACED TO A COLLECTIVE SHELTER (LUPD TESTIMONY COLLECTION, 2024)

Across these testimonies, a recurring theme is not only physical hardship but also the loss of safety, belonging, autonomy, privacy, identity and meaningful participation in family and community life. These dimensions of well-being are often less visible in humanitarian assessments and responses, yet they are fundamental to the dignity, protection and recovery of women and girls with disabilities during displacement.



GBV: ELEVATED AND UNDERREPORTED RISKS

Conflict and displacement increase the risk of gender-based violence (GBV) for all women and girls. For women and girls with disabilities,

these risks are further intensified by the interaction of gender inequality, disability and forced displacement. Physical inaccessibility, overcrowded living conditions, lack of privacy, increased dependence on others for daily support, inaccessible complaints and reporting mechanisms, and unequal access to confidential services combine to increase exposure to violence while simultaneously reducing opportunities to seek protection and assistance. These intersecting barriers mean that women and girls with disabilities may face both a greater risk of violence and greater obstacles to accessing support once violence occurs.

Evidence from UN Women's Rapid Gender Assessment conducted during the 2024 crisis illustrates the broader protection environment affecting displaced women and girls. The assessment found that 57 per cent of women did not know how to report GBV, while 69 per cent of adolescent girls and young women lacked privacy in collective shelters¹⁰. At the same time, more than 85 per cent of displaced women and girls are living outside formal shelter settings—in host families, rented accommodation or informal arrangements—making them less visible to GBV prevention, risk mitigation and response.¹¹

GBV affecting women and girls with disabilities is likely to remain significantly underreported. During displacement, many women with disabilities may not identify themselves as survivors of GBV, particularly when immediate survival priorities—including food, shelter, medication, personal safety and the protection of family members—take precedence. Communication barriers, dependence on caregivers, fear of losing essential support,

10. UN Women Lebanon. 2026. Rapid Gender Analysis: Gendered impacts of displacement outside collective shelters in Lebanon. March.

11. UN Women Lebanon. 2026. "It feels like the whole world is complicit." April.

social stigma and inaccessible reporting mechanisms may further discourage disclosure. Nevertheless, testimonies collected for this alert indicate that violence, coercion, neglect and psychological abuse have intensified during displacement.

Displacement also alters power relations in ways that may increase vulnerability to abuse and exploitation. Economic dependence can deepen when women with disabilities lose livelihoods or become increasingly reliant on partners, relatives, landlords or caregivers for accommodation, mobility or daily support. Families requiring ground-floor accommodation, reliable water access or proximity to essential services may experience additional pressure within housing markets or face exploitative housing arrangements. Within collective shelters, overcrowding, the absence of sex-segregated bathrooms, inadequate locks and limited private space further undermine safety and dignity. Women with mobility impairments may be unable to move away from threatening situations, while women and girls with intellectual disabilities may face additional barriers to recognizing abuse, disclosing violence or safely accessing standard reporting and referral mechanisms. OPD representatives also reported strong resistance to tent-based accommodation, particularly among families with girls, because of concerns relating to safety, privacy, dignity and protection.

Consultations further highlighted that physical accessibility alone does not ensure protection. A shelter described as accessible or inclusive may nevertheless remain unsafe or unsuitable for women with disabilities and persons

with intellectual disabilities where privacy, appropriate support, safe shelter design and accessible complaints and feedback mechanisms are absent. These findings demonstrate that accessibility and protection cannot be considered separately; both must be addressed simultaneously to ensure that women and girls with disabilities can access assistance safely and with dignity.

Access to GBV services for women and girls with disabilities has also deteriorated during the current crisis and varies considerably across geographic areas. In some locations, available services are limited primarily to psychological support. In hard-to-reach and high-risk areas, services were already limited before the escalation of hostilities, and some organizations have since closed service centres or shifted to remote delivery. For many women and girls with disabilities, remote services may themselves be inaccessible because they lack privacy, reliable internet connectivity, appropriate devices or safe communication channels. Existing complaints and referral mechanisms frequently assume levels of communication, privacy and self-advocacy that are not available in collective shelters or overcrowded housing, particularly for women and girls with intellectual or communication-related disabilities. As a result, women and girls with disabilities may face barriers at every stage of the protection pathway—from identifying risks and disclosing violence to accessing services, referrals and justice.



