DANISH RED CROSS

INTEGRATION OF NON-COMMUNICABLE DISEASE CARE IN HUMANITARIAN SETTINGS TO SUPPORT HEALTH SYSTEM STRENGTHENING

A Multi-Country Case Study

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Disclaimer: This case study report was finalised in November 2024, building on key informant interviews conducted between August and September 2024. Within months of its publication, there have been significant developments across the case study countries. The authors make no guarantees about the accuracy or completeness of this report and do not assume responsibility for any potential errors, omissions, or inaccuracies.

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CONTENTS

ABBREVIATIONS

AUB	American University of Beirut
ARCS	Afghan Red Crescent Society
BPHS	Basic Package of Health Services
CBHFA	Community-Based Health and First Aid
CHW	Community Health Worker
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CRD	Chronic Respiratory Disease
CVD	Cardiovascular Disease
DALY	Disability-Adjusted Life Year
DHIS	District Health Information System
DKA	Diabetic Ketoacidosis
DM	Diabetes Mellitus
DRC	Danish Red Cross
ECHO	European Civil Protection and Humanitarian Aid Operations
EHCP	Essential Health Care Benefit Package
EML	Essential Medicines List
EPHS	Essential Package of Health Services
EPHS	Essential Package of Hospital Services (Afghanistan case study)
FCDO	Foreign, Commonwealth & Development Office
FMOH	Federal Ministry of Health
FRC	Finnish Red Cross
HER	Health Emergency Response project
HCP	Health Care Provider
HIS	Health Information System
HMIS	Health Management Information System
HRP	Humanitarian Response Plan
HSSP	Health Sector Strategic Plan
IDP	Internally Displaced Person
INGO	International Non-Governmental Organisation
IPEHS	Integrated Package of Essential Health Services
IRC	International Rescue Committee
ICRC	International Committee of the Red Cross
IDF	International Diabetes Federation
IFRC	International Federation of Red Cross and Red Crescent Societies
LHA	Local Health Authority
LMIC	Low- and Middle-Income Country
LRC	Lebanese Red Cross
MENA	Middle East and North Africa
MHHS	Ministry of Health and Human Services
MHPSS	Mental Health and Psychosocial Support
MHU	Mobile Health Units
MIRA	Multi-sector Initial Rapid Assessment
MoH	Ministry of Health
MOHD	Ministry of Health Development
MoPH	Ministry of Public Health
MSF	Médecins Sans Frontières (Doctors Without Borders)
NCD	Non-Communicable Disease
NES	North-East Syria
NGO	Non-Governmental Organization
NRC	Norwegian Red Cross
OFDA	Office of U.S. Foreign Disaster Assistance
OOP	Out-of-pocket Payment
PHC	Primary Health Care
PHEOC	Public Health Emergency Operations Centre
PHSA	Public Health Situation Analysis
PLWNCD	Person Living with Non-Communicable Disease
PSI	Population Services International
SARC	Syrian Arab Red Crescent
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedures
SRCS	Somali Red Crescent Society
STEPS	WHO's STEPwise approach to Surveillance
TWG	Technical Working Group
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization
WHO-HEPR	WHO Health Emergency Preparedness, Response and Resilience Framework
WHO PEN	WHO Package of Essential Noncommunicable Disease Interventions for Primary Health Care

INTRODUCTION

Emergencies impact physical and mental health directly and indirectly, especially in fragile, under-resourced settings lacking resilient services. Trauma, infectious diseases, and maternal and child health have long been focal points in emergency response. Until recently, however, the needs of people with non-communicable diseases (NCDs) were often overlooked, despite the high mortality and disability rates from NCDs in humanitarian crises.

Globally, NCDs are responsible for around 74% of deaths - making them the leading cause of death. The vast majority of NCD deaths occur in low- and middle-income countries and regions experiencing humanitarian crises are not spared. People living with NCDs (PLWNCDs) in humanitarian settings – whether displaced or not – are at a considerably higher risk of their condition worsening and complications. This may stem from the experienced stress, interruption of services or medications, difficulty accessing or affording care, loss of social networks, or supply chain disruptions (e.g., healthy food availability). Recently, NCDs in humanitarian settings have received more attention, including through global initiatives, increasing research and advocacy, and operational actors' recognition of NCDs as a reality on the ground.

In recent years, there has been substantial improvement in the knowledge of how to best address NCDs in humanitarian crises. Research and operational experiences have highlighted the need for - among other things - ensuring continuity of care (especially medicines), flexible and context-appropriate models of care, strong cohort monitoring and follow-up, and simplified treatment approaches (e.g., task-shifting). Despite this progress, NCDs are often not included in humanitarian or development efforts. Their exclusion is embedded throughout the system, with NCDs often ignored in needs assessments, absent from funding calls, left out from basic care packages, or sidelined by donors - with each part of the system influencing the others. As a result, PLWNCDs are left to carry the responsibility and burden of care. Since the majority of humanitarian crises today are protracted, PLWNCDs face not only increasing risk of mortality and disability as service disruption continues, but also the risk of impoverishment for their families and themselves due to the ongoing cost of sourcing and purchasing drugs in order to stay alive.

The case studies presented here examine the challenges around delivering and sustaining NCD care in very protracted crises, building on the experience of Red Cross and Red Crescent staff, other agencies, and PLWNCDs who have accessed services in these settings. The analysis highlights lessons for NCD programming specific to each setting, as well as transversal recommendations for strengthening NCD care in protracted humanitarian crises globally.

Purpose and scope

The Danish Red Cross (DRC) commissioned the development of these four country case studies - Afghanistan, Lebanon, Somalia and Syria - to support the Red Cross and Red Crescent Movement in strengthening NCD service delivery in all phases of the humanitarian response, in countries experiencing protracted crisis situations. In addition to directly informing the Movement's programming, these findings are intended to support dialogue with and between organisations delivering, coordinating, and funding healthcare in humanitarian settings.

All four case studies are on countries experiencing protracted crises, representing the general shift of humanitarian crises globally. These case studies provide an important exploration of this 'new normal' of humanitarian settings, examining these changing dynamics through the lens of NCDs. They explore how the similarities and differences of what is considered a 'protracted crisis' shape the approach taken by different actors including governmental and humanitarian. In particular, they examine the interplay between building health system capacity and ensuring the capacity to respond to recurring acute crises. The traditional humanitarian program cycle is unable to capture these settings well, as preparedness, response and recovery efforts often occur simultaneously. At the same time, the case studies explore the need to include NCDs - based on the reasoning of needs-based humanitarian action - in the face of stretched humanitarian budgets.

Methods and materials

The case studies build on two primary information sources: a desk-based review and interviews with key stakeholders. The desk review informed the preparation for stakeholder interviews, while both methods were continuously updated and cross-checked to fill gaps in the case studies.

Desk-based review

The desk-based review used a rapid iterative approach. The search focused on grey literature (e.g. Google Scholar, Reliefweb, Base Search, Global Index Medicus, World Health Organization (WHO) Iris, and key actors' websites), recommendations from key stakeholders, and published literature (e.g. Pubmed, Global Health). Keywords included those related to NCDs (e.g. "chronic diseases", "NCD", "diabetes", "epilepsy"), to the case study countries (e.g., "Somalia", "Somaliland"), and to the humanitarian or health system response (e.g. "prevention", "rehabilitation", "care", "supply chain"). The data was extracted directly into a first draft of the report - using the WHO-HEPR framework categories as section headings - starting from documents that were perceived as most relevant. The findings were continuously updated throughout the project period.

Stakeholder interviews

The primary source of information for these case studies was stakeholder interviews. The interview questionnaire was structured around the categories of the WHO-HEPR (Health Emergency Preparedness, Response and Resilience) framework (see page 7). The team reached out to respondents from within the Red Cross Red Crescent Movement as well as from other actors, including government, international organisations, and national or international non-governmental organisations (NGOs). Respondents were identified purposively through recommendations by the DRC country team and snowball sampling of organisations. In total - across the four case study countries - 27 interviews were conducted. Table 1 provides a summary of the respondents' characteristics.

Table 1: Selected respondent characteristics across four case study countries; Abbreviations: UN (United Nations), MoH (Ministry of Health), INGO (International Non-governmental Organisation), RCRC (Red Cross Red Crescent Movement)

TYPE OF ORGANISATIONS	RESPONDENT ROLE	RESPONDENT SEX
14 RCRC	7 Country managers	15 male
8 INGO	5 NCD officer	12 female
4 UN	14 Health officer	
1 MoH	1 Research lead	

LATAKIA, SYRIA
SARC mobile health unit doctor tells about the health situation in Latakia, Syria.
© IFRC/Jani Savolainen

The interviews were conducted online between August and September 2024. All participants provided verbal informed consent to participate in this project and the anonymous use of their data. Interviews lasted about one hour and the project team took notes and recorded the conversation. Audio recordings were deleted after the analysis was completed. After the initial analysis, written follow-up with respondents helped to clarify aspects or fill specific gaps.

The data analysis employed a rapid qualitative analysis approach as a fast, systematic, and action-oriented approach to analysing qualitative data. The basis of analysis was the interview notes, with transcripts (or recordings) used for quality control or to identify specific quotes. Analysis matrices are often used for rapid qualitative analysis approaches to identify themes. The extraction and analysis were done by the primary author and consisted of (i) familiarising with the data by re-listening to interviews, (ii) inductive coding of a sub-set of interviews (n=2), (iii) review and discussion of matrix format, (iv) data extraction into the matrix, (v) validation of findings with key project stakeholders. The project matrix primarily followed the WHO-HEPR framework domains, as inductive themes fell within existing dimensions.

WHO-HEPR framework

In 2022, WHO published a strategic approach for strengthening Health Emergency Preparedness, Response and Resilience (HEPR), which is based on three main themes: global governance, financing and HEPR systems (see *Figure 1*). Included in the HEPR systems are five interconnected core health components known as the five C's – collaborative surveillance; community protection; safe and scalable care; access to countermeasures; and emergency coordination – that outline what is needed to prevent, prepare, detect and respond to emergencies.

HEPR aligns strategic actions on health emergency risk reduction and resilience building, health emergency preparedness, and response to health emergencies.

Although HEPR was developed for health emergencies rather than humanitarian emergencies per se, it provides a comprehensive foundation for encapsulating preparedness and risk reduction activities aimed at mitigating the impact on health due to all types of emergencies. In this project, the framework's components were adapted to fit the case study objectives (see *Table 2*).

Figure 1: Adapted from the WHO strategic framework for strengthening Health Emergency Preparedness, Response and Resilience[1]

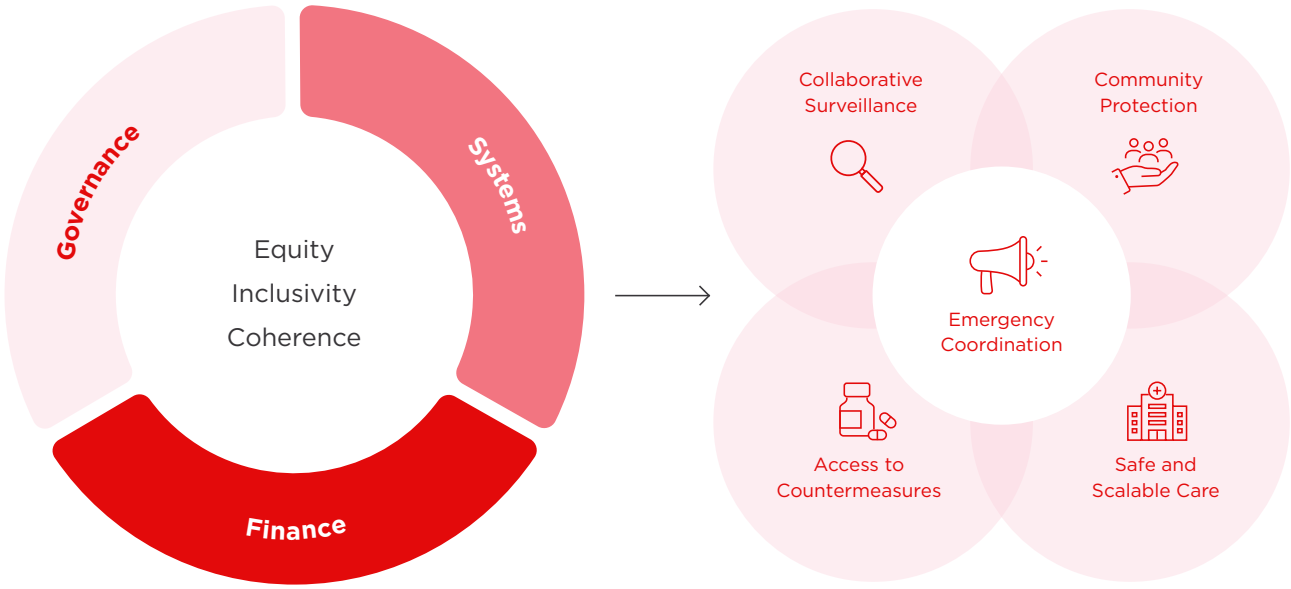

Table 2: HEPR framework category definitions used for the case studies

Governance	• Global health governance with respect to health and humanitarian emergencies • International and national policies and legislation (including for refugees, importation regulations and regulations related to healthcare professionals) • Health systems governance, including agreements with private sector and non-state actors (including international NGOs)
Financing	• Humanitarian response resource mobilisation • Health system (long-term) financing mechanisms • Affordability of care
Collaborative Surveillance	• Health information systems • Disease surveillance and reporting • Needs assessments • Diagnostic and laboratory capacity strengthening
Community Protection	• Engagement of PLWNCDs • Community-based health, including health promotion, case finding and referral, care delivery, therapeutic support and self-care education • Community feedback mechanisms for accountability
Safe and Scalable Care	• Primary, secondary and tertiary models of care • Continuity and continuum of care • Training and capacity building
Access to Countermeasures	• Resilient medicines and equipment supply chain • Buffer stocks and other stock management measures • Implementation research and developing new treatment modalities
Emergency Coordination	• Mechanisms for collaborative emergency preparedness planning (all sectors, all society) • Emergency coordination mechanisms (all sectors, all society), including coordination of health actors in protracted crises • Operational partnerships (including cross-border) in multi-country emergencies and for medical evacuation

LEBANON
NCD PSG group
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Structure of case studies

The findings from this project are presented for each country case study separately, integrating data from both the desk review as well as the stakeholder interviews. Whilst the interview questionnaire was based on the WHO-HEPR framework, respondents were actively asked to reflect on the different disaster management cycle phases and across the whole continuum of care. However, relatively few responses were specific to individual categories within these two continua, such as preparedness or rehabilitation. As such, the WHO-HEPR was maintained as the core structure, while any points relating to specific crisis phases or the continuum of care are highlighted within the narrative summary or as a separate section. Key messages are presented for each case study separately, while findings and key recommendations are added at the end, synthesising recommendations across the four case studies.

AFGHANISTAN

Total population	38 million[2]
Population in need of humanitarian aid	24 million[3] (62% of total population)
NCD burden	50% of deaths (2019)[2]
Risk of premature NCD death	35% (2019)[2]
Top 5 NCDs (all-causes of death ranking)[4]	1. Cardiovascular diseases (CVD) 2. Other NCDs (primarily congenital heart disease) 3. Neoplasms 4. Diabetes Mellitus (DM) and chronic kidney disease (CKD) 5. Chronic respiratory diseases (CRD)

Background

Afghanistan has been in persistent conflict since the Soviet-Afghan war in 1979, challenging the country's development and recovery. Despite major progress since the beginning of the century - for example in under-five mortality[5] - the country ranked 182 of 189 in the 2023 UNDP Human Development Index[6] and the vast majority of the population (90%) live below the poverty line.[7] Healthcare system challenges, such as an over-reliance on external funding, were amplified with the Taliban takeover of the government in August 2021.[8]

In 2010, a landmark study for NCDs was conducted, the Afghan Mortality Survey. It revealed – for the first time – that NCDs were a major issue, responsible for around 35% of all deaths.[9] This share is estimated to have since risen to 53%[4], with Afghanistan's age-standardised NCD disability-adjusted life years (DALY) rate being amongst the ten highest in the world.[4] A 2024 systematic review and meta-analysis explored the prevalence of key NCDs in Afghanistan,[7] capturing a lack of population-representative and high-quality data on major NCDs. The study identified significant prevalence of key risk factors (e.g., smoking 25%, snuff use 12%, sedentary behaviours 35-65%, hypertension prevalence 31%, and overweight 35%). Evidence on NCD prevalence was limited and highly variable: general population prevalence rates were between 8% and 22% for DM and around 10% for Chronic Obstructive Pulmonary Disease (COPD). Cancer prevalence rates varied widely, largely driven by differences in the study samples. Only one study focused on cancer was done at the population level, which identified an overall prevalence of 0.15% (33% of which were breast cancers, 17% blood cancers, and 14% liver cancers). Importantly, there were no population-level prevalence studies on CVD, despite it being the highest-burden NCD nationally. Other studies emphasised the major role of undiagnosed NCDs, as, typically, more than two-thirds of those with a condition are estimated not to have been diagnosed.[10–12] There is a lack of gender-disaggregated data in the share of undiagnosed NCDs.

NCD response

This section of the case study primarily focuses on the period since the Taliban takeover as the de-facto authorities of Afghanistan in August 2021. Despite the leadership change, many key health system mechanisms and processes remain the same, for example, the national Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). This section thus summarises the national healthcare system in general, while specifically highlighting changes since the takeover. *Box 1* provides a general overview of the primary changes since 2021.

PUSHT-E-KOH, HERAT, AFGHANISTAN
ARCS's Herat branch mobile health team. Pharmacist dispensing medicine to a patient.
© ARCS

BOX 1: Afghanistan health system since 2021

Since the Taliban's takeover of the government in 2021, some aspects of the healthcare system remain unchanged while others have seen significant alterations.[8] In 2021, the prospect of the Taliban takeover led to speculations of a total collapse of the healthcare system. However, service availability was largely maintained, especially due to healthcare workers commitment, flexible contracting and operational mechanisms, and improved security and an increased humanitarian space. In contrast, several other health system challenges worsened. These include leadership and coordination challenges with the de-facto authorities, linked to lack of technical capacity of governmental staff and the MoPH adding new permissions and bureaucracy, such as a no-objection certificate.[8] Disruption extended to other health system functions, such as issues with international supply chains and the out-migration of healthcare staff. Respondents provided specific efforts that were discontinued since 2021, including a WHO-PEN pilot led by WHO, Afghan Red Crescent Society (ARCS), and Primary Care International in 2020, or the Afghan Cancer Association headed by the former First Lady.

A 2024 study explored key changes in the healthcare system after the Taliban takeover.[8] With the shift in government, contracting-out extensions with NGOs were delayed and international funding was temporarily stopped, raising fears of large-scale service disruption. Through emergency funding from the UN and International Committee of the Red Cross (ICRC), external development partners were able to plan a transition from Sehatmandi* to a UNICEF-administered Health Emergency Response project (HER) covering the contracted-out services.[8] This model allowed international funding to move through the UNICEF system in parallel to the new government, to avoid sanctions and concerns of funding the Taliban. The continuity of services may have also benefited from the historically well-established role of NGOs and the pay-for-performance model.[8] International actors with independent funding mechanisms reported fewer disruptions. While ensuring continuity, the model is criticised for being unsustainable and some points of friction have emerged with the new Ministry of Public Health (MoPH), given the model's exclusion from the Ministry's decision-making processes.

Amongst the most impactful changes since the Taliban takeover were new laws restricting the employment, education and movement of Afghan women.[15] With increasingly severe restrictions, international actors called for their recognition as 'crimes against humanity' and 'gender apartheid'.[16] These restrictive policies - with new ones being put in place continuously - affect all aspects of women's lives, including health. Impacts are both direct as well as indirect. Women experience greater access barriers to seek care (e.g, male doctors are not allowed to see female patients), face worsening mental health issues, are disproportionately affected by poverty and food insecurity, have restricted economic opportunities and are barred from secondary education.[17,18]

Despite the risks, women in Afghanistan continue to boldly protest against gender-restrictive policies, demonstrating extraordinary courage in the face of oppression. The challenges of gender-restrictive policies were also brought up by humanitarian actors during interviews. Although the health sector was exempt from the ban on women working with NGOs, respondents highlighted other far-reaching impacts of these policies on their ability to reach and provide care to communities. These include the 'Mahram' policy, requiring women to be accompanied by a male relative guardian (even when working as healthcare professionals), women being removed from leadership positions, and restrictions on interactions between female and male staff, including sex-separated offices.

Researchers have previously highlighted the importance of the international community in advocating for women's rights in Afghanistan. Calls included hiring women into senior management positions, advocating for the removal of educational bans, recruiting and training female health workers, and implementing interventions that increase women's access to care.[15] While women do currently practise as healthcare professionals (including as doctors), the restrictions on all secondary education prevent a new generation of women being trained as doctors (only nursing and midwifery are exempted).[17,18] With these bans, the government is threatening the long-term sustainability of the health care system, especially in providing equitable care.

* The Sehatmandi project aimed to enhance the delivery of healthcare services across Afghanistan by supporting the BPHS and EPHS frameworks. Funded by the World Bank, the European Union, and USAID, it worked to improve access to essential health services through a network of contracted NGOs.

AFGHANISTAN	
National NCD policy and legislation?	Limited legislation on NCD "best buys", with some tobacco taxation and diet-related policies implemented; status of legislation is uncertain[13]
National NCD strategy/ action plan?	Yes (National NCD Strategy 2015-2020, National Implementation Plan for NCDIs (2018-2020 & 2021-2025)). Plans are not implemented
NCDs included in the national care package?	Partially. **Basic Package of Health Services (BPHS)** covers limited NCD inclusion (e.g. hypertensive disorders in pregnancy) at primary care level. The **Essential Package of Hospital Services (EPHS)** partially includes NCDs (e.g. hypertension at all levels; DM at regional or provincial hospitals). The **Integrated Package of Essential Health Services (IPEHS)** will potentially ensure greater coverage of NCDs, including at primary care level (e.g. DM and hypertension screening and care), but this is not yet implemented.
NCD unit in health ministry?	Yes (NCD department, since 2012)
National NCD clinical guidelines exist?	Yes. Standard treatment guidelines for BPHS exist (2013); EPHS standard treatment guidelines could not be accessed.
EML includes NCDs?	Yes (2014)[14]
NCDs included in the information system?	Partially, with limited data on DM and hypertension. Last STEPS survey in 2018.
Regular NCD access and quality assessments?	No. Annual Balanced Scorecards used from 2015-18 (no NCD-specific data)

in place/ existing partially set up not in place/ existing

Governance

NCDs historically received little attention in Afghanistan. The country's essential care packages - the BPHS and EPHS - have largely sidelined NCDs. Their relative absence from the BPHS focused on primary care, resulted in NCD care being centred at higher-level facilities. This left them inaccessible to large parts of the population, pushing the (financial) burden onto people living with these conditions.[5] Prior to the Taliban takeover, the implementation of the packages was monitored by independent partners through an annual Balanced Scorecard. Only in 2019 were NCDs included in the new IPEHS,[19] intended to replace the BPHS and EPHS, but this has not been implemented to date due to financial challenges and the change in government. Other key policy initiatives include a National Strategy for NCDs (2015–2020) and the National NCD Implementation Plan (2018–2020).[7] However, updated versions of these documents - such as the National Strategic Plan on NCDs, drafted before the Taliban takeover - were never approved. The plans have not yet been translated into standardised treatment guidelines to instruct health professionals (November 2024).

Despite these challenges, several stakeholders noted a general openness from the MoPH to work on NCDs, especially in primary health care. A 2023 analysis of NCD governance in Afghanistan[20] highlighted several opportunities, including the presence of an existing NCD unit at the MoPH, the existence of national NCD strategies and legislation around risk factors, and the overall consideration of NCDs across government policies. Insights from the interviews provided a more layered picture, highlighting some of the challenges to the MoPH's NCD leadership and governance mechanisms.

A respondent noted that the MoPH had not yet reviewed policies inherited from the previous government given its priorities around strong 'law enforcement'. Another added that the MoPH had many young doctors who lacked expertise in running NCD programs, which other researchers have also described.[8] This lack of awareness and capacity around NCDs reportedly expanded across national and subnational actors, including implementing NGOs and healthcare providers. Other factors which limit the MoPH's capacity

to perform its normative role include its weak international status, the donor-driven nature of the health sector response (which has historically focused on communicable diseases as the primary health burden), and the fact that NCDs are often more complex for the general population to understand. These challenges were corroborated by desk review findings, highlighting a lack of motive and budget at the MoPH to implement plans, donors' lack of interest in NCDs, the change in government and a non-functioning NCD policymaking cycle as key issues.[8,20]

Various coordination mechanisms for health actors exist. This include working relationships between the UN and the de facto authorities, with the MoPH and other ministries. In contrast, interviewed INGOs and the RCRC Movement reportedly had no direct engagement with the de-facto authorities. The government has allowed the cluster system to be active in Afghanistan (see below) led by UNICEF and WHO, with the latter having focal points in most provinces and coordinating with the de-facto authorities and implementing NGOs. Of note, the 2023 Afghanistan Humanitarian Response Plan does include NCDs amongst priority health actions for humanitarian agencies, but only includes 'initial treatment' as opposed to long term care.

BOX 2: Afghanistan - which NCDs?

Non-state health actors that address NCDs typically focus on hypertension, diabetes, CVD, and COPD, including during pregnancy. Mental health was frequently brought up as a focus area, while respondents voiced concerns about it being insufficiently addressed and integrated with NCDs in the current system. The above-listed NCDs were typically addressed as part of primary care efforts, while other NCDs were less commonly mentioned and efforts were more project-based.

For example, respondents described efforts around cancer by the WHO and a congenital heart disease program from the ARCS (both described below). The cancer agenda in Afghanistan is often seen as outside NCDs, which is likely due to cancer (and dialysis) programs spanning multiple healthcare levels and are often more 'vertical'.

ADRASKAN, HERAT, AFGHANISTAN
ARCS's Herat branch mobile health team. Visitors entering the midwife consultation clinic.
© ARCS

Financing

Health services in the public primary healthcare sector are generally free of charge and remain so under the Taliban. However, due to service delivery gaps and ineffective arrangements, out-of-pocket payments are estimated to account for around 80% of national health expenditures.[21,22] There is no national insurance scheme or prepayment mechanism (such as a health card or health voucher). Catastrophic health expenditure is a major issue in Afghanistan.[22]

Health system financing in Afghanistan relies heavily on external donors, which essentially shape the health system priorities. Key international donors supported the provision of the BPHS and EPHS, prior to the Taliban takeover.[17] Before 2021, a contracting-out model was used, under which NGOs provided healthcare services on behalf of the MoPH in 31 out of 34 provinces.[8] However, as their contracts were based on the BPHS/EPHS, organisations often lacked the mandate for implementing NCD care specifically. This may be especially pronounced for initiatives funded by development donors, as humanitarian funding typically prioritises financing based on needs assessments. This was confirmed by an assessment of primary-level care, showing a persistent gap and near-absence of NCD services, leading to medical tourism.[23] WHO reports from 2016 had also highlighted the lack of NCD prevention and care capacities in Afghanistan, with no national NCD functions or activities shown to have a stable funding source.[24,25] Traditional medicine is also commonly used in addition to or in parallel with health facility services.[26]

During stakeholder interviews, some NCD-specific funding was mentioned. However, multiple respondents acknowledged that the overall interest in NCDs is minimal and typically limited to project-based or short-term funds. Projects often relied on short-term humanitarian financing, while some tried to tap into longer-term, more developmental funding. For example, the WHO reportedly received multiple funding streams to support mental health,, NCDs, and cancers with capacity building of healthcare professionals and strengthening community-based care. Within the RCRC Movement, few donors were seen as prioritising NCDs - though the DRC was mentioned as one exception. Other funders with some focus on NCDs included the Asian Development Bank, European Civil Protection and Humanitarian Aid Operations (ECHO), the UK Foreign, Commonwealth & Development Office (FCDO), and the Islamic Development Bank of Saudi Arabia. The absence of systematic long-term funding resulted in implementers not starting, limiting, or downscaling their NCD programming. The availability and - especially - the quality of funding was seen as a key barrier to delivering NCD care and addressing its behavioural aspects. The global shift of attention away from Afghanistan may amplify these challenges.

Collaborative surveillance

The Health Information System (HIS) is seen as a major challenge. While facilities collect NCD information - i.e. diagnosis - at the patient level, these are not reported systematically to the MoPH for aggregation. Data from private providers is fully invisible, as it is not integrated with the public HIS and due to a lack of rules regulating the data sharing. The current HIS captured virtually no information on NCDs, challenging actors' ability to make informed decisions. Previous reports[27] noted partial collection of data around diabetes and hypertension, which was, however, limited to certain parts of the healthcare system (e.g., outpatient departments only). Gaps around NCD data-gathering by ARCS were also noted by respondents. The organisation does not capture any NCD data in aggregate form. Patient-level health information is held in a paper-based format at facilities, though the quality of this data is uncertain.

Respondents did raise anecdotal evidence of increasing levels of NCDs to highlight the urgency of improving data collection and analysis at the health system level. A national STEPS survey was conducted in 2018, highlighting the increasing role of NCDs in Afghanistan.[7]

There are currently no government-run NCD patient registries in Afghanistan; while individual organisations may hold their own registries, these are not shared. Despite the limited data on NCDs, surveillance on other health issueswas seen as a key success story in Afghanistan due to recurring communicable disease outbreaks. This may provide an opportunity for people in the NCD space to build on.

Needs assessments were commonly used to justify the scope of humanitarian interventions, while it is not clear to what degree NCDs are included in the data collection for needs assessments across different actors. In one instance, a 2024 multi-sectoral rapid needs assessment of Afghan returnees, NCDs are not specifically included, although mental health is included.[28] Nevertheless, the inclusion of NCDs in the Afghanistan Humanitarian Response Plan (HRP) implies that this need would have been flagged during earlier needs assessments (e.g. Public Health Situation Analysis - PHSA). However, the HRP's focus on 'initial treatment for NCDs', means that humanitarian donors are unlikely to finance ongoing care for NCDs.

Community protection

Community-based healthcare guidelines exist within the BPHS, outlining the general role of community health workers (CHWs) around awareness raising, tracing, and follow-up. Respondents noted that CHWs may be aware of some NCD-related messages (e.g., linking smoking to cancer) but that the primary attention, as for the rest of the healthcare system, is focused on communicable diseases. Even in the absence of NCD-specific messaging, some relevant awareness-raising themes may be covered as part of other topic areas. As an example, the role of healthy foods or smoking during pregnancy was mentioned. The potential and interest of expanding existing CHW network activities to cover NCDs were noted several times, including for the ARCS.

ARCS reportedly has 37,000 volunteers nationally and implements a strong community-based health and first aid (CbHFA) component, building on IFRC guidance materials. While the IFRC materials do include a module on NCDs, no volunteers have been trained on it so far. Several respondents were keen on expanding the NCD work in their community health component. Some continued suggesting to start with building the capacity of CHWs, including their ability to refer people, before building the capacity of PHC centres. This contrasts many humanitarian actors' approaches, focused on ensuring PHC centres are able to deal with an increase in demand.

Another respondent from an INGO reported on a CHW component that included NCDs. Their work included nutrition screening, health messaging, and basic demographic profiling - including the number of people living with NCDs. The organisation had future plans to train CHWs on basic screening and referrals of NCDs. CHW programs - in order to conform with Taliban policies - selected one man and one woman from the same family.

Stakeholders mentioned the need to complement community-based work with policy initiatives, such as tobacco taxes. This was made more urgent due to the increasing impact of aggressive marketing practices from health-harming industries and lack of regulation. Despite the lack of population-based health awareness raising, multiple respondents noted that more and more stories from individuals are emerging. Especially diabetes and cancers were seen to get more attention. A specific initiative, led by WHO, to work with the national cricket team for awareness raising was brought up as a potential avenue. In addition, one respondent highlighted that the reach of smartphones and the internet is increasing, which - coupled with people's increased appetite to learn more - can provide new opportunities.

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

Safe and scalable care

Health services were previously delivered under the Sehatmandi project, which shifted to the UNICEF-run "HER" project after the Taliban take-over. This led to a significant increase in health-related programming for some INGOs after August 2021. All respondents from implementing humanitarian actors - whether or not they were formal BPHS implementers - reported following the BPHS and EPHS packages, though with some variation. Organisations typically addressed NCDs as part of their general health programming (e.g., primary care services) rather than as a stand-alone effort. Priority NCDs were seen as hypertension and DM with a focus on refilling medicines, providing short consultations, and stabilising and referring patients with more complex needs (e.g., diabetic ketoacidosis - DKA). High patient workloads result in few physicians being able to spend time on health education messages. However, referrals were reportedly incredibly challenging even for organisations with well-established pathways that included a clear mapping of facilities, provision of referral slips, and informing focal points. Defaulters were frequent due to the difficult travel conditions and the direct/ indirect costs associated with travel. Potential cash-based support was viewed with scepticism due to people spending the money on other priorities instead.

Mental health was reportedly not seen by many healthcare providers as a disease, with a significant taboo and stigma associated with these conditions. Respondents acknowledged the major repercussions a mental health diagnosis may have for a person's acceptance in their community. Despite these challenges, some actors reported implementing basic screening and psychological first aid and received positive responses from their participants to counselling sessions.

Humanitarian organisations generally reported working in hard-to-reach areas to fill existing service gaps. Mobile health units were sometimes used to expand an organisation's reach, while a 2023 decree from de-facto authorities required implementers to move towards fixed structures. Some respondents perceived this as challenging given the lack of support in finding appropriate structures to rehabilitate. To address this, one organisation mentioned efforts to identify vacant buildings with the help of the community. Multiple respondents noted the current drive to move from a crisis to a longer-term health system-strengthening approach. WHO support

for NCDs in Afghanistan has been relatively weak historically, as, for example, only 37 healthcare workers were trained on the WHO PEN in 2023.[29]

Access to NCD care was a key theme brought up by several stakeholders. Rural areas were described as hard-to-reach areas with few facilities available. Many PLWNCDs, including in rural areas, cannot afford private providers, even if they are available. This gap in service provision has direct and devastating impacts. One person recounted vivid stories of pregnant women dying in transit to larger cities due to complications with the delivery. Even in existing healthcare facilities, what is seen in terms of NCDs was described as 'the tip of the iceberg', given a lack of proactive screening. One INGO respondent highlighted that most NCD patients access the facility to obtain free-of-charge medicines. Its internal data suggests that the majority of people arrive at their centres having been diagnosed elsewhere, which may suggest that the most vulnerable people are left behind. One respondent noted that the public health sector had seen an increase in patient numbers in 2022, due to a drop in the population's purchasing power.

In urban centres, higher-level government facilities provide specialised NCD services and act as referral centers for PHC. Their role is especially important for NCDs that are not currently addressed elsewhere, such as cancers. The MoPH is reportedly working on strengthening NCD care at governmental centers and teaching hospitals. This includes establishing provincial hospitals as the main focal point for cancer management, including a core clinical team and laboratory, and the launch of a new cancer centre at Kabul University Hospital in 2025. In addition, an ongoing feasibility study on establishing a tertiary CVD hospital in Kabul was mentioned and will inform the MoPH and key partners.

The RCRC movement's focus in Afghanistan is on hard-to-reach and disaster-prone areas, where there is no access to MoPH facilities. This can amplify challenges with provision of continuity of care due to frequent population movement. ARCS addresses NCDs under its primary healthcare approach in 46 centres - following the BPHS guidelines. Partner societies support ARCS with training for healthcare professionals and CHWs, the provision of medicines and equipment, and - at times - by paying for specific elements such as patient referrals to higher-level centres. Capacity building is done in collaboration with the MoPH and movement partners. However, the NCD package was seen as "very limited" by respondents, due to a lack of resources and trained healthcare professionals. To date, no ARCS staff (volunteer or paid) has been trained on NCDs and supplies were limited to basic hypertension, type 2 DM, and COPD medicines. Patients with complex care needs are referred to higher-level or specialised hospitals. In addition to its primary level centres, ARCS does have a dedicated congenital heart disease hospital in Kabul. However, while the centre is 'open' it is reportedly 'non-functioning' due to funding issues.

ADRASKAN, HERAT, AFGHANISTAN
ARCS's Herat branch mobile health team midwife examining patient's blood pressure.
© ARCS

Access to countermeasures

Medicines were one of the main priorities of implementing actors and part of typical support packages from international NGOs. Some NCD medicines were usually included, going beyond what is outlined in the BPHS. One example was the use of the mhGap which enables doctors to use around 10 mental health drugs, while the BPHS only included one drug (diazepam). However, actors highlighted the still limited scope (often focused on DM, hypertension, and COPD) as well as the lack of availability of equipment. Issues with equipment availability were even noted for provincial hospitals where, for example, mammograms or CT scans were often absent. Due to the major issues with NCD medicines' availability in the country, WHO has been advocating for international donors to include NCD drugs in its essential medicines and procurement lists.

Within the RCRC movement, NCD medicines are part of the partner societies' support of ARCS. Their support is guided by a jointly negotiated medicines list, which is reviewed twice yearly. The scope of NCD medicines was limited due to budget constraints and procurement challenges. Partner societies are monitoring drug consumption and tracking their distribution to the end user level. International procurement is done by ICRC and handed over to ARCS for distribution.

One INGOs respondent highlighted that its procurement list was recently expanded to include essential NCD diagnostics equipment (e.g. glucometers and tests for asthma).

Emergency coordination

Emergency coordination is primarily centred around the active cluster system. The Health Cluster coordinates at national and sub-national levels with over 50 partners providing health services across Afghanistan's 34 provinces. In 2022, it reached 14.7 million people in need according to the Health Cluster website, although it is unclear exactly how those people benefited from this. NCDs in emergencies were reportedly a priority for the WHO and the Health Cluster objectives of the 2024 Afghanistan Humanitarian Response Plan include (i) maintaining and increasing access to life-saving and -sustaining services for those most vulnerable, (ii) strengthening the health sector capacity on disease outbreaks, (iii) ensuring access to services for survivors of violence, and (iv) strengthening the provision of integrated rehabilitative care.[30] NCDs are included at the primary and secondary level under point (i) while not being specifically mentioned, unlike mental health.

Respondents flagged the Health Cluster's limited capacity to work on NCDs due to the prioritisation of disease outbreaks and disaster responses. Specific - though sporadic - examples of NCD-related emergency responses were provided, such as a WHO training-of-trainers and the use of the emergency medicines kit after the 2023 earthquake in Herat. The RCRC movement does not have an NCD-specific coordination mechanism.

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

KEY MESSAGES

Policy messages

- Leadership needs to be ensured at all levels, including at implementing NGOs (such as ARCS) and the de-facto authorities. Can we find entry points to build the health leadership capacity at different levels within the health system?
- NCD approaches need to be integrated into the BPHS, for delivery at PHC level, prioritising conditions with the highest prevalence and feasibility of implementation.
- Health care is essentially funded out of pocket - can RCRC find ways to financially support the most vulnerable to access care, or otherwise to organise and cover the costs of referrals?
- All actors need to challenge the 'permanent crisis' narrative in Afghanistan, that focuses health policy attention on infectious disease outbreaks and trauma, to a longer-term 'system strengthening' narrative that prioritises a minimum package for NCDs. Otherwise NCDs 'are always on the back burner'. WHO (and humanitarian donors) should be challenged for their lack of prioritisation of NCDs.
- Whilst a direct challenge to gender discrimination policies may be impossible, RCRC should be actively looking for entry points here (e.g. arguing on the basis of empirical evidence for an extended role for female CHWs), and at the very least should be modelling non-discriminatory practice where possible (e.g. ensuring balanced representation of female employees in management positions).

Operational messages

- ARCS CHWs could play a valuable role in NCD service delivery.
- Collaborating with community-based institutions is key, including on health education and promotion and referral.
- Mental health needs to be seen as an integral part of NCDs, mainstreamed across all aspects of humanitarian responses.
- Can RCRC use its position of relative credibility to bring more health actors to the table in existing coordination mechanisms?
- With an increasing reach of smartphones and the internet, new opportunities may emerge to reach rural areas (e.g., mHealth). This requires an active role for policymakers.

LEBANON*

Total population	6.8 million[31,2]
Population in need of humanitarian aid	3.7 million in July 2024[32] (64% of total population)
NCD burden	89% of deaths (2019)[2]
Risk of premature NCD death	20% (2019)[2]
Top 5 NCDs (all-causes of death ranking)[4]	1. Cardiovascular diseases (2) 2. Neoplasms (3) 3. Diabetes Mellitus and chronic kidney disease (5) 4. Neurological disorders (6) 5. Chronic respiratory (7)

Background

Lebanon has been in ongoing and complex emergencies since 2011, with the start of the Syrian Civil War. People fleeing the country in search of safety has resulted in Lebanon hosting the largest number of refugees per capita globally: around 1.5 million Syrian refugees and 0.5 million Palestinian refugees resided in Lebanon in 2023.[33] Multi-layered crises have ravaged the country and its healthcare system since, beginning with a severe socioeconomic crises in 2019, followed by the Covid-19 pandemic, the 2020 explosion in the port at Beirut, infectious disease outbreaks, and - most recently - Israel's war with Hezbollah.

Severe escalations and ongoing attacks have caused at least 1,540 conflict-related deaths, injured thousands, and left more than 210,000 people displaced by end of September 2024.[34] The data for this case study were collected in August 2024 and present a snapshot in time, but some aspects have significantly changed in the intervening period, especially around the emergency preparedness and response.

Care in Lebanon is delivered through a mix of public and private providers. The Lebanese PHC system is pluralistic, including diverse religious and political groups providing services, a strong private sector, and an active civil society with powerful NGOs.[35] Most government institutions are operating at 'less than 20 percent of their normal capacity' and with a much reduced operational budget.[36] Multi-layered crises and funding shortfalls have led to shortages of essential medicines and equipment, skyrocketing costs for imported products and tertiary-level care (owing to the ending of government subsidies), reduced public sector capacity, and have accelerated the emigration of health professionals, with more than 40% of the workforce having left the country.[36,37] Health care delivery for Palestinian refugees is organised separately through UNRWA.[38]

The burden of disease in Lebanon is dominated by NCDs, accounting for 83% of deaths in 2019. The prevalence of modifiable NCD risk factors such as physical inactivity and tobacco use has been increasing among the Lebanese population and is similarly high among Syrian refugees.[39,40]

A study from 2016 revealed that over half of Lebanese households reported a family member with at least one NCD suggesting that the country would not achieve the NCD-related SDG.[41] Gaps remain in the screening and early detection of NCDs as well as shortcomings in the extent of treatment services.[38] Mental health conditions are also an especially growing concern. While data remain scarce, recent evidence suggests an increase in the suicide death toll, and Lebanese health experts were warning of a mental health pandemic[42] even prior to the current attacks.[38,40]

* 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

LEBANON	
National NCD policy and legislation?	Partially. Some prevention policies were implemented, such as restrictions on the availability of alcohol and smoke-free policies.*
National NCD strategy/ action plan?	Yes. The NCD Prevention and Control Plan 2015-2020, which is currently being updated.
NCDs included in the national care package?	Partially. Diabetes and hypertension are the priority NCDs that were integrated into the Essential Health Care Benefit Package.
NCD unit in health ministry?	No NCD department at the MoPH. There is an existing diabetes unit at the MoPH. A mental health department exists.
National NCD clinical guidelines exist?	Yes, 2023 updated clinical care algorithms exist for an expanded list of NCDs.
EML includes NCDs?	Yes. NCD medicines are included in the national EML.
NCDs included in the information system?	NCDs are included in the national HIS but issues with data quality and reporting practices exist.
Regular NCD access and quality assessments?	Quality of care monitoring includes NCDs as part of the PHC level. However, indicators are limited and remain process-focused.

in place/ existing partially set up not in place/ existing

NCD response

Governance

In Lebanon, the MoPH's responsibility includes overall coordination and guidance, encompassing the provision of selected medicines and equipment free-of-charge, a HIS, and training. The MoPH does not run its own facilities; instead, this is the responsibility of NGOs who are implementing care based on MoPH policies and procedures. Any NGO planning to work in a healthcare centre has to follow a set of MoPH programs including maternal health, wellness, mental health and disability. NCDs prevention, screening and management is included under the 'Wellness' program.

There is no NCD department at the MoPH to act as a coordinating body, leaving NCDs fragmented between different sections of the MoPH, including the PHC department and a specific unit on diabetes. In contrast, a dedicated department for mental health exists at the MoPH, which has developed a national strategy, coordinates health promotion campaigns, and facilitates the work of an MHPSS Taskforce for emergencies. To push the NCD agenda, various actors - including the WHO - have been calling for the establishment of an NCD department. The MoPH is reportedly working to update the current NCD Prevention and Control Plan, with the most recent version being from 2015-2020. The National Mental Health Program has developed a strategic plan and associated protocols for the diagnosis and screening of mental health conditions. These are integrated into the PHC network through the MoPH programs. Complementary to the MoPH, professional associations play a key role in coordinating activities around specific disease areas (e.g., CHANCE for childhood cancer).

The MoPH developed a standardised package of care - the Essential Health Care Benefit Package (EHCP) - which includes NCDs at the PHC level. The priority NCDs are diabetes and hypertension which were included as stand-alone packages in the EHCP. Broader initiatives, such as clinical algorithms and the essential medicines list (EML), cover a wider set of NCDs. In 2023, the MoPH and WHO developed updated clinical care algorithms for the PHC level based on a list of the most prevalent conditions.

* Data from WHO NCD Portal: Lebanon (2024). https://ncdportal.org/CountryProfile/GHE110/LBN

The guidelines cover 33 priority conditions, including many NCDs (such as diabetes, hypertension, dyslipidemia, COPD, asthma, and depression) and were developed in collaboration with professional societies. Cancer and renal disease are reportedly a priority, but support for these has been challenging due to a lack of donor interest, given their associated costs. The majority of physicians at the PHC centres have been trained to provide unified treatment based on the clinical algorithms. However, another respondent flagged the need to train PHC providers in NCD care. The WHO provides support in developing materials and conducting trainings around NCD care. The basic service package as well as the NCD screening protocol is currently being reviewed by the MoPH and WHO, as it is perceived as 'too expensive' for some implementing actors. For the 200 centres that are not yet supported, the WHO is working on affordable packages including essential laboratory tests.

WHO supports the MoPH with coordination, including co-leading a monthly Health Sector Working Group with 100+ partners, including INGOs and UN agencies, to discuss issues related to the health system. In mid-2024, WHO and MoPH initiated a small new committee with a sole focus on NCDs, while a larger multi-sectoral committee is at the planning stage. The creation of the committees was triggered by a national conference on NCDs in 2023. The small committee working on NCDs does not include NGOs, as there are 50+ such organisations in Lebanon - including the LRC - thus creating issues around equity and transparency. Some limited cross-sector collaboration on NCDs already exists. For example, the MoPH and WHO work with other ministries on specific projects, such as with the Ministry of Interior on incarcerated populations or with the Ministry of Economy and Trade on the elimination of trans-fatty acids. However, respondents noted that these collaborations are largely ad-hoc and small initiatives, which face bureaucratic challenges and a lack of prioritisation by partners.

The Lebanese Red Cross (LRC) collaborates with several partners at the national level, including the International Medical Corps. These partnerships are driven by the overwhelming need of the population with few organisations able to provide all required services. Collaboration has existed to date with the MoPH; however, recent discussions on scaling-up partnerships and projects are taking place. Within the RCRC Movement, the DRC was mentioned as the only national society that supports the LRC around mental health and NCDs. The LRC was seen as a 'partner' given their co-location, on-the-ground technical support, and strong involvement in ongoing projects. Other RCRC partners are less visible to the LRC, with collaborations limited to sending funds and requiring a quarterly report.

BOX 3: Lebanon - which NCDs?

The national EHCP prioritises diabetes and hypertension through stand-alone care packages. A larger set of NCDs is considered for broader health system initiatives, including COPD, cancers, and dyslipidemia among others. Interviewed INGOs focus typically on CVDs, hypertension, diabetes (type 1 and 2), and mental health (e.g., psychotic diseases and depression). Some have wider packages that include respiratory illnesses and seizures. Community health efforts often have a broader focus, such as awareness messaging around tobacco and cancers (see page 22). In LRC centres, priority NCDs include CVD, diabetes, and hypertension.

Financing

Lebanon's health sector has multiple payers who pool funds for different population groups and reimburse healthcare providers. The main payers include patients, NGOs, the government, the National Social Security Fund, and private insurers.[43] Patients' out-of-pocket (OOP) payments for care account for around 30% of all health expenditure, primarily directed toward medicines purchases. The second largest share is covered by NGOs (around 27%), with the MoPH being a relatively small payer primarily limited to hospital care for uninsured persons. The variability of payers and reimbursement systems present challenges for patients' access and lead to inequities between groups.

The currency devaluation after 2019 led to a significant increase in poverty levels and triggered a severe shortage of medicines, including in the private sector.[44] Multiple respondents noted that more people had to rely on PHC centres with private sector and tertiary level care becoming vastly more unaffordable. Before the economic crisis, public PHC centres were primarily used by Syrian refugees, but the share of Lebanese people accessing them has increased significantly since. This shift was caused by people being unable to afford private sector fees or able to purchase private insurance. For example, a simple consultation at the American

University of Beirut (AUB) costs around 100 USD, with specific treatments going far beyond that. According to the president of CHANCE, treatment for childhood leukaemia can cost 50,000 USD per patient, payable entirely by the patient. (Ref: letter to Director General, WHO).* People were left with no choice; either go to a public PHC centre or be without medical care. This change may have been even more significant for people living with NCDs, due to the need for continuous access to medicines. One person noted the difficulty for Lebanese people to accept having to go to public PHC centres, with patients trying to get early appointments, to avoid their neighbours seeing them, because of the stigma associated with attending the public centres. Actors attempted to mitigate this by emphasising the role of PHC centres in providing equal care to all. In response to the increasing patient numbers, existing MoPH efforts to strengthen the PHC network were scaled up by increasing the number of PHC centres and standardising service delivery, prevention and algorithms for NCD management.

The LRC healthcare services are primarily financed through donors as well as some funds from the MoPH for the accredited PHC centres. Patients pay very little – and if they are unable to pay, the fees are waived. The primary NCD project is the Bridging the Gap Project, funded by the Novo Nordisk Foundation. The initial project ended in 2024 and a new four-year project has been signed.

Many humanitarian actors working in Lebanon are funded through key US or EU donors (e.g., US Bureau of Population Refugee and Migration, ECHO). In terms of funding flexibilities, one respondent noted that their humanitarian funding (e.g., from ECHO) allows them also to work on systems strengthening initiatives, such as improving the HIS and conducting training. This was contrasted by examples of donor 'quotas' for humanitarian actors, such as funders requiring that a certain percentage of those reached by a project should be Syrian refugees.

Collaborative surveillance

Some form of electronic data capture exists at some centres at the PHC level (albeit with limited functionality), and other centres still rely on pen-and-paper data collection. However, even if data is digitalised it is barely used afterwards, including data on medicines. The existing facility-level data is used by the MoPH and WHO to monitor PHC-level indicators. One use of the data is reviewing the consultation numbers to try to ensure appropriate medicines availability at the centres. There is a gap around NCD indicators at facility level. The WHO is providing technical support to implement the WHO NCD facility-based monitoring framework. The quality and scope of the data is a key gap, with centres using diverging definitions for reporting and a lack of outcome indicators. With the current system focused on process indicators, there is a lack of insights around the quality of care. For example, the percentage of diabetes patients with a controlled HbA1c.

Humanitarian actors have a variety of in-house health information systems in place, often relying on organisation-specific tools or standards. This ranged from pen-and-paper data collection to robust cohort management systems including detailed prescription data and defaulter tracing. This data was used primarily for clinical and operational decision-making, with one organisation also using it for operational research and advocacy. These actors share only certain data with the MoPH based on their reporting requirements. This requirement only spans government-accredited centres. This may exclude a large number of other centres - for example, only four of LRC's 36 PHC centres are accredited. LRC is currently working to implement a novel HIS to be used across all centres, which is compatible with the MoPH system.

BEIRUT, LEBANON
Adnan Hamad, 47, from Syria showed up to his routine wound care and check-up at the ICRC ward in Rafik Hariri University Hospital (RHUH) in Beirut, Lebanon.
© ICRC/Yara, Al Chehayed

* CHANCE is an officially registered charity in Lebanon since 2005 and is focused on treatment for children with cancers and blood disorders.

There are a number of national disease registries – for example on diabetes – that are maintained by the MoPH with WHO support. A separate registry for type 1 diabetes is currently being discussed. The CVD registry was developed in collaboration between AUB, WHO and other partners in the past. However, it was discontinued due to the time-consuming nature of the questionnaire and lack of sustainable funding.

National population-based surveillance is conducted periodically, supported by WHO. This includes a household survey on specific risk factors as well as STEPS surveys, with one conducted in 2016 and an updated version (data from 2023) currently being finalised.

A separate assessment on the continuity of care was conducted by the MoPH in 2023, with NCDs and mental health as two of its core focus areas. The assessment showed major gaps in accessing quality care, especially for people living with mental health. NCDs are also only partially included in rapid needs assessments during acute emergencies. For example, some assessments after the Beirut explosion included NCDs[45] while several others did not.[46,47] A Multi-sector Initial Rapid Needs Assessment (MIRA) at the outbreak of the Israel-Hamas war in 2023, led to a WHO flash appeal that emphasised the need for ensuring continuity of NCD care in Lebanon.[36]

Community protection

The MoPH is implementing - with WHO support - various NCD-related activities. An updated NCD Prevention and Control Plan is being developed, which will include prevention and health promotion. A yearly awareness raising calendar for PHC centres exists that includes NCDs. One of the key initiatives that was brought up is a collaboration with the World Diabetes Foundation and AUB for the past two years. The project included the development of unified Arabic materials on NCD awareness and a component of one-to-one awareness in 100 pilot centres, together with partnership with the municipality on awareness raising. Awareness-raising sessions are often coupled with screening of people at high risk, for example around tobacco and stress as key risk factors. One respondent flagged that the population's general mentality is illness-focused and few people will make use of free screening options (e.g., six-monthly blood tests offered through the Wellness program). Other INGOs reported conducting campaigns at PHC centres during specific health days (e.g. World Heart Day), including topics such as NCD prevention and management. Some have developed and disseminated their own booklets on NCD self-care.

Key health system actors noted a trend towards community engagement work, with INGOs increasingly having budgets to work in communities. Several respondents saw this positively and as an opportunity to reach people who live further away from health centres and to raise the visibility of PHC centres. Community-based efforts by humanitarian actors consisted of working with CHW networks, awareness-raising campaigns, covering group transportation options, and home visit programs. Peer support groups were mentioned as one specific modality used by several organisations, building on HIV/tuberculosis models of care.

For some organisations, CHW components went beyond health promotion to actively engage community leaders and seek feedback, which is particularly effective for organisations that are well-established in a certain location and are trusted by and have strong ties to the community. The frequently changing nature of the situation made these engagement efforts difficult. One INGO respondent described their rationale for increased community-based efforts, arguing that the economic crisis limited people's ability to travel, giving increased importance to bringing services closer to people. Others noted that community-based efforts, such as peer support, helped ensure sustainability by supporting people's agency and ability for self-care.

The LRC has a strong volunteer network with around 600 volunteers in the medical-social sector alone. All volunteers are trained on basic health topics, including mental health and NCDs. Volunteers may help centres with logistics (e.g., organising a location for screening activities), facilitate certain sessions and events, and help with screening activities. They also provide administrative assistance in health centres, link patients to other facilities and services, and assist with health needs assessments and surveys. Volunteers are continuously informed about key messages shared by the MoPH for them to distribute. A more comprehensive community-based program, including peer support groups, exists at the PHC centres selected as pilots for the BtG project (see page 23).

Safe and scalable care

The health care system in Lebanon is unlike others in the MENA region. The PHC system is not operationally run by the MoPH; instead, it is a partnership between implementing actors and the

MoPH. This contracting-out mechanisms has been employed since the 1990s in an effort to strengthen the primary care sector.[48,49] Actors include local and international NGOs, managing the largest share of PHC centres, as well as sectarian associations and non-sectarian organisations.

There are currently around 300 government accredited PHC centres. These consist of satellite centres and the fixed PHC centres – the latter providing a broader set of services including x-rays and laboratory tests. Dispensaries, the lowest level of health facilities, can become accredited PHC centres by meeting the minimum care standards and signing a service delivery contract with the MoPH. Of the 300 centres, around one-third are supported by INGOs providing subsidised services based on the same MoPH-set parameters that need to be followed. These centres - in theory - provide the same level of care at a minimal cost (e.g. 3 USD administrative fee) to the patient. The remaining centres are supported by national NGOs, where patients pay the full amount for consultations (around 15 USD). NGOs previously subsidised the fee for the most vulnerable populations. However, this was discontinued following the economic crisis due to financing challenges. PHC centres serve both the host population and refugees equally. Treatment algorithms are provided to all government-accredited centres.

Since 2013 there has been an initiative in the PHC centres to integrate NCD services into the PHC system based on WHO guidelines. The primary focus is the provision of NCD medicines at the facilities. In addition, patients with diabetes or hypertension have - at a minimum - a routine six-monthly follow-up to monitor disease control and potential complications. Centres also offer screening for both conditions for any patient at age 40 or older. An additional home visit component has been instated with NGOs in the South, due to the direct impact of war in South Lebanon and the resulting displacement. The MoPH is reportedly reviewing, in collaboration with the WHO, the NCD screening and treatment protocol as the current package is 'too expensive' for some implementing partners.

The aim is to create a simplified, affordable package including essential medicines and equipment. Upwards referrals from the PHC centres have become increasingly difficult since the onset of the economic crisis, with few people able to afford hospital-level care. A WHO-supported program is trying to address this by sponsoring hospitalisation for 'life- and limb-saving' treatments.

LEBANON
NCD PSG group
© LRC

The LRC runs 36 PHC centres, which provide essential health care. The centres follow the MoPH guidelines for NCD management, screening and prevention. NCD care is provided at the facility level, spanning clinical consultations, medication and regular monitoring, and is complemented with community outreach activities, including health promotion and screening campaigns. The main NCDs seen at the LRC centres are CVD and diabetes. The LRC centres are known for treating these conditions, given their dedicated outreach, and are perceived by patients as 'NCD health centres', with local implementing partners (for example other humanitarian actors) linking people living with NCDs to LRC facilities. The prevention component, at the community level, covers a broader set of conditions including cancers and reproductive health. Mental health is mainstreamed across all LRC programs, including NCD programs. If people with other NCDs arrive, they would receive general consultations, linkage to higher-level facilities and be given medicines if they are available at the centre. However, LRC does not currently provide home visits, rehabilitation, or palliative care services due to the lack of dedicated staff, guidelines, or health strategy.

A subset of LRC centres provides a more comprehensive NCD package of care, under the Bridging the Gap project. The project includes a peer support component with an associated implementation research study, led by the London School of Hygiene and Tropical Medicine. Sessions are led by social workers and volunteers and integrate both mental health and NCD topics. Staff from beyond the six project-supported facilities were trained on standard operating procedures (SOPs) and protocols, allowing for the scaling up of peer support groups to nine health centres. The peer support groups were built on LRC's previous experience with running mental health peer support modalities.

One INGO interviewee described ongoing primary care projects focused on providing essential care including NCDs. The centres provided a multi-disciplinary and extensive NCD program, beyond services covered by other centres. As an INGO-run centre, services were provided at no cost to the patient, including medicines and laboratory tests. Its approach was more comprehensive than that of other interviewees by covering newer NCD medicines, employing a patient-centred self-care app, using task-shifting for follow-up and by providing financial support for hospitalisations.

Access to countermeasures

An essential medicines list for Lebanon is guiding the provision of medicines at the different health system levels. Several NCDs and mental health conditions are included in the list, including some cancer medicines. The availability of NCD medicines is seen as a key priority by several actors amidst ongoing stock-out issues for certain medicines, especially for cancer treatment. The national supply chain system is financially supported by the WHO and EU donors, supporting logistic costs. The MoPH manages the budget, while the WHO is given the responsibility to purchase medicines, which are then handed over to the YMCA Lebanon to distribute them and manage the supply chain. Patients must pay a 'small' fee to receive medicines through the YMCA system, as the primary supply chain system supporting the public health system in Lebanon. One respondent noted a challenge, as doctors may prescribe newer medicines, which are not covered in the EML, thus requiring patients to purchase them out-of-pocket from the private sector. This was seen as an issue of an 'outdated' EML, while other actors argued that the focus on generic medicines is key to ensure sustainability as few NGOs would be able to procure newer-generation medicines.

The WHO further supports advocacy around the use of the EML and around increasing the local procurement and manufacturing capacity. Local procurement was seen as especially important for emergency preparedness, due to flight cancellations and supply chain disruptions that are occurring during the ongoing war between Hezbollah and Israel. The WHO may procure NCD kits for specific events or to cover gaps (e.g., insulin). For example, the WHO provided ad-hoc support after the Beirut blast around care for multiple sclerosis, cancer, and dialysis services.

Several actors support WHO and MoPH supply chain efforts, with Anera mentioned as one key operational partner in NCD medicine supply supporting MoPH centres with NCD medicines procurement and distribution. Its supply chain runs parallel to the YMCA-managed system. Anera's primary program is the procurement of essential medicines covering around 10% of the medicine needs for MoPH patients. Medicines are purchased - primarily from national manufacturers - based on the Lebanon EML with financial support from government funders including the US, Canada and the UK. Medicines are provided to patients free-of-charge based on an application and vulnerability assessment. Anera medicines are stored and marked separately at the facility level. A separate in-kind donation program manages medicines donated by NGOs and typically covers high-cost treatments or low-prevalence conditions (e.g., cancers). As donations, the availability of these medicines is sporadic and variable as well as facing issues of close-to-expiry products and a lack of a national medical waste management system.

To monitor high-value medicines, a detailed tracking system was put in place to prevent fraud. The donation program may be the only source for certain highly-specific medicines in the public healthcare system. Anera's essential medicine program came to an end in August 2024 due to a loss of funding, with patients being transitioned to the MoPH-YMCA supply chain. Despite the transition plan, continuity of care issues may emerge. The MoPH is reportedly used to actors 'coming in and out' and is seeking to cover the gap through other funding streams. However, this raises questions on how to best ensure a robust and resilient supply chain, given the multitude and changing nature of actors involved. In this project, one other interviewee reported plans of closing down existing projects and handing over to the MoPH.

There are also examples of implementation science research on NCDs - for example, the MoPH is working with several universities globally to conduct implementation science research to improve the quality of care and service delivery (e.g. the AUB-World Diabetes Foundation project).

Emergency coordination

A pre-existing Public Health Emergency Operation Centre (PHEOC) was revitalised in October 2023 – to centrally manage all public health emergencies.[50,51] According to respondents, the unit would reportedly include NCDs as part of their efforts around ensuring continuity of essential care. However, a handbook published in August 2023 does not specifically mention NCDs.[50] The Lebanon Response Plan is the primary guide to establishing an 'integrated

humanitarian and stabilization response'.[52] The plan does include a limited set of NCD-related indicators as part of its health sector logframe 2024/2025.[53]

A separate mental health and psychosocial support (MHPSS) taskforce for emergencies exists at the MoPH level. The MoPH is closely coordinating with implementing NGOs around emergencies, due to their central role in providing care. One respondent flagged the challenges of the government to fulfil its role due to having to work at lower-than-usual capacity as a result of resource constraints following the economic crisis and currency devaluation.

Respondents described efforts to prepare for and address potential emergencies. In response to the ongoing conflict between Israel and Hezbollah in Southern Lebanon in 2024, these included the activation of mobile clinics to conduct home visits and maintain essential services, including NCDs. Governmental contingency stocks and funding were activated, while reviews of essential medicines availability revealed insufficient stock levels including for NCD medicines.[54–56] Further emergency preparedness efforts for PHC centres and hospitals were reportedly being developed by PHEOC.

INGOs reported implementing various efforts to sustain continuity of care in case of emergencies, given their frequency in Lebanon over the past years. For NCDs, access to medicines was seen as a key issue. Ongoing efforts include pre-positioning at least three months of stock, allowing multiple-month medicines dispensing during emergencies, identifying key vulnerable groups (e.g., people living with T1 diabetes) and determining key suppliers to set up framework agreements. In addition, organisations described infection prevention and control measures to protect staff and patients. The MoPH was seen as a key actor to coordinate these preparedness efforts and facilitate agreements with manufacturers.

The LRC had already put in place proactive efforts to respond to and prepare for any escalation of the conflict between Hezbollah and Israel. A specific response plan was developed, which is communicated to staff by the director of each LRC 'sector'. The plan outlines the overall collaboration with different ministries and partners as well as clear response steps. It was also being expanded based on different scenarios, including an escalation of the war to the whole country. High-level efforts included stockpiling medicines and consumables, identifying staff and volunteers who are willing to keep working in case of further escalations, and supporting staff living in the war zone through peer and volunteer support as well as a free psychotherapy hotline.

A specific health sector response plan was developed, which included considerations around continuity of care for people living with NCDs and expected increases in worsening mental health. Their inclusion was reportedly a given, as LRC already works on these topics during routine care.

At the time of writing, LRC has had to adjust its service delivery due to the war. It closed four centres in the South and moved them to less affected areas that were hosting IDPs. These decisions were all taken closely with the MoPH as the key coordinating actor. Patients were called to inform them of the change and patient files were forwarded to the new centre. In addition, prescriptions were extended to three-month refills and continuous contact was maintained. To complement these facilities, mobile clinics were activated to reach home-bound patients and people were referred to the national mental health hotline, where relevant.

LEBANON
NCD PSG group
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KEY MESSAGES

Policy messages

- At the national level, multi-sectoral NCD action and collaboration needs to be strengthened to drive prevention efforts.
- There needs to be stronger integration of NCDs and mental health programming, ensuring that people are assessed and referrals are in place.
- Donors should not have funding restricted to certain population groups or nationalities, to ensure that care can be provided on a needs basis. Implementing actors should maintain current equity-focused approaches.
- In protracted crises, some humanitarian donors may fund health systems strengthening, but this will usually require a strong data-driven proposal from the implementer.
- Donors financing contracted-out health service delivery should anticipate future disruptions and put mechanisms in place to limit their impact
- In light of the pluralistic healthcare system, out-of-pocket funding, and impoverishment of the population, healthcare - especially chronic care for NCDs - is increasingly unaffordable to significant proportions of the population. Can RCRC find ways to financially support the most vulnerable to access care, or otherwise to organise and cover the costs of referrals?
- Prevention has to go beyond campaigns, exploring options from a systems perspective including legislation and efforts to go beyond a focus of improving knowledge.

Operational messages

- NCDs are the biggest burden but are hidden due to a lack of quality data from health service delivery.
- Across all activities, actors need to work closely with communities, involving them in service design and through strong feedback mechanisms.
- LRC provides NCD services but does not currently provide home visits, rehabilitation, or palliative care services due to the lack of dedicated staff, guidelines, or strategies. This may be a future avenue to explore.
- Actors should advocate for addressing PLWNCD's full range of needs, beyond medical needs. People may feel isolated, face challenges in their social life and their psychological wellbeing, and need addressing.
- There is a need to build the capacity of general practitioners in PHC centres in NCDs and ensure regular patient follow-up.
- Supply chain disruptions directly affect people living with NCDs. Efforts of MoPH, WHO and other actors should focus on building resilient supply chains and reducing dependence on individual actors.
- Emergency preparedness and response planning for NCDs can be further strengthened. NCDs were omitted in the 2023 PHEOC handbook; however, they have been included in the 2024 Lebanese Response Plan. The existing mental health taskforce for emergencies can serve as a blueprint for a similar unit focused on NCDs.

SOMALIA

Total population	16.9 million[57]
Population in need of humanitarian aid	8.25 million in 2023 (Around 49% of total population)[57]
NCD burden	30% of deaths (2019)[2]
Risk of premature NCD death	30% (2019)[2]
Top 5 NCDs (all-causes of death ranking)[4]	1. CVD (6) 2. Neoplasms (7) 3. Digestive diseases (8) 4. Other NCDs (10)* 5. Diabetes and CKD (12)

Background

Somalia is undergoing a recovery process from decades of conflict, civil unrest, underdevelopment, and political instability. Since the establishment of a new federal government in 2012, the country has achieved considerable strides towards peace, stability, and sustainable development.[58] Despite this progress, territorial control remains divided between different groups, none of which have a completely legitimate claim of authority. The country is highly vulnerable to the increasing impacts of climate change, experiencing a famine in 2010/12 and a prolonged drought from 2016 to 2018. Somalia ranks at the bottom of the 2022 Human Development Index (193 of 193). Somalia has five federal states in addition to the capital region. Somaliland in the North-West declared independence from Somalia in 1991 and has since been a self-governing region with its capital in Hargeisa. This case study describes the situation in Somalia across all regions, including Centre/South Somalia, Somaliland, and Puntland. Descriptions in this section apply across all regions, or are otherwise marked as such (e.g., in 'Federal Somalia' or 'Somaliland'). The de-facto health authorities are the Ministry of Health and Human Services in Federal Somalia (MHHS) and the Ministry of Health Development (MOHD) in Somaliland.

The civil war severely damaged Somalia's infrastructure, particularly its health system. The health sector is struggling to rebuild due to a shortage of qualified personnel, insufficient funding, and ineffective governance.[59] Additionally, post-war decentralisation, deregulation, and widespread privatisation of the service sector have drastically changed the healthcare landscape.

Data on NCDs and risk factors in Somalia are scarce.[60] A landmark study was the 2018-2019 Somali Health and Demographic Survey, which captured the key role of NCDs in the country,[61] highlighting that around 6% of respondents lived with at least one NCD. The most common NCDs were hypertension (33%), diabetes (20%), and kidney disease and arthritis (at 8% each). People residing in urban areas and wealthier population groups tend to have higher rates of NCDs. It also brought to attention the 5% of Somalis living with a disability, of whom 40% had received no care for their disability in the previous year.[62] Of those diagnosed with a chronic disease by a physician, around two-thirds (68%) were receiving treatment.

A cross-sectional study in Somaliland using the STEPwise approach[60] identified a high prevalence of NCD risk factors in adults. It found that most participants ate less than one portion of fruit or vegetables per day (98%) and hypertension, physical inactivity and overweight were highly prevalent. The national drug, khat, was used by around two-thirds of the male population and was identified as a potential risk factor for cardiovascular conditions.[63] Respondents noted that there was an increasing awareness of the role that NCDs play in Somalia, both through informal and anecdotal evidence from facilities and increasing discussions of NCDs on social media platforms, especially around cancers.

* "Other NCDs" primarily include congenital defects as well as sudden infant death syndrome, urinary diseases, and hemoglobinopathies.

SOMALIA	
National NCD policy and legislation?	Legislation on NCD prevention is largely absent[64]
National NCD strategy/ action plan?	No.[65] A joint MoH-WHO workshop in July 2024 will define a road map leading to a multi-sectoral strategy by the end of 2026. NCDs are also included in the WHO Country Cooperation Strategy and the Somali Health Policy (2014)[66]
NCDs included in the national care package?	Yes. The Essential Packages of Health Services (EPHS, 2020) covers NCD including at the primary care level. However, despite its inclusion most NCD services are within the scope of maternal-child health.[67]
NCD unit in health ministry?	Yes (NCD unit in Public Health Department at MHHS).[68] Technical Working Group on NCDs established at the MHHS in 2022, no similar group exists at the Ministry of Health Development (MOHD) in Somaliland.[65]
National NCD clinical guidelines exist?	Partially. Reportedly in development by MHHS in 2023.[69] Clinical SOPs developed by MOHD in collaboration with Somalia Red Crescent Society (SRCS).
EML includes NCDs?	Yes (2019)[70]
NCDs included in the information system?	Partially (2023).[69] No nationwide STEPS survey conducted
Regular NCD access and quality assessments?	WHO Country Cooperation Strategy includes one NCD indicator (medicines availability).

in place/ existing partially set up not in place/ existing

NCD response

Governance

NCDs are reported to be of growing importance over the last few years, representing a slow shift away from the humanitarian sector's historic focus on communicable diseases. The current Health Sector Strategic Plan (HSSP) 2022-2026 calls for NCD prioritisation while highlighting the need to maintain communicable disease services. NCDs are among the top three health priorities identified by the government and are one of the priority interventions in the EPHS.[65] Similarly, multiple respondents agreed that national stakeholders - including the MHHS - have realised the importance of NCDs and noted recent improvements in national leadership. This awareness transpired despite a lack of 'exact' NCD data.

Reasons for this realisation were linked to anecdotal evidence, growing social media coverage (especially around cancers), increasing numbers of people seeking care, and findings from regional and national studies. According to one respondent, this made it 'obvious' that NCDs are becoming a key issue. However, this attention has not yet been translated into a national NCD strategy. This shift has been reported across the whole country, while the South/Central region faces additional governance challenges due to the ongoing conflict and infectious disease outbreaks.

An NCD division now exists at the MHHS and a national NCD Technical Working Group (TWG) was set up, both in 2022. The TWG's core mandate is to facilitate a coordinated response, strengthen national capacity for NCDs across the continuum of care, and support the nascent national NCD multi-sectoral plan.[65] It meets quarterly and is co-chaired by the MHHS and the International Rescue Committee (IRC). The group has around 15 member organisations and is open to all MHHS health partners, with previous participation by IRC, International Medical Corps, WHO, Population Services International, World Bank, and private sector partners, as well as people living with NCDs and professional associations. However, the TWG reportedly has challenges with engaging service delivery partners in its work as actors' association with the government may present a security risk for operating in non-state-controlled areas. The initiative relies on IRC's project-based

financing for key NCD staff at MHHS, with a hope for continued MoH leadership even after the funding ends. The national Health Cluster is active and functioning, with some respondents noting that they try to advocate for its members to include NCDs in PHC. A separate informal NCD working group exists in Somaliland, initiated by the Somali Red Crescent Society (SRCS) and DRC.

Several other initiatives were mentioned by respondents during the interviews. The MHHS, with WHO and other partners' support, has developed a national NCD curriculum and a community health strategy, which includes NCDs and has been rolled out at the federal level. National awareness days (e.g., Hypertension Day) were initiated and workforce capacity-building initiatives have been launched in five states. The development of guidelines, based on the WHO HEARTS and PEN, is ongoing and is to be implemented with key humanitarian partners such as the IRC and International Organization for Migration. In parallel, the Framework Convention on Tobacco Control is also set to be ratified in Somalia. Respondents did describe a general sense of the health system shifting from an 'emergency basis' to the 'development side'.

Future health system efforts around NCDs will be guided by a national NCD roadmap, currently in development. The roadmap builds on a recently completed situational analysis report, which led to a national stakeholder meeting in July 2024. The roadmap will include a focus on risk reduction and the recovery phase. Despite this progress, one respondent highlighted that major gaps remain around the integration of NCDs at the PHC level.

BOX 4: Somalia - which NCDs?

The priority NCDs are guided by the EPHS, serving as a basis for all service delivery planning. The EPHS is aligned with the high-level development strategies (National Development Plan) and is translated into specific organisations' strategies (such as the WHO Country Cooperation Strategy). The National Development Plan is being updated as the National Transformation Plan, which reportedly will include NCDs. This was seen as a success, as it can be used for advocacy with donors and national ministries (e.g., Ministry of Finance). INGOs were typically guided by the EPHS and MoH/ WHO essential medicines list, while another INGO followed its internal NCD strategy. Mental health was seen as a key challenge, with very limited focus nationally, mostly localised interventions, and centred around psychosocial rather than clinical care. Despite the EPHS coverage of NCDs, its implementation was challenged by recurring conflicts and outbreaks, diverting attention and resources. As such, access to (free-of-charge) NCD services remains limited and most people have to pay for care out-of-pocket.

The SRCS's efforts nationally are guided by a five-year health strategy, which has diabetes, hypertension, asthma, and epilepsy as well as mental health as the focus NCDs.

SOMALILAND
SCRS mobile health clinic midwife and nurse Hibak daind Abdi checks the health of pregnant and lactating women living in remote, drought-affected communities.
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Similarly, humanitarian organisations reportedly had an increasing focus on NCDs in Somalia. Their realisation may be primarily driven by increasing numbers of people seeking care at their facilities. One INGO respondent was cautious, flagging that leadership buy-in challenges remain, highlighting the need for a clear narrative ("If you just say 'NCDs are important globally', that will not come across. [You need to say] 'patients come to us who are wounded but they are also diabetic – and we can't take care of them'; INGO). One respondent noted a similar narrative within the WHO, where NCDs were reportedly not a priority until 2023, when internal advocacy had led to some changes. One respondent also perceived a tension for humanitarian organisations between returning to solely lifesaving interventions and the need to pivot towards NCD work.

The RCRC Movement is a key health system partner in Somalia, with SRCS working auxiliary to the government. SRCS operates across the whole country, including in areas controlled by non-state actors. The RCRC Movement typically works - as do other international and humanitarian actors - through two coordination offices, in Mogadishu and Hargeisa. The SRCS is supported by the IFRC in the North and in collaboration with ICRC in South-Central Somalia as well as collaborating with other humanitarian actors, such as SOS Children's Villages and Pharo Foundation. It reportedly has good relationships with the MoH in Somaliland, where SRCS was amongst the first NCD-focused partners, but it does not have formal collaboration with the MHHS in Mogadishu. SRCS has become a key advocacy organisation, calling for actors to scale up NCD care, decentralise services to the PHC centre, and include NCD medicines in the WHO EML. The SRCS organises a health technical working group with key movement partners, which has recently started including community health and NCDs.

SRCS receives financial and technical support from partners within and beyond the RCRC Movement. For the SRCS, NCDs are considered part of its Integrated Health Care model. Yet, their implementation varies depending on the available resources. For example, the inclusion of NCDs at specific facilities follows the Partner National Society's specific technical and financial support. DRC and the Finnish Red Cross had NCDs as a key agenda item, while the Norwegian Red Cross (NRC) has only implemented minimal NCD programming (though is looking to scale up). SRCS has its own SOPs and treatment guidelines for hypertension, diabetes, and gestational diabetes, and was reportedly amongst the first NGOs to integrate NCDs into PHC. Mental health is also recognised as an important NCD issue, but resources for dedicated teams and medications are currently limited. At the national society level, staff have been trained at facilities to do triage and screening.

Financing

Financing is a key explanatory factor in the lack of progress around NCDs. Interview respondents argued that limited resources - rather than a lack of MHSS leadership - was the reason for slow progress. The public health sector receives most of its funding from international donors,[59] with budget distribution direct to healthcare providers, bypassing government systems and budgets. This model was set up in response to the low trust placed by donors in the national governance system, despite the challenges that such a model poses to the health sector's sustainability and accountability. Progress may also be hampered by key stakeholders, including the MoH, viewing NCD programming as 'expensive', with the national system unable to sustain funding for it.[65]

Several interviewees highlighted that the national health priorities, both from the government and humanitarian organisations, are donor-driven: "Health services are primarily donor-dependent and guided by the interests of the donors." (INGO). Donors were seen as focused on communicable diseases, especially infectious disease outbreaks (e.g., Mpox). Though no donor was interviewed, respondents noted this may be due to NCDs being seen as more expensive and having less clear success measures than communicable diseases (for example, the number of vaccines provided).

With the national health system's lack of focus on NCDs, the burden is pushed onto people living with NCDs. Access to free-of-charge NCD services is vastly limited, thus requiring most people to pay for care out-of-pocket. Around half of Somali households report paying for healthcare out-of-pocket.[71] Most households have had no financial risk protection since the collapse of the national healthcare infrastructure. A lack of financial protection and reliance on the private sector, push many people into catastrophic health expenditure[58] and have major access implications (see safe and scalable care on page 32). INGO providers fill some of these gaps, by providing care to people unable to afford private facilities, which are very costly. One respondent did note that diaspora funding did play a role, with European medicines reaching some communities with links abroad.

NCD-related funding has been received by various humanitarian organisations; however, this remained non-systematic. As an example, one organisation noted that its funder did not want to be mentioned publicly. For the SRCS the inclusion of NCDs as part of a basic care package relied on non-earmarked funding. This was reportedly the case for funding from within the RCRC Movement, while external funding had at times specific terms and conditions attached. This highlights the still sporadic and ad-hoc nature of NCD financing.

SOMALILAND
Families leave after being treated at an SRCS mobile health clinic.
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Collaborative surveillance

The national HIS is managed by the MoH, and uses DHIS2. Government-run facilities and implementing partners, such as INGOs, provide facility-level data to the HIS. NCD indicators have been partially integrated into the national DHIS2/HMIS system.[65] However, respondents flagged that NCDs are lumped together into an 'other' category, such that essential data on the number of NCD-related visits, specific diagnosis, and the type of drug prescribed is lacking. Some respondents noted the planned implementation of a new DHIS2-based system that would expand NCD-related data. The current system also faces issues of duplication, with people registered multiple times across clinics due to a lack of unique identifier or harmonised system. The NCD module is presented per visit (rather than patient) thus limiting the ability to monitor follow-up.

Facilities, including those managed by the SRCS, often use paper-based collection tools and registries, which are collected and digitalised - losing detail at the aggregation stage. In the current system there is a major lack of NCD indicators, affecting actors' ability to advocate for NCDs which had to rely on anecdotal evidence instead. Some INGOs reported having more comprehensive data collection systems, at times including community-based data collected through apps. One respondent from such an organisation noted that despite the better data collection system, few people with NCDs were seeking care at the facilities. There may be several reasons for this. It could suggest a large burden of undiagnosed NCDs, in the absence of screening efforts, highlight people's inability to pay for care/medicines, or be an indicator for most people seeking care from the private sector. Data visibility issues are amplified by the large share of private sector care seeking as well as the complete lack of data on areas controlled by armed non-state actors, such as Al Shabab, where there is no visibility of people's needs and care-seeking patterns.

One respondent noted that the NCD-related surveillance infrastructure is improving, noting that some simple NCD indicators were added to the HIS and an ongoing STEPS survey. A 2022 review of health publications on the NCD burden in Somalia has shown almost no publications on the NCD burden, but such studies are available for communicable diseases.[72]

Community protection

Prevention is reportedly inadequately addressed due to the primary attention being on service delivery challenges (e.g., supply chain disruptions). Despite these challenges, one respondent noted that more could be done around prevention. Respondents agreed that there is a lack of health literacy around NCDs in the general population, despite sporadic awareness campaigns (e.g., around cervical and breast cancer). