DANISH RED CROSS

THE LONGER THE CRISIS, THE GREATER THE NEED

Messages from people with lived experiences of non-communicable diseases in four humanitarian settings

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NON-COMMUNICABLE DISEASES: AN UNDER-SERVED NEED

The country examples and advocacy messages from Afghanistan, Lebanon, Somalia and Syria are based on a desk review across the four countries and on over 25 interviews with in-country staff from national Red Cross / Red Crescent Societies, international NGOs, and UN agencies.* The stories of five people who are living with NCDs and who have been directly affected by humanitarian crises are presented within the country examples, and their opinions are also reflected in the advocacy messages.

* The interviews and desk review have additionally informed a more detailed set of case studies, which can be found at en.rodekors.dk/publications.

SOMALILAND
SRCS mobile health clinic midwife and nurse Hibak daind Abdi checks the health of pregnant and lactating women living in a remove, drought-affected community.
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As of November 2024, the World Health Organization (WHO) was responding to over 40 health emergencies in all corners of the world. Increasing numbers of these crises are proving to be intractable, sometimes lasting for decades and spanning generations.

The historic paradigm of a short-term health response to an acute emergency has not responded appropriately to changes in the diseases that people face or to the protracted nature of crises. Health systems everywhere – and the people living within them – need to be supported to adapt to interlinked, long-term challenges and remain as resilient as possible to any additional shocks.

Health responses in humanitarian settings have often focused on acute needs and on specific conditions, such as infectious disease, injury or maternal and child health. This has successfully improved the health and wellbeing of millions of people, but with the consequence that non-communicable diseases (NCDs) have not been at the heart of the response.

Population health needs continue to transition towards NCDs and it is often the most vulnerable people who are at most risk of serious illness and death from NCDs.

However, all too often this reality is not sufficiently reflected in on-the-ground provision of health services for NCDs in humanitarian settings. Vulnerable people of all ages who are living with or at risk of NCDs are being left behind for months and years. More action to ensure NCD prevention, diagnosis and treatment is urgently needed, by government, by health service providers and by humanitarian agencies. Hope must be possible, even here.

FOUR DIFFERENT HUMANITARIAN SETTINGS, ONE SET OF MESSAGES

Every one of the four countries behind this set of messages – Afghanistan, Lebanon, Somalia and Syria – is in the midst of a protracted crisis that has lasted years. Each country faces a unique combination of issues including conflict and political unrest, the impacts of climate change and extreme weather, and economic crisis. The four countries face different patterns of disease: overall prevalence of NCDs is lower in Afghanistan and Somalia than in Lebanon and Syria.

The different settings inevitably require carefully tailored responses to ensure that the NCD response is appropriate. But, despite these differences, people living with NCDs themselves and those working to develop and deliver services gave strong, consistent messages during the interviews for this project, among them:

- NCDs affect all communities
- There is only limited access to NCD care within primary care
- People living with NCDs and their families usually have to pay out-of-pocket for care
- Supply chains are disrupted
- There are almost no services at all for more complex NCDs, such as cancer treatment and dialysis
- Medicines are unaffordable
- Financing for NCDs falls short of what is needed

The most common NCDs mentioned include diabetes, hypertension, asthma and mental health conditions – but the near-invisibility within health systems of diseases such as cancer in some of these humanitarian settings may simply be the result of people with these more complex diseases never making it into the health system at all: they do not seek care as they know that there will be no care available to them.

The voices within this report are much more than just testimonies of their own experience: their stories can and should direct the thinking and action on NCDs of those working in humanitarian settings, in sustainable development and in health. The messages provide some clear avenues for action on NCDs in protracted humanitarian settings, which are drawn out further later in this report:

1. NCDs need to be embedded throughout health systems in humanitarian settings, with a focus on primary care
2. People must be at the heart of the response
3. Better data and improved coordination on NCDs are essential
4. Strong leadership is needed, implementing strong policy
5. Financing solutions are needed to ensure affordable access to care and medications

Together, this can build a new narrative and approach to meet the needs of people living with NCDs in humanitarian settings.

SOMALILAND
SRCS mobile health clinics travel to rural villages in Somaliland.
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Of course, these messages are not specific to Afghanistan, Lebanon, Somalia and Syria. COVID-19 demonstrated how rapidly access to health systems can be undermined for people living with NCDs. Every day the news is full of ongoing, long-drawn-out crises around the world, reinforcing the urgency of the need for coordinated action. There are just five years to go to the Sustainable Development Goals horizon in 2030 – but the goals on universal health coverage and on NCDs are far out of reach for many people living with NCDs in humanitarian settings.

The 2025 United Nations High-level Meeting on NCDs is an important opportunity to bring these messages to the fore, ensuring that the needs of those living in humanitarian settings are included as a priority in the discussion, and that the Political Declaration leads to practical action that makes a difference to the lives of millions of people living in some of the world's most challenging contexts, who are today too often being left behind.

Global government commitments on NCDs

Sustainable Development Goal 3.4 states that:

“ By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. ”

The WHO Global NCD Compact 2020–2030 includes the aim, by 2030, of:

“ protecting 1.7 billion people living with NCDs by ensuring that they have access to the medicines and care they need during humanitarian emergencies ”

KOHBAND, AFGHANISTAN
ARCS's Kapisa branch mobile health team going back to the branch office after finishing their daily mission of providing health assistance.
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COUNTRY EXAMPLES

AFGHANISTAN

What is the humanitarian setting?

The ongoing humanitarian crisis in Afghanistan has lasted many decades. It has combined persistent conflict – including invasion by both the Soviet Union (in 1979) and the United States (in 2001) – with poverty and a succession of natural disasters (earthquakes and flooding). The conflict has led to an estimated 250,000 deaths between October 2001 and August 2021.

The Taliban takeover of the country in 2021 has resulted in the country being plunged even deeper into economic crisis: 90% of the population now live below the poverty line. Some donors have withdrawn aid and development assistance, which is an essential source of health funding. Restrictions on the rights of women and girls are affecting both women's own access to health care and their ability to provide care: although women are still permitted to take some health roles (such as community health workers), they must be accompanied by a male guardian and cannot take on leadership positions.

Almost three-quarters of the population live in rural areas, which are often extremely challenging to reach, with limited access both to primary care centres and to more complex care, which tends to be available only in the large cities.

Based on OCHA. The boundaries and names shown and the designations used on this map do not imply official endorsement or accceptance by the Danish Red Cross.

How are NCDs being addressed?

A Basic Package of Health Services (BPHS) at primary care level and an Essential Package of Hospital Services was developed prior to the Taliban takeover, in 2001 (since revised) and 2005, respectively. These remain the basis of the health system today, but they include only extremely limited provision for NCDs.[1] This means that people living with NCDs cannot access free diagnosis or treatment for their conditions and are often forced to spend out of their own pocket for private care, which can be catastrophic for family finances.

NCD FACTS: AFGHANISTAN

NCDs cause **50%** of all deaths

The risk of premature death from an NCD is **35%**

Cardiovascular disease is the second-highest cause of death, with cancer, diabetes and chronic kidney disease all in the top 10

Chronic lung disease is also common, and **hypertension** is estimated to affect around a third of the population

These data are from WHO, collected in 2019 prior to the Taliban taking power. Note, however, that data collection is often very challenging in humanitarian settings, including Afghanistan. The risk of premature death is the probability (as calculated by WHO) of dying between the ages of 30 and 70 years from cardiovascular disease, cancer, diabetes or chronic respiratory disease.

[1] An Integrated Package of Essential Health Services will potentially include greater NCD coverage, including in primary care – but this is not yet implemented.

Some implementing organisations are delivering NCD services even though NCDs are not part of the BPHS; however, the primary focus of humanitarian agencies, non-governmental organisations (NGOs) and donors tends to be on the historical priorities–namely, communicable disease and maternal and child health.

This failure fully to appreciate the realities of the health burden is exacerbated by the lack of a comprehensive, coordinated health information system that would make population needs more evident. Health facilities collect information on patients, but it is not systematically reported to the Ministry of Public Health, so it is difficult for the administration, implementers or donors to make fully informed decisions.

There is an NCD department within the Ministry of Public Health, and the Ministry is open to working on NCDs, especially in primary care, and there are NCD policies in place. For example, the previous government had established a National NCD Strategy 2015–2020 and a National Implementation Plan for NCDIs (NCDs and injuries), which had just been updated for 2021–2025. However, these are currently not being implemented, in part because of a lack of prioritisation and in part as those in leadership roles do not necessarily have the operational and management experience required to successfully push for and deliver what is needed in practice.

PUSHT-E-KOH, HERAT, AFGHANISTAN
ARCS Female Health volunteer educating women on reproductive health, child health, antenatal and postnatal care.
© ARCS

Following the Taliban takeover, some NCD efforts were discontinued, among them a pilot of the WHO's Package of Essential NCD Interventions. There do, however, remain some limited channels through which humanitarian actors provide NCD care in communities to fill gaps in government-provided services. These include mobile health units to reach remote areas and the establishment of a small number of clinics to provide diagnosis, treatment and referral for NCDs (for example, the Afghanistan Red Crescent Society (ARCS) clinic in Herat that is the setting for the Voices below). The ARCS also has 37,000 community volunteers who are trained using guidance materials from the IFRC, with the potential to expand this training to include the NCD module.

What do the people working on NCDs in Afghanistan want you to know?

Those interviewed for the case study had clear messages about both the situation and what can and should be done.

“ Many, many people across the country are in dire need of support for NCDs – but their needs are not met and they are dying in their own homes, without support even from a frontline worker: ‘Hear the unheard voices of people with NCDs!’ ”

“ Afghanistan faces multiple crises, and in crises communicable diseases tend to be prioritised: ‘NCDs are always on the backburner.’ Instead, NCDs and mental health should be mainstreamed into the response to every emergency. ”

“ NCDs should be included in all health programming, including working with the Ministry of Public Health to integrate NCDs into the basic package of health services: ‘If we can have minimum protocols for reproductive health, why not for NCDs, too?’ This should begin with primary health care within communities and work up to more complex care at hospital level when funding is available. ”

“ ‘Religion is strongly community based’, so helping people to help themselves (both self-care and prevention) at community level could be justified from a religious perspective, which could speak strongly to the Taliban authorities. ”

Voices of lived experience: stories from an ARCS clinic

The Danish Red Cross is particularly grateful to Ghulam Hazrat and Bismillah for so generously sharing their stories. Thanks also to Dr Ramin Naqshbandi (Health Project Officer, ARCS/DRC) for facilitating the interview and Dr Ghulam Sediq Mirzaey (Health/MHPSS Focal Point, West Zone, Herat) for translation.

Ghulam, person living with NCDs receiving care at the ARCS clinic (left) and Bismillah, pharmacist, ARCS clinic (right)

Ghulam Hazrat is a patient at the Hazrat Abu Bakar Sediq clinic where Bismillah is the pharmacist. It is run by the ARCS in the West Zone of Herat.

Ghulam is 48 years old, and lives with his wife and family in Buland Aab, a village in Engeel District in Herat Province. He was diagnosed with hypertension and diabetes about eight years ago, although he suspects that he had been living with diabetes for some time, as he had felt weak and had been forced to take time off his work as a construction labourer. He relies on a wage that is paid daily, which means that when he is ill, the family has no income at all: his eldest child is 19 and can barely meet the needs of his own family, and his other children are too young to work. The family had sometimes been unable to afford schoolbooks because of Ghulam's time off work.

When he was first diagnosed, he and his wife were both very worried about their future. Having access to the clinic, which provides free medication, has made a huge difference to their lives. He tries to attend every appointment, but the journey to the clinic is not easy: it requires taking two different hired vehicles. When he is there, he is prescribed his medication by a doctor, and then he receives it from the pharmacist, Bismillah.

Ghulam is not alone in his family in having an NCD. His brother's wife also attended the clinic but was referred to the hospital and has since had to go over the border to Pakistan where she will be operated on for stomach cancer, as there is no care available to her in Afghanistan. There are also many people in his home village with NCDs – but for many it is simply too expensive and difficult to travel to the clinic.

Bismillah has worked as a pharmacist for 15 years. 'Ever since I was a child, I saw people suffering from NCDs and other diseases, and I have always had the wish to help people of my community – so that's why I chose to become a community health worker.'

Up to 200 patients a day come to the clinic – and seeing how they improve under his care gives him the motivation and encouragement to do his job. He also uses his knowledge beyond the clinic itself, and mentioned a recent chat he had with a stranger in the queue at the bank, during which Bismillah recognised the symptoms that the man was describing: he was persuaded to come to the clinic and was diagnosed with diabetes.

There are many patients with diabetes and hypertension, and Bismillah also sees people with chronic obstructive pulmonary disorder and asthma. Most people with NCDs are 'older – in their 40s' and many are women. NCDs are often connected to mental health, and events of recent years have notably increased the anxiety and stress faced by women in Afghanistan. Patients not only need medication for their NCDs: they also need psychosocial support. It is important that families and local communities understand about NCDs to help to prevent stigma and ostracisation, so families are encouraged to come to the clinic with the patient. There is a health committee made up of about 30 local elders and mullahs who come to the clinic to learn about NCDs and other health conditions and who then take their new knowledge back to their own villages.

Bismillah agreed with Ghulam that, too often, it is poverty that prevents patients from receiving the care they need. Even where free treatment is offered, the cost of transport may simply be too high, whether to reach a local clinic or a larger regional hospital when a referral is made – he has even been known to pay for transport for a patient out of his own pocket. Community health workers do a huge amount of work and the income that they receive often does not reflect this workload. His job would be made easier by larger stocks of essential medicines (which sometimes run out) and equipment and what he asked for most insistently was that the clinic be consulted about what medicines and other supplies are actually required: 'We receive some medication that is not used by our patients. Even though a lot of money has been allocated to buy these medications, but they will not help our patients so they are useless here!'

Ghulam's experience is of a comprehensive model of care, implemented in his local ARCS clinic where Bismillah is the pharmacist. Unfortunately, the care that Ghulam receives is not reflective of the experience of people in other areas of the country where this is not accessible.

LEBANON

Note: This case study was finalised in November 2024, amid the escalation in the conflict between Israel and Hezbollah. It reflects primarily the pre-conflict status while parts may become outdated given the rapidly evolving situation.

What is the humanitarian setting?

Lebanon shares borders with Syria and Israel, and today hosts the highest proportion of refugees (one refugee for every four nationals) of any country in the world: 1.5 million Syrians and around 500,000 Palestinians, nine in ten of whom require humanitarian assistance to meet basic needs.[2] Added to this huge influx of refugees, the country has undergone a succession of domestic crises after the end of the 15-year-long civil war in 1990 and the Israeli withdrawal in 2000: the 2006 Israeli military offensive in Lebanon, a severe economic crisis since 2019 (that led to a significant jump in the poverty level and currency devaluation), the COVID-19 epidemic, the explosion in the port in Beirut, and the escalation of conflict from October 2023.

The impact on access to healthcare has been serious and persistent. The economic crisis has led to greatly increased costs of imported medicines, leading to serious shortages of essential medicines (including for NCDs) and the emigration of an estimated 40% of the health workforce. A crisis in mental health was also emerging even before the latest escalation of conflict.

How are NCDs being addressed?

Health provision in Lebanon is fragmented, with a mixture of public and private health providers. Until the last few years, the Lebanese population generally used the government-funded primary health care system less, instead favouring private, hospital-based care. However, since the economic crisis the government-funded primary health care system (which is available equally to refugees and the host community) is now used by many more Lebanese. Essential NCD medicines are difficult to afford for many people (even where these are available), so the primary health care system has become a core access point to health for all, providing medicines either free or at much reduced cost.

Responsibility for running the 300 government-supported primary health care facilities is contracted out to NGOs, and since 2013 efforts have been made to integrate NCD services into primary care packages and guidelines, albeit with significant variation in the capabilities of those delivering services. Care is based on the Essential Health Care Benefit Package, which

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NCD FACTS: LEBANON (2019)

NCDs cause **83%** of all deaths

The risk of premature death from an NCD is **20%**

Cardiovascular disease is the second-leading cause of death, with cancers, diabetes and chronic kidney disease all also in the top five

These data are from WHO, collected in 2019. Note, however, that data collection is often very challenging in humanitarian settings including Lebanon. The risk of premature death is the probability (as calculated by WHO) of dying between the ages of 30 and 70 years from cardiovascular disease, cancer, diabetes or chronic respiratory disease.

[2] By January 2025. UNHCR reported that the number of Syrians departing Lebanon through official border crossings following the fall of Assad remained 'low but steady'.

includes focus on some NCDs – but gaps remain, with priority afforded to diabetes and hypertension. NGOs are also increasingly part of community-level efforts, including greater use of community health workers, prevention (such as awareness-raising on NCD risk factors and cancer prevention) and home-visit programmes.

The Lebanese Red Cross (LRC) runs 36 primary care clinics (of which a handful are accredited by the Ministry of Public Health – MoPH), most of which focus primarily on CVD and diabetes. Five of the centres provide more comprehensive NCD care under the Bridging the Gap initiative, which involves an aspect of implementation research. Peer support groups are offered at the five centres, and this has now been scaled up to 16 centres, bringing integrated mental health and NCD support to more who need it.

At the national level, responsibility for NCDs is spread across different departments of the Ministry of Public Health, as there is no dedicated NCD department. However, clinical care algorithms for NCDs do exist (guidelines for these algorithms were expanded in 2023 to include 33 conditions, including many NCDs), NCD medicines are included in the country's essential medicines list, and the NCD Prevention and Control Plan 2015–2020 is currently being updated.

NCDs are included in emergency planning, with the UN 2024 Lebanon Response Plan including a limited set of NCD indicators. Mobile clinics can be sent to local communities and government contingency stocks of medicines are available – although reviews suggest that these are insufficient. The LRC had already developed a response plan prior to the escalation of conflict in the south on the border with Israel, and was, at the time of the interviews for this case study, considering the response, where the conflict to spread to the whole country.

Understanding the full NCD picture is a serious challenge. Where electronic systems are available, these often have only limited functionality, and some health care centres continue to rely on paper records. Different humanitarian actors have different data-gathering systems in place, which are used for clinical decision-making (and sometimes operational research), but are only partially shared with the MoPH, and only MoPH-accredited centres. Rapid needs assessments at the outbreak of an acute crisis do not routinely and fully include NCDs. There are clear gaps in accessing quality care (notably for people with mental health conditions), and the data to underpin informed decision-making on how best to fill these gaps are not available.

What do the people working on NCDs in Lebanon want you to know?

Those interviewed for the case study had clear messages about both the situation and what can and should be done.

“ 'NCDs are the biggest burden – but are hidden because of the lack of quality data' and a lack of coordination between different data systems. ”

“ There is a need to build greater NCD capacity into primary care, including addressing 'disrupted supply chains, which are the main concern' and which affect both refugees and the host community. ”

“ 'The needs of NCD patients go beyond the treatment they need for their condition.' The resilience of the whole population has been undermined by multiple crisis, and many people living with NCDs are isolated, which increases the threat to their mental health. ”

“ 'Prevention of NCDs is about more than education campaigns': it requires taking a systems perspective and strengthening collaboration on NCDs. ”

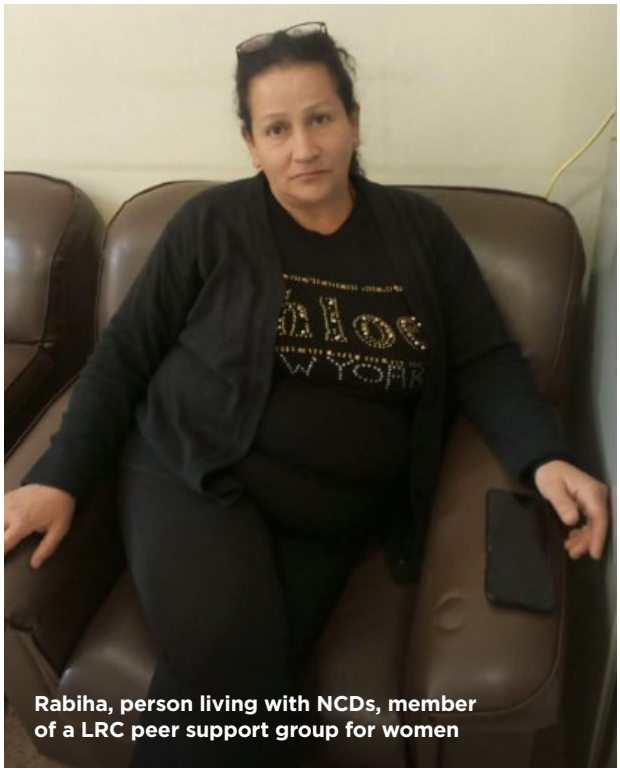
LEBANON
NCD Open Day
© LRC

Voices of lived experience: Rabiha's story

The Danish Red Cross is very grateful to Rabiha Yammine for so generously sharing her story. Thanks also to Carla Njem (Social Workers Manager, NCD focal point, LRC) for facilitating the interview, to Rima Kighsro Naimi (Program Health Manager, Danish Red Cross) for facilitating the interview and translation, and to Malak Moussa (social worker, Qob Elias Health Centre) for attending the interview with Rabiha Yammine.

Rabiha Yammine worked as a nurse in Beirut until she married, at which point she moved to the Beqaa Valley, where she now lives with her husband and two teenage children. Her husband works for the municipality, but his salary is low and the economic crisis has had serious impacts for the family. Their house is very run down and, for the last five years, all their clothes have been second-hand.

Rabiha's mother – a widow – tries to help them financially, and Rabiha hopes, eventually, to be able to pay her back. 'Thank God, we all support each other in our community – but not as much as we used to be able to.' She is concerned about her children's education: her daughter is 17 and wants to enrol for university but cannot currently do so because of the conflict. There have been many air strikes in the Beqaa Valley recently, but – when we spoke – these were not taking place in the immediate area in which Rabiha and her family live.



Rabiha, person living with NCDs, member of a LRC peer support group for women

Five years ago, when she was 45, Rabiha realised that her health was suffering because of the worry and distress of the financial pressures. She visited the Lebanese Red Cross clinic, where she was diagnosed with hypertension, diabetes and high cholesterol. There is a history of NCDs in her family – her father had diabetes – so she wasn't surprised by the diagnosis, but it adds another level of concern for her and her family.

The care provided by the LRC clinic is very important, both to Rabiha and to her husband, who has a heart condition. She sees a doctor every couple of months and her prescription is renewed every six months. The cost of the medication is heavily subsidised [with the minimum fee set by the Ministry of Health], but the contribution that the family must make for the various drugs needed by both Rabiha and her husband still takes a serious toll on the family's finances.

For the last six months, she has been a member of a LRC peer support group for women (mostly in their 40s and 50s) with NCDs, which meets regularly. They discuss their conditions and, despite having once worked in a hospital, Rabiha has found that she learns something new and helpful in every session. She particularly enjoys being able to talk freely about the issues in her life that are difficult, and has made friends through the group whom she meets outside the sessions. 'I leave the house and meet people, and can feel my wellbeing improving. It is only one or two hours, but I feel happy when I get home!' She feels more able to go for walks, which relieves stress – although she is not able to afford healthy food for herself and her family, which worries her.

Rabiha is very grateful for the LRC clinic and the peer support, but is still in need of assistance. She noted that the LRC gives packages of food to some people but that these are not available to her[3] and also that more help with buying the medications would be particularly welcome: 'I don't want to be rich, but I do want to be able to afford what my children need.'

Rabiha's experience is of a comprehensive model of care, implemented in her local LRC clinic. Unfortunately, the care that she receives is not reflective of the experience of people in other areas of the country where this is not accessible.

[3] The LRC, in collaboration with the government and other partners, is currently distributing basic need kits to people living in designated shelter settings (including the large population of Syrian refugees in the Beqaa Valley area). As Rabiha's family are living at home, they do not qualify for this assistance.

SOMALIA

What is the humanitarian setting?

The humanitarian crisis in Somalia is complex and entrenched, and the country has been affected by decades of conflict and political instability. The south/central region of the country is still particularly affected by violence, with extremely challenging access to care, including for NCDs. The north of the country – Somaliland – is a self-declared state, with its own health authority: work or travel between the two areas is limited.

The country is also prone to disasters including drought and floods, which are exacerbated by climate change and have resulted in chronic food insecurity, which led to the deaths of a quarter of a million people in 2010–12 alone. There are outbreaks of infectious disease, including cholera and measles. The combination of conflict and climate-related crises has led to an estimated 3.9 million people being forcibly displaced. In addition, the disease burden in Somalia is shifting away from primarily infectious diseases toward NCDs, driven by shifting diets and a change from nomadic lifestyles.

How are NCDs being addressed?

Historically, the main focus of the federal government and donors has been – and remains – on communicable diseases, but there are clear indications that NCDs are being taken increasingly seriously. There is an NCD division within the Ministry of Health in Mogadishu and, since 2022, the Ministry has convened a technical working group on NCDs that brings together a range of health partners, such as WHO, IRC and the World Bank. There is also an informal working group in Somaliland that engages the main actors in NCDs, including the Somali Red Crescent Society (SRCS).

Based on OCHA. The boundaries and names shown and the designations used on this map do not imply official endorsement or accceptance by the Danish Red Cross.

Since 2020, NCDs have been included in primary care services as part of the Essential Package of Health Services (EPHS), although this often has yet to translate into on-the-ground provision of NCD care by many health actors. The authorities in Mogadishu are working with WHO to establish an NCD roadmap (including the inclusion of NCDs in risk reduction and recovery after a crisis), which is hoped to lead to the development of a multi-sectoral strategy on NCDs by the end of 2026. In Hargeisa, an NCD section has been established in the Public Health Department and there is a hope to develop a strategy on NCDs in the future.

Lack of financing is a primary reason for the relatively slow progress in implementing NCD plans. Estimates are that up to 80% of health care is provided privately rather than through the public health system, leaving many people living with NCDs to pay for expensive care out of their own pockets, with serious financial repercussions for their families, if they can afford it at all.

NCD FACTS: SOMALIA

NCDs cause **50%** of all deaths

The risk of premature death from an NCD is **30%**

The most common NCDs are **hypertension and diabetes**

CVD and cancer are both in the top 10 causes of death

5% of the population is living with a disability and **40%** of them have received no care

These data are from WHO, published in 2019. Note, however, that data collection is very challenging in humanitarian settings including Somalia. The risk of premature death is the probability (as calculated by WHO) of dying between the ages of 30 and 70 years from cardiovascular disease, cancer, diabetes or chronic respiratory disease.

Ongoing support is needed to enable the health authorities to strengthen planning, better embed NCDs within national health information systems, produce guides for health worker training and clinical guidance in NCDs, and improve regulatory frameworks to enable local production of medicines rather than having to rely on procurement from abroad. A high-level National Transformation Plan, the primary focus of which is longer-term development, is being finalised, and this is reported to include NCDs.

Humanitarian actors are also taking an increasing interest in NCDs across the country, as the need grows and becomes more and more evident. For example, the SRCS established a home-based component of community care for people living with HIV, and it quickly became clear that the needs of people who are housebound include NCDs. Today, the SRCS five-year health strategy (which covers the coordinating offices in both Mogadishu and Hargeisa) specifically includes diabetes, hypertension, asthma, epilepsy and mental health conditions.

An SRCS pilot initiative has been established in two health facilities, using experiences from the Kenyan Red Cross to improve NCD care. This includes training volunteers to provide basic health education on NCDs and to screen and refer patients to their local primary care clinic. As part of this project, peer support groups have been developed for people living with NCDs to better understand and manage their condition (and the story of a member of one of these groups is the Voice below).

Other actors are also concentrating on strengthening services for NCD – for example, IRC is integrating NCD services into its existing primary care services, focusing on the most vulnerable people (such as internally displaced people) who have no access to private care. NGO emergency planning tends to take the form of maintaining emergency stocks and the use of mobile health clinics that can be sent to affected areas at short notice.

But despite these efforts, many donors are still not prioritising the needs of people living with NCDs, whether at primary care level or hospital level, and NCDs are not mentioned in the 2024 Somalia Humanitarian Response Plan. This may be because of a lack of facility-level NCD data leading to a failure to appreciate the extent of the burden: there is no national health information system that centralises data from government, private and humanitarian providers.

SOMALILAND
A nurse checks a patient's blood pressure in the mobile health clinic.
© SRCS

What do the people working on NCDs in Somalia want you to know?

Those interviewed for the case study had clear messages about both the situation and what can and should be done.

“ For all the talk of universal health coverage and not leaving anyone behind, NCDs are still being forgotten compared to war injuries or communicable diseases (most recently mpox – despite there not having been any known cases in the country): ‘Forget what donors want – and think about people!’ ”

“ NCDs (including mental health) are a reality in Somalia, including during crises. NCDs must be integrated into the health system and the emergency response system, with appropriate capacity and supplies at all levels, from local communities to hospitals: ‘Integration, integration, integration!’ ”

“ Community health workers need to be supported and trained to deliver NCD prevention, awareness-raising and care: ‘All NCDs must be dealt with in locations within the community. ”

“ Data is knowledge’, which enables us to advocate for mobilisation, inclusion, action and even for the community itself. ”

Voices of lived experience: Xaliimo's story

The Danish Red Cross is particularly grateful to Xaliimo Abdi Ige for so generously sharing her story. Thanks also to Dr Mustakim Mohamed (SRCS Deputy Integrated Health Care Programme Director) for facilitating the interview.

Xaliimo Abdi Ige is 57 and lives with her husband and three children in Allaybadey, Somaliland, near the border with Ethiopia. Xaliimo has been displaced by the prolonged drought in her local area and moved to Allaybadey to better support her family. She knew she had been unwell for some time prior to her diagnosis, as she had been struggling with excessive thirst and tiredness. She worried increasingly about not being able to look after her family, particularly as her husband had hypertension and was unemployed, so she was the main breadwinner.

In early 2023, she was diagnosed with diabetes. Traveling into the nearest city, Gabiley, to collect medicine cost money that the family simply didn't have, so Xaliimo was forced to miss doses of her medication and continued to be very unwell. Health promotion initiatives run by SRCS volunteers alerted Xaliimo to the SCRS-run NCD clinic in the Allaybadey Health Facility – and this has transformed her life. She and her husband can now access affordable medication and regular, face-to-face follow-ups, which has brought invaluable peace of mind to the whole family: 'I always go to the clinic the day before I finish my medication, which works nicely. I no longer need to miss doses!'

The clinic provides more than treatment from health workers: Xaliimo has joined a peer support group that meets twice a month, led by SCRS volunteers trained in NCDs. The 10 members have become friends, discussing their experiences and learning from each other, talking about their medication, and sharing ideas for staying active. The sense of community that this brings is invaluable to her health and wellbeing: 'What I love most about being part of the peer support group is the opportunity to share life experiences. I've found comfort and motivation in having friends who understand my challenges.'

Although Xaliimo was initially very worried about the impact of her diabetes, she now has her condition under control. The support that she is receiving from the clinic and peer support group help her manage her diabetes through medication, diet and physical activity, following a treatment plan that she developed with a health worker at the clinic. She is happy that her family are also involved, helping her to keep track of her blood sugar and accompanying her on walks, which encourages healthier habits for everyone.

There are many people in Xaliimo's circle of family and friends who also have diabetes and hypertension. She is now taking a role as an advocate within this wider community, helping to organise local events to help others to understand more about preventing and managing NCDs and highlighting the care that is available through the NCD clinic.

Xaliimo's experience is of a comprehensive model of care, implemented in her local SRCS clinic. Unfortunately, the care that she receives is not reflective of the experience of people in other areas of the country where this is not accessible.

Xaliimo, person living with diabetes, receives care at the SCRS clinic and is a member of a SCRS peer support group

SYRIAN ARAB REPUBLIC

What is the humanitarian setting?

Over 13 years of conflict in Syria has had a devastating effect on the Syrian people, with an estimated 350,000 deaths between 2011 and 2023. This case study was researched prior to the events of late 2024, when Hay'at Tahrir al-Sham (HTS) and other armed groups defeated the regime of Bashar Al-Assad, taking the capital Damascus on 8 December. Tension still prevails in the north between the Kurdish-led Syria Democratic Forces (SDF) and the Turkish-backed Syrian National Army (SNA), but in the rest of the country the conflict has largely stopped.

Based on OCHA. The boundaries and names shown and the designations used on this map do not imply official endorsement or accceptance by the Danish Red Cross.

The years of conflict have seen over half the population – around 14 million people – being displaced, either within Syria (7.4 million before the events at the end of 2024) or as refugees in neighbouring countries (6 million). The situation was worsened in the north-west by the 2023 earthquake on the border with Türkiye. The escalation of hostilities at the end of November 2024 resulted in a further 1.1 million people being internally displaced. As of January 2025, approximately 627,000 people remained newly displaced, while nearly 523,000 people have returned to their areas of origin, mainly in the Hama and Aleppo governorates.

90% of the population live below the poverty line and 70% are thought to be in need of humanitarian aid. The health system has been seriously impacted. Half of health facilities have been destroyed or damaged (by attacks on infrastructure and by the earthquake), local pharmaceutical production has drastically reduced, and 70% of health workers are thought to have left the country. This is compounded by transport challenges and by the effects of sanctions that seriously limit the importation of medicines (such as for cancer and kidney disease) and raw materials.

How are NCDs being addressed?

The importance of NCDs was recognised by their inclusion in 2006 in Syria's 10th Five-Year Plan for development of the country, but they remain a lesser priority than infectious disease and trauma, particularly since the start of the war, and internal boundaries have complicated service provision.

There is an NCD Department within the Ministry of Health in Damascus, an NCD action plan is reportedly being drawn up with WHO, and there are clinical guidelines for a number of NCDs (although these were primarily used in government-controlled areas). There is a national NCD programme covering 16 conditions (including diabetes, COPD, CVD, kidney disease and sickle cell disease).

NCD FACTS: SYRIA (2019)

NCDs cause **75%** of all deaths

The risk of premature death from an NCD is **22%**

Cardiovascular disease is the leading cause of death, with cancer the third-leading cause and diabetes and chronic kidney disease the fourth

These data are from WHO, collected in 2019. Note, however, that data collection is very challenging in humanitarian settings including Syria. The risk of premature death is the probability (as calculated by WHO) of dying between the ages of 30 and 70 years from cardiovascular disease, cancer, diabetes or chronic respiratory disease.

The recently updated essential service package for primary care cannot be fully implemented, due to a lack of human resources and the widespread destruction of health infrastructure. Primary care is theoretically subsidised by the government and delivered through about 1,370 publicly funded clinics in government-controlled areas, while increasingly opening up to private provision. There is no national health insurance system – so, in practice, patients often have to pay out-of-pocket for medicines (which may, in any case, not be available at all).

The Ministry of Health does not have capacity to work on prevention or screening programmes, but there is some focus on NCD risk factors through the community-based health and first aid programme of the Syrian Arab Red Crescent (SARC). SARC's community health workers have strong relationships with families within their community, but struggle to refer patients, both because of the lack of capacity within local health services and the practical and financial challenges facing anyone needing to travel.

The divide between government- and non-government-controlled areas dramatically complicated coordination between areas and between humanitarian actors and UN agencies prior to HTS taking over (in the north-west, for example, WHO had developed a separate essential package of health services in 2016/17).

UN agencies are still constrained in the north-east of the country, as this is largely run as an autonomous region by the Syrian Democratic Forces (SDF), with its own local health administration, and is not for now included in the Health Cluster. With the change at the end of 2024, there are no longer internal 'borders' between central and north-west Syria. Entering the north-east, there is still some coordination between the HTS and SDF to allow the passing of humanitarian aid and personnel.

Humanitarian actors working in Syria focus on complementing the existing system rather than establishing parallel processes. This can include provision of specific NCD services or bringing services to vulnerable populations in remote areas, and humanitarian actors were sometimes given contracts by the government to do so. ICRC plays a key role in the medicines supply chain, procuring internationally and providing up to 30% of the Ministry of Health's insulin supply. Health information systems are not joined up, but SARC is working to develop a new data-gathering system that will be launched in 2025.

The persistent and pervasive lack of access to NCD diagnosis and care in the country is clearly illustrated by just 200,000 people being registered with the Ministry of Health as having diabetes. This is only a fraction of the total number likely to have the disease, given the prevalence rates in the country. Conflict and stress are also driving a huge burden of chronic anxiety and depression, and high tobacco use is storing up future health issues.

In terms of acute emergency response, it is not clear if NCDs are included in national health emergency preparedness and response plans, but the Ministry of Health can deploy mobile clinics, and SARC is currently developing an emergency health plan that is intended to include NCDs. Following the 2023 earthquake, Red Cross Movement partners supported SARC's response and WHO provided mobile health teams providing essential services including for NCDs.

What do the people working on NCDs in Syria want you to know?

Those interviewed for the case study had clear messages about both the situation and what can and should be done.

“ NCDs are underserved and out of sight in Syria, and should be a focus for resourcing and action by both government and international partners. 'Financing for NCDs, including for medication, is a very big gap.' ”

“ NCDs need to be much better integrated into basic service packages, with links made with cross-cutting programmes such as mental health, nutrition and disability: 'We need more comprehensive integration because of limited resources.' ”

“ Donors need to be told that NCDs should be a serious part of the response, as they still do not understand that action on NCDs is worthwhile and can make a big impact on lives: 'A response to conflict is not only about trauma, and the longer the crisis the greater the need.' ”

“ Sanctions play a significant role in poor health outcomes in Syria, creating barriers to the importation of raw materials and procurement of lifesaving medication: 'Sanctions should not be placed on people's health.' ”

Voices of lived experience: Rehab's story

The Danish Red Cross is particularly grateful to Rehab Mohamad for so generously sharing her story. Thanks also to Ali Ahmad (Senior Health Manager, Raqqa & Deir-ez-Zor, IRC) for facilitating and contributing to the interview and for translation. Rehab has asked that we do not use her real name. Note that the Danish Red Cross is not working with IRC in Syria; this story has been included to provide another example of the situation of people living with NCDs in a humanitarian setting. The interview took place before the events at the end of 2024.

Rehab Mohamad is 41 and lives in Raqqa in north-east Syria. She, her husband and their six children – who are aged between 18 months and 15 years – have had to move several times during the years since the civil war began: to Tal Abiad, which has since been occupied by Türkiye, before spending time living in a rural area outside Raqqa until the city came under SDF control. She worries about her children and the limited education opportunities that they have, compared to her own. Before the war, she trained as a nurse in Raqqa – and four years ago answered a call from the IRC for community health workers: 'I love this career more than being a nurse! It brings me close to my patients, and my advice may save their life.' Her IRC training has been wide-ranging, including NCDs and communicable diseases, psychological first aid, health promotion and communication skills. She is paid a salary for her work – but is relieved that her husband also has a job, as her salary alone would not be enough to support her family.

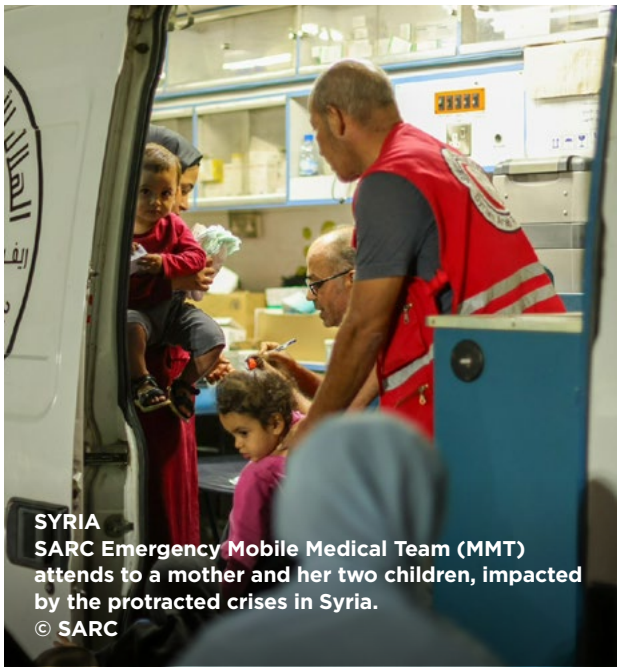
NCDs are common in her local community and in the two camps for displaced people where Rehab currently works, where she sees five families a day. She has patients with diabetes, hypertension, thyroid issues and stroke, including people who are living with disabilities and paralysis. Mental health is a huge concern: 'People used to live in houses, now they live in tents, and the economic situation is so hard. Their lifestyles have changed – everything has changed!' The profound stress of the war and displacement has put middle-aged people at increased risk of NCDs and, once diagnosed, they often become more depressed and find themselves unable to take their medication or care for their family. Younger people are seriously affected, too: 'We are seeing children who have developed diabetes after seeing the shock and trauma of explosions in front of their eyes.'

Rates of cancer are also rising. People suspected of having cancer are referred to nearby hospitals, but it is often diagnosed only at end stage and, in any case, treatment is only available in Damascus, which is in the government-controlled area and impossible for many to reach. In the camp, there is nothing available for people living with cancer other than some mental health first aid and basic painkillers. There are also real challenges for people with diabetes: there is always a shortage of insulin, which is compounded by the lack of fridges or solar panels to provide the electricity to keep it cool. 'The economic situation is so hard for people living in the camp! If insulin isn't available in an NGO-supported facility, they can't access it at all.'

As a community health worker, Rehab helps people connect to local health services, taking their blood glucose and blood pressure measurements and referring them to clinics as needed. IRC has software to store basic information about patients, and this can be compared with clinic-level information to check who has taken up referrals.

Rehab sees her role in preventing disease before it occurs as being particularly important, advising on salt and fat reduction and on the importance of physical activity and stress reduction. But it is difficult to convince people about the need for healthy lifestyles in the camps – not least as their choices are so constrained: 'Sometimes we ask them about their intake of specific foods, but they simply don't have the capacity to purchase this.'

Rehab works with the IRC to implement a comprehensive model of care in her community. Unfortunately, the care that she provides is not available country-wide.



SYRIA
SARC Emergency Mobile Medical Team (MMT) attends to a mother and her two children, impacted by the protracted crises in Syria.
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MESSAGES FROM THE CASE STUDY COUNTRIES

1. NCDs need to be embedded throughout health systems in humanitarian settings, with a focus on primary care

Too many people living with NCDs in humanitarian settings are not receiving the care that they need and many will never enter the health system at all: they remain unseen, undiagnosed and untreated. The chronic, lifelong nature of NCDs makes it essential that care should be delivered as cheaply, effectively and as close to home as possible through an integrated primary health care system.

Take a holistic, integrated approach to health services: Primary health care services span services from health promotion, prevention to treatment, including palliative care (which is often almost non-existent). A core aspect of integration is to address the huge unrealised mental-health needs of people living in humanitarian settings that exacerbate and are exacerbated by the additional challenges of living with NCDs.

Consider how to develop care for the full range of NCDs experienced by people living in humanitarian settings: NCDs such as cancer and kidney disease present particularly difficult challenges, and travel to other countries is often the only option available, which is out of reach of the majority of the population. However, as the Syria case study shows, basic cancer care can be provided at district hospital level through workforce capacity building, a referral system and access to surgical care.

Care can be provided effectively at community level, and by people who understand the needs of the community: Community-based services should be recognised as an integral part of resilient primary health care systems in resource poor, humanitarian settings. Health care can be cost-effectively delivered by community health workers and volunteers, working across diseases (including NCDs) and across the continuum of care: prevention, health promotion, screening and identification of high-risk people, and local provision of care (particularly important in humanitarian settings, where travel may be prohibitively expensive, dangerous or impossible). Home-based care for vulnerable and housebound people can also better reach older people or those living with a disability who are also living with NCDs. Community health workers themselves often have a deep understanding of local needs and can act as conduits for community feedback.

> “ We focus on medical needs, but this isn’t the only need. People living with NCDs are really isolated – they face many challenges in their social life and their psychological wellbeing. ”

2. People must be at the heart of the response

In every humanitarian setting, the understanding and experiences of those in affected communities – people living with NCDs, their families and health workers – are essential to effective NCD prevention and treatment.

The views of people in affected communities should be sought out, heard and acted upon: People living with NCDs (both within the host community and the refugee community) and the health workers who deliver services bring vital local perspectives, which can reveal the need for action on NCDs and direct the required response. Gathering and acting on lived experience is both feasible in humanitarian settings and vital in building more relevant, resilient, locally based and effective health systems.

> “ Ask us what we need! ”

3. Better data and improved coordination on NCDs are essential

Too often, there is too little understanding of the extent of the NCD burden and what needs to be done. The lack of robust, up-to-date data

leads to decisions that are based on out-of-date priorities reflecting outdated patterns of disease or that do not apply to humanitarian settings. Accurate data make clear that addressing NCDs is part of people's basic needs, which is at the core of the humanitarian response. Genuinely needs-based action on NCD prevention and treatment will be most effective when the actors involved in crisis settings – from government (whether national or local) to UN agencies to NGOs to local communities and people living with NCDs themselves – work together on a coordinated response.

All health actors should work together to improve data collection, data sharing and data alignment: Improved data is essential to understand the health needs of the population and to take an appropriate response. However, data collection is often inadequate, with different actors sometimes using different, incompatible health information systems and with many systems not fully including NCDs (which may result in some diseases – and people – being invisible to the system). There are some encouraging examples of the use of new technology to gather and track data. Information-sharing can also help to avoid developing parallel systems.

Better multi-sector coordination appropriate for NCDs is needed: Although emergency coordination is provided through the health cluster mechanism (typically led by WHO and the MoH), this may extend to non-government-controlled areas, where alternative coordination mechanisms may be needed to align the work of relevant agencies. Coordination that considers NCDs is also needed between government departments, UN agencies, donors, civil society and NGOs, and the private sector. (Partners may need to be flexible in how they engage with de facto authorities that are operating outside the government.)

Cross-sector collaboration can improve long-term prevention of NCDs: A systems perspective is needed to investigate and understand changing patterns of risk factors and the impact on health over the long term. Action can include limiting access to alcohol and tobacco (such as through licensing laws and health taxes) and improving access to affordable, healthy food and physical activity.

> “ Without data you have nothing – numbers speak! ”

4. Strong leadership is needed, implementing strong policy

Acting to prioritise NCDs in the face of many competing issues requires contextualised policy that is based on need – coupled with brave, knowledgeable, supported leadership – to change the narrative and ensure action on NCDs.

Every country should include NCDs in the essential package of health services anchored within a strong primary health care system: Every country's NCD policy should be grounded on population-level health interventions and an essential package of health services that is based on population need, which fully embeds NCDs, and which can largely be delivered through primary care. The package forms the basis of equitable delivery of health services. To ensure sustainability of services, humanitarian actors' health services should be aligned with the national plans.

Staff should be supported to ensure they are able to guide, oversee and implement integration of NCDs in health service delivery: This is true for all those with responsibility for delivery of NCD policies or services, whether in the national or local health authorities, in NGOs or in national Red Cross Red Crescent societies.

> “ NCDs are always on the backburner! ”

5. Financing solutions are needed to ensure affordable access to care and medications

Better resourcing, supported by strong data, is essential in order to ensure that health care is accessible to all. All too often, in all four emergency settings, people living with NCDs, already impoverished due to the crisis, face out-of-pocket payments for NCD services, which can be catastrophic for family finances. Ensuring reliable supply chains that can deliver access to NCD care at affordable cost also remains a huge challenge for the agencies and governments sourcing the medicines.

More investment is needed to make health care accessible to all: Health financing in all four countries comes from multiple sources: domestic government resourcing (which is often very limited), out-of-pocket payments paid by people living with NCDs and their families (largely used for private-sector provision) and international

assistance (including humanitarian funding from humanitarian response plans and flash appeal mechanisms, and some long-term development assistance). Better data is the key to help set priorities based on real needs, and secure more financing for NCDs.

Reliable access to NCD medications and supplies should be available at affordable cost: In many humanitarian settings, supply chains of NCD medicines or diagnostics are subject to disruption or shortages, leading to price rises. Even where drugs are heavily subsidised by government or by humanitarian actors, co-payments can still cause huge financial problems for families – not least as people living with NCDs often require treatment for the rest of their lives. Providing sustainable access empowers people to seek care: once it becomes know that services are available, more will come forward to use them.

> “ Financing is the first, very big, gap. ”

Together, this can build a new narrative and approach to meet the needs of people living with NCDs in humanitarian settings

Stories of people with lived experience of NCDs – such as those presented in this paper – shine a light onto the reality of NCDs, creating a new, powerful narrative:

People living with NCDs in humanitarian settings are often sidelined in the response, due to structural challenges and a lack of data: But there are devastating consequences for death, disability and suffering when NCD services are disrupted or do not exist at all. People living with NCDs must be considered from the very start of a crisis: they are a vulnerable group whose needs cannot simply be pushed into the future, especially as many crises (as the situations in Afghanistan, Lebanon, Somalia and Syria are demonstrating) become protracted.

Long-term support is needed for the long-term problem of NCDs within health systems strengthening: Poor visibility of NCDs can be addressed by development and humanitarian actors actively pushing for inclusion of NCDs in funding requests. This can be facilitated by actively gathering data on NCDs, alongside other diseases, which makes it easier for health actors to build a case for inclusion of NCDs alongside other health priorities in their funding requests.

There are positive examples that can be successfully scaled up: Enough is known about promising models to scale these up, including the use of peer support groups for people living with NCDs and of NCD modules within guidance materials for community volunteers. New technologies can also be beneficial, including digital tools for collection and analysis of data, clinical algorithms to be used by community health workers, and apps for people living with NCDs to better control their condition.

Understanding the urgency of NCDs, coupled with the knowledge that action is possible, can mobilise the financial and human resources that are needed to bring the hope of sustainable NCD prevention and treatment to millions of people living in humanitarian settings around the world.

SOMALILAND
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IN SHORT: ACTION IS NEEDED NOW!

Too often, the most vulnerable people living with NCDs in humanitarian settings are simply left behind compared to the progress and priority afforded to issues such as infectious disease (including COVID-19) and maternal and child health, vital though those services undoubtedly are. The need for greatly increased access to NCD services is already crystal clear, despite the lack of perfect data. The four case studies presented here paint a picture of inequity across the NCD continuum of care that must be addressed if universal health coverage is to become a reality and the Sustainable Development Goals achieved.

BAGRAM, AFGHANISTAN
ARCS's Parwan branch mobile health team midwife checking the health of the villagers.
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