SEXUAL AND REPRODUCTIVE HEALTH AND MENSTRUAL HYGIENE

Sexual and reproductive health (SRH), including menstrual hygiene management, remains a critical yet insufficiently addressed area of the humanitarian response for women and girls with disabilities. Menstrual hygiene products were not distributed consistently across collective shelters, and available items often did not meet disability-specific or medical needs. At the same time, inaccessible bathrooms, overcrowded living conditions, lack of privacy and limited access to adapted SRH information created additional barriers for women and girls with physical, intellectual or multiple disabilities, reducing their ability to manage menstruation safely, independently and with dignity.

For women and girls with physical disabilities, managing menstruation in inaccessible bathrooms or shared spaces can be extremely difficult and may increase dependence on others for personal care while exposing them to humiliation and health risks. For women and girls with intellectual disabilities, standard SRH awareness sessions are often inaccessible because they are not adapted to different communication needs, cognitive accessibility requirements or privacy considerations. Consultations also indicated that some women and girls felt unable to request menstrual hygiene products in shared settings because of embarrassment, lack of privacy or fear of stigma.

These findings illustrate that barriers to SRH extend beyond the availability of supplies. They also reflect broader challenges relating to accessibility, privacy, communication, dignity and the adaptation of services to the diverse needs of women and girls with disabilities.

The following cases illustrate how gaps in SRH services and menstrual hygiene management intersect with disability, privacy, caregiver support and dignity during displacement.



A woman in her early thirties with an intellectual disability, displaced from the south to a shelter in Bekaa, was refusing to use pads – apparently because prior to displacement someone had been supporting her with this. Shelter residents became concerned when she had blood on her clothing. The situation became known to everyone in the shelter, causing significant distress to the woman. Shelter focal points were responsive but did not know how to handle the situation. General sessions on sexual and reproductive health were being conducted, but they were not adapted for women with intellectual disabilities.

—FGD WITH LUPD FIELD STAFF, 2026



A young migrant woman from the South, living with her two daughters in a Husseiniyeh in a village, has two daughters with physical and intellectual disabilities who also have diabetes and obesity. Their condition requires specialized, high-absorbency pads costing approximately USD 18 each. “Despite the distribution of generic pads, the needs of the girls remained unmet.

—FGD WITH LUPD FIELD STAFF, 2026

These cases demonstrate that menstrual hygiene management is not simply a gap in the distribution of non-food items (NFIs). For women and girls with disabilities, it is fundamentally a matter of dignity, health, privacy, protection and the realization of sexual and reproductive health rights. Addressing these needs requires more than the provision of menstrual hygiene products. SRH and NFI interventions should be adapted to different disability types, communication and accessibility requirements, caregiver arrangements, and the realities of overcrowded collective shelters and other displacement settings to ensure that women and girls with disabilities can manage menstruation safely, independently and with dignity.



CAREGIVERS OF PERSONS WITH DISABILITIES

Caregivers of persons with disabilities remain largely invisible within humanitarian responses, despite their essential role in ensuring the

safety, well-being and daily functioning of persons with disabilities during displacement. In Lebanon, care is provided predominantly within families because of limited formal care and support services. Within these family-based care arrangements, caregiving responsibilities fall overwhelmingly on women and girls, reflecting long-standing gender inequalities and the unequal distribution of unpaid care work. As a result, displacement not only increases humanitarian needs but also deepens pre-existing gender inequalities by significantly expanding women’s caregiving responsibilities at a time when their own access to resources, services and support is simultaneously reduced.

Displacement places additional physical, emotional and financial pressures on caregivers. Collective shelters generally do not provide dedicated caregiving support, while overcrowding, inaccessible environments and the uncertainty associated with displacement make providing care substantially more difficult than in familiar home settings. The loss of assistive devices and adapted equipment further increases the physical demands placed on caregivers, many of whom must compensate manually for equipment that is no longer available. At the same time, caregiving responsibilities may reduce opportunities to access humanitarian assistance, earn an income, participate in community life or attend to their own health and well-being.

Field evidence also indicates that caregiving responsibilities can directly influence displacement decisions and access to safety. In some documented cases, women caregivers and the persons they supported were left behind because their presence was perceived as complicating evacuation or because host families were considered unlikely to accommodate them. These

experiences demonstrate that caregiving is not only a household responsibility but also a factor influencing evacuation, displacement pathways, protection risks and access to humanitarian assistance.

For women caregivers who are themselves persons with disabilities, these challenges are further compounded. They must manage their own disability-related needs while simultaneously providing care to injured or

disabled family members in environments where formal support systems, assistive services and opportunities for respite are largely absent. The intersection of disability, gender and caregiving responsibilities can increase physical exhaustion, emotional strain and dependence while further limiting access to healthcare, humanitarian assistance, psychosocial support and other essential services.



