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Launching a new series on non-communicable prevention in humanitarian settings

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During the first few months of the COVID-19 pandemic in 2020, we set out a call for papers on non-communicable disease (NCD) prevention in humanitarian settings. The purpose of this series is to provide evidence on the importance of preventative efforts to address the growing challenge of NCDs in humanitarian settings—those affected by ongoing conflict, early recovery or post conflict; refugee hosting nations; and regions providing cross-border care for conflict-affected populations.[1] The link between NCDs and poor outcomes of a COVID-19 infection made this series even more important.[2] Despite the overwhelming and unprecedented global effects of the pandemic, our call generated much interest with several submissions from diverse humanitarian settings such as Yemen, Syria, Thailand, Kenya, Libya and Venezuela. So far five papers and perspectives have been published in this series covering aspects such as adaptation of care for continuity of NCD services during the COVID-19 pandemic, strengthening technical capacity of front-line health workers to manage NCDs at primary care level, analysis of policy, institutions and type 2 diabetes as well as assessing NCD medicine supply systems for humanitarian systems.

The global humanitarian system is facing chronic economic and geopolitical challenges after emerging from COVID-19, challenges from Russia's invasion of Ukraine in February 2022 and crippling inflationary and domestic economic crisis in large donor countries. However, preventing NCDs is cost-effective, saves time and takes up far less humanitarian and development resources in the long term. What are the main messages of the papers published in the series so far and what is missing for tackling NCDs effectively in the long-term?

First, we learn how the COVID-19 pandemic has been a major setback for NCD prevention and how care for all NCDs had to be adapted or in some conflict-affected situations put on hold completely. A paper by Laura Miller *et al* suggests that adapting models of care in five humanitarian settings during the COVID-19 pandemic ensured continuity of care and prevented secondary complications among people living with NCDs. The study highlights how information on increased risk to certain sections of the population allowed for quick shifts in service delivery modalities ensuring access to sustained care. NCDs are increasing among key health risks for conflict-affected populations and countries. In Ukraine, millions of conflict-affected populations living with chronic conditions are at risk of acute exacerbations and death due to poor living conditions, limited access to essential medicines and interruption of care. Furthermore, attacks on healthcare has contributed to disruption of essential services including for NCDs.[3]

Second, the large influx of refugees and the COVID-19 pandemic have increased pressures on health systems in host nations, such as Turkey, Lebanon, Jordan and Uganda, exceeding these governments' ability to provide adequate care. This is cause for major concern, and further amplifies the already growing prevalence of NCDs in nations hosting displaced populations such as Poland, Jordan, Nigeria and several others.[4] When establishing health services in a humanitarian context, it is essential to respect the principle of equity. Resident or host populations should have access to similar services as Internally Displaced Persons (IDPs) and refugees.[5]

Third, there are several field-tested toolkits and guidelines available for NCD management in crisis situations. The Sphere Handbook (Humanitarian Charter) includes guidelines for integrating NCD management and prevention in the programming systems of humanitarian actors, although the costs of tackling these diseases and the long-term

commitment required to tackle them ha ve still not been achieved.[4] Challenges in continuity of care and medication access after the start of the conflict in several countries such as Libya, Sudan, Yemen, Syria, Central African Republic, Burkina Faso, Democratic Republic of Congo and many others were frequently reported, suggesting a need for integration of NCD programming (including mental health services) into primary healthcare and targeted intervention planning in future response efforts.[6] Programmes to address the high cost of both healthcare and medication need to be developed and aligned with the government's declaration of free healthcare and medications for displaced populations.[7] Strengthening the primary care workforce to deliver high-quality care for NCDs in refugee settings is also important as lessons learnt from a UNHCR (The UN Refugee Agency) partnership with Primary Care International to implement NCD trainings for front-line health workers shows. While this ensures continuity of care and addresses secondary prevention of NCD complications.

Fourth, enabling funding and partnerships is essential for stakeholders such as governments, stakeholders and policy-makers involved in the provision of social and health services for refugees; and they must partner to implement rigorous management plans necessary to address and control NCDs among this population in these unprecedented circumstances. Additionally, international and non-governmental organisations should consider seeking diversified funding, aiding in prioritisation for equitable policy change and preventative interventions for NCDs.[4] In order to address NCDs in a comprehensive way in humanitarian emergencies, a multistakeholder approach that includes healthcare providers, governments, humanitarian agencies and academic institutions as well as voices of people living with NCDs is required.[5]

Fifth, closer collaboration with non-health sectors such as food security, nutrition, shelter and site planning would support advocacy for preventive behaviour through healthier lifestyles.[6] Provision of healthy food is a particularly relevant example, as affected populations are often dependent on food distribution and choice/control of their diet therefore relies on humanitarian agencies. Also, smoke-free areas and sites for physical activities can be organised when planning a camp. Including patient education and patient-centred approaches at all levels of care by various healthcare workers is very important.[5]

Sixth, we are seeing much more interest in research from operational humanitarian agencies with International Committee of the Red Cross, International Rescue Committee, Médecins San Frontiers and Primary Care International conducting research on aspects of NCDs; these efforts must be scaled up further. Research schemes such as Enhanced Learning and Research for Humanitarian Assistance (ELRHA) and research for health in humanitarian crises have been supporting impactful evidence generation.[8] ELRHA has recently funded an NCD research prioritisation exercise led by International Rescue Committee (IRC) and the American University of Beirut.

But what is missing in the series so far? The most critical dimension of the prevention strategy is lifestyle management at the individual level, with a focus on policy actions, such innovations, which can help society to increase the awareness of risk factors management, to take health policy decisions at a country level and to develop a health strategy at the global level.[9] The ability to make healthy lifestyle choices is even more complicated in humanitarian and fragile settings with commercial determinants of NCDs, corporate behaviour and policy influence in humanitarian contexts. We also need to learn more about how the commercial beverage and ultraprocessed food sectors are taking advantage of these contexts. In addition, how can we work with policy-makers, health workers and people living with NCDs to innovate and capture learning on lessons learnt from different conflict-affected contexts? In September 2021, a virtual meeting on implementation of the WHO Framework Convention on Tobacco Control by countries experiencing complex emergency situations (Afghanistan, Iraq, Libya, Sudan, Syria and Yemen) was held to discuss to participate in efforts to tackle tobacco use in these contexts as well as other conflict-affected ones. This is an important development for tobacco-control policies in conflict-affected situations.[10] Also, absent from our series is age-related and gender-related challenges in addressing NCDs. While cardiovascular diseases (CVDs) equally affect both sexes, men suffer from higher incidences than women. Obesity affects more women than men especially in the Middle East and North Africa (MENA) region.

The COVID-19 pandemic has clearly taught us that the costs of investing in prevention and early response, to tackle the root causes of health crises, are minute compared with the costs of paying for the consequences of underinvestment. The inaugural International Strategic Dialogue on NCDs and the Sustainable Development Goals, held in Accra, Ghana, where a new Global Compact on NCDs was launched, co-hosted by WHO, together with Ghana and Norway did not mention of humanitarian or conflict in this new compact.[11] This is despite the Global Action Plan for the prevention and control of NCDs, and the 2030 Agenda for Sustainable Development Goals are strongly committed to leaving no one including the growing numbers of IDPs and refugees around the world.[4]

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