A case documented by LUPD illustrates the additional caregiving burden experienced by many women during displacement::

A 60-year-old woman was caring for her 70-year-old husband, who had a physical disability and cancer and relied on diapers, while living in a collective shelter with no accessible bathroom or dignified space to change him. She was managing his personal hygiene alone, without adequate supplies or assistance, in a shared space with other displaced families.

— A 60-YEAR-OLD WOMAN WAS CARING FOR HER 70-YEAR-OLD HUSBAND, WHO HAD A PHYSICAL DISABILITY AND CANCER AND RELIED ON DIAPERS, WHILE LIVING IN A COLLECTIVE SHELTER WITH NO ACCESSIBLE BATHROOM OR DIGNIFIED SPACE TO CHANGE HIM. SHE WAS MANAGING HIS PERSONAL

Across the consultations, caregiving emerged not simply as an individual or family responsibility, but as a critical yet often overlooked dimension of disability-inclusive humanitarian response. The findings demonstrate that the well-being of persons with disabilities is closely linked to the well-being, capacity and support available to their

LUPD and Trócaire staff undertake assessments and registration activities with displaced persons in a collective shelter, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD

caregivers. When caregivers lack assistance, accessible services or opportunities for respite, the consequences extend beyond the caregiver to affect the safety, dignity and well-being of the persons with disabilities who depend on them.

The consequences of unsupported caregiving are significant but often remain invisible within humanitarian responses. Caregivers experience considerable physical, emotional and psychological strain, particularly where displacement is prolonged or repeated, or where the person they support requires ongoing personal care, medication, assistive devices or continuous supervision. Consultations also indicated that some caregivers isolate themselves within shelters to avoid stigma or negative reactions from co-residents and shelter staff. This isolation can further reduce access to information, humanitarian assistance, distributions and psychosocial support. In some documented cases, the absence of appropriate medical and caregiving support led families to adopt unsafe coping strategies in an effort to manage complex care needs on their own.

The findings also suggest that humanitarian responses often address the needs of caregivers and persons with disabilities separately, despite their strong interdependence. The well-being, safety and dignity of many persons with disabilities are closely linked to the well-being and capacity of those providing daily care. Where caregivers lack appropriate support, respite, accessible services or mental health and psychosocial support, the consequences extend beyond the caregiver to affect the protection, health and well-being of the persons with disabilities who depend on them.



LUPD and Trócaire staff undertake assessments and registration activities with displaced persons in a collective shelter, helping identify needs and facilitate access to protection and humanitarian assistance. Photo: © 2026 LUPD

RECOMMENDATIONS

The findings of this alert demonstrate that disability inclusion should not be treated as a stand-alone or specialized intervention. Rather, it should be systematically integrated across humanitarian preparedness, response, early recovery and recovery efforts through an intersectional, rights-based and gender-responsive approach that recognizes persons with disabilities, particularly women and girls with disabilities, as rights holders and active participants in humanitarian action.

The recommendations below are organized around immediate humanitarian priorities and longer-term systems strengthening. They are directed to the Government of Lebanon, humanitarian leadership, UN agencies, donors, municipalities, humanitarian partners and Organizations of Persons with Disabilities (OPDs), and are grounded in the findings presented throughout this alert.

Data, identification and registration

- **Standardize disability identification across response systems.** MoSA, DRM, UN agencies, NGOs and municipalities could align definitions of disability and use a consistent approach to identification to avoid both undercounting and misclassification.
- **Apply the Washington Group Questions across registration systems.** The Washington Group Questions should be used consistently in shelter registration, municipal displacement registers and MoSA's self-registration platform, with training for staff and volunteers responsible for data collection.
- **Establish safe mechanisms for sharing aggregated disability-disaggregated analysis.** Relevant government bodies and

humanitarian partners could establish a protected mechanism for regularly sharing aggregated disability-disaggregated analysis from registration systems, shelter monitoring, municipal records and OPD outreach, while ensuring data protection and confidentiality. Where available, analysis should be disaggregated by sex, age, disability type, location, shelter status, nationality and data source.

- **Strengthen municipal disability data collection.** Municipalities and unions of municipalities should be equipped and trained to identify and record disability-related needs among displaced people, including those outside collective shelters.

Shelter, accessibility and physical infrastructure

- **Designate and resource inclusive shelters in each governorate, and where possible in each district.** At least one inclusive model shelter should be identified and resourced in each governorate, with efforts made to expand this to the district level where feasible, particularly in high-receiving areas such as Bekaa and Mount Lebanon. These shelters should apply agreed minimum accessibility and protection standards, establish clear procedures to prioritise admission for persons with disabilities, and be clearly communicated to persons with disabilities, their families, OPDs, municipalities, and referral actors. OPDs should be supported to help identify and refer persons with disabilities in their networks to these sites as early as possible, before capacity is reached.

- **Develop alternative accessible accommodation options for persons with disabilities with high support needs.**

Collective shelters may be unsuitable for some persons with intellectual, psychosocial, communication-related or multiple disabilities, particularly where families require privacy, routine, supervision, or personal assistance. Relevant government bodies, municipalities, OPDs and humanitarian actors could identify and resource small-scale, accessible and supported accommodation options, including private housing, community spaces, or specialised facilities where appropriate. Municipalities could play an important role in identifying suitable local spaces and facilitating referrals, provided they are supported with resources, technical guidance and clear protection safeguards.

- **Establish minimum accessibility standards for shelter activation.** Relevant government bodies, DRM-related structures, shelter actors, municipalities, OPDs and partners could adopt a practical checklist for shelter accessibility, including entrances, internal pathways, ground-floor accommodation, accessible WASH, privacy and complaint/referral access.

- **Prioritize accessible rooms and WASH facilities for persons with disabilities.** Shelter management should prioritize ground-floor rooms and nearby accessible bathrooms for persons with disabilities, particularly those with physical disabilities, older persons with disabilities, women and girls with disabilities, and persons requiring personal assistance.

- **Implement immediate accessibility and privacy modifications.** High-density shelters could be supported to

install low-cost accessibility and privacy modifications such as ramps, grab bars, bathroom locks, privacy solutions, widened access points where possible and accessible bathing/toilet arrangements. Public buildings designated for repeated emergency use should receive permanent accessibility upgrades in line with Law 220/2000.

- **Map accessible shelters and referral options.** Shelter actors, relevant government structures, OPDs, municipalities and UN agencies could jointly maintain and update a map of shelters with accessibility features, including what types of disability-related needs each site can accommodate.

Humanitarian assistance, health and rehabilitation

- **Provide targeted cash assistance for disability-related costs.** Cash assistance should include disability-related top-ups or targeted support for households with persons with disabilities, recognizing costs that generic assistance does not cover, including specialized nutrition, transport, assistive-device repairs, communication needs, hygiene items, menstrual hygiene products and individual support requirements. Women with disabilities, caregivers, persons outside collective shelters and non-Lebanese persons with disabilities should be considered in vulnerability and prioritization criteria, where relevant.

- **Provide disability-specific items not covered by standard distributions.** Humanitarian actors should prioritize disability-specific items identified by persons with disabilities and OPDs, including quality diapers, catheters,

colostomy bags, pressure-relief materials, specialized hygiene items, blended or soft foods and other items not consistently available through generic aid packages.

- **Provide assistive devices through individual assessment, fitting and follow-up.** Wheelchairs, walkers, crutches, hearing devices, mattresses, medical beds, shower chairs, commode chairs and other assistive devices should be provided based on individual assessment, appropriate specifications, fitting, user training, repair and follow-up. Generic assistive-device distribution should be avoided.
- **Strengthen access to medication, wound care and rehabilitation.** Health actors and relevant partners should strengthen referral pathways for persons with disabilities requiring specialist medication, wound care, pressure sore management, post-surgical follow-up, physiotherapy and rehabilitation. Medication support should be handled through appropriate medical supervision and referral systems, not treated as a generic distribution item. Where services cannot be provided in shelters, mobile medical and rehabilitation teams should be deployed.
- **Create pathways for newly acquired disabilities.** People injured during the escalation should be systematically identified, assessed and referred to rehabilitation, assistive devices, psychosocial support and

Protection, GBV, SRH and MHPSS

- **Make complaint and referral mechanisms accessible.** Shelter actors, protection partners, OPDs and relevant government counterparts could strengthen accessible

complaint and feedback systems to persons with physical, sensory, intellectual, psychosocial and communication-related disabilities. Hotlines and leaflets should be accompanied by active explanation, confidential support and accessible formats.

- **Adapt GBV, SRH and MHPSS services for persons with disabilities, where relevant.** GBV case management, SRH information, menstrual hygiene support and MHPSS should be adapted for women and girls with disabilities, older persons with disabilities, caregivers and persons with intellectual, psychosocial and communication-related disabilities. Services should use accessible formats, provide privacy, and be coordinated with OPDs and protection actors.
- **Provide sustained MHPSS and caregiver support beyond the acute phase.** Humanitarian actors should prioritize resources for peer support, caregiver-focused MHPSS, respite options and post-crisis mental health support for persons with disabilities and their caregivers, particularly those affected by repeated displacement, loss of routine and high-support care responsibilities.

Coordination, communication and preparedness

- **Strengthen OPD participation in response coordination and decision-making.** Coordination leads, UN agencies, DRM-related structures and relevant government and humanitarian actors could strengthen structured OPD participation in operational and coordination spaces, including DRM/DRR structures, shelter coordination, protection coordination, gender/GBV coordination and inter-sector discussions. Persons with disabilities and



Persons with disabilities and representatives of LUPD participate in a press conference in Beirut advocating for accessible services, inclusive emergency response, and the protection of the rights and dignity of displaced persons with disabilities. Photo © 2026 LUPD

- their representative organisations should be engaged as experts and technical partners in the design, implementation and monitoring of inclusive services, not only consulted as beneficiaries. Participation would be most effective when resourced, linked to clear follow-up mechanisms and treated as technical partnership rather than ad hoc consultation.
- **Establish or strengthen disability-inclusion focal points across sectors and coordination structures.** Relevant sectors, DRM-related structures and shelter coordination mechanisms would benefit from trained disability-inclusion focal points who can coordinate with OPDs, support referrals, review sector tools, monitor implementation and follow up on disability-related barriers raised by persons with disabilities and OPDs.
 - **Strengthen municipalities as active partners in the disability response.** Municipalities should be supported as key local actors in disability-inclusive preparedness and response, including through training, resources, and clear roles to collect disability-disaggregated data, apply inclusive standards, support referrals, and coordinate with OPDs and service providers.
 - **Map disability-related services and partner capacity.** Relevant coordination actors, including the ETF, OPDs, UN agencies, NGOs, specialised service providers and the LRC, could develop and regularly update a shared mapping of services for persons with disabilities, including partner capacity, geographic coverage, referral pathways, eligibility criteria and current caseload where appropriate. This would help identify gaps, reduce duplication, strengthen referrals and support more targeted advocacy and resource mobilisation.
 - **Mainstream accessible communication across the response.** MoSA, DRM-related structures, municipalities, UN agencies and humanitarian actors are encouraged to make key information on registration, assistance, safety, referrals, complaints and services available in multiple accessible formats, including easy-read, pictorial, audio, visual and sign-language-supported formats. OPDs could be funded and supported to provide interpretation, accessible communication content, hotlines and referral support where direct communication services are not feasible.

- **Facilitate timely OPD access to shelters and affected communities.** During emergencies, approval processes for OPDs and humanitarian organizations to visit shelters, assess needs, verify referrals and follow up with persons with disabilities could be streamlined through clear authorization procedures, designated focal points and safeguards for dignity, consent and data protection.
- **Provide direct, flexible and sustained funding to OPDs.** Donors, UN agencies and humanitarian partners should prioritize direct and flexible funding to OPDs for outreach, technical guidance, referral support, assistive-device assessment and follow-up, accessible communication, shelter monitoring, community-based support and participation in coordination. Funding should cover staff time, transport, communication costs, interpretation, data collection and follow-up, rather than relying on unpaid OPD participation.
- **Integrate disability inclusion into emergency preparedness, response, and recovery systems.** Lessons from the 2024 and 2026 responses could be systematically documented and used to strengthen national DRR protocols, accessible evacuation planning, shelter preparedness, municipal response systems, inclusive social protection, and post-conflict reconstruction. Persons with disabilities and OPDs should contribute meaningfully to the development and testing of emergency response, recovery, reconstruction, and rehabilitation plans, so that disability inclusion is built in from the outset rather than retrofitted after decisions have been made.



We are here. We are doing well, and we have what we need. But there is one thing: please pass this on. People come to us, they ask questions, and then they leave. No one listens. It is time to listen—and let us speak.

— MOTHER OF A CHILD WITH AUTISM, FOCUS GROUP DISCUSSION WITH ORGANIZATIONS OF PERSONS WITH DISABILITIES (OPDS), 2026.



Dolly Attallah, 48, works in the LUPD Access Kitchen in Beirut.
Photo: UN Women/Lauren Rooney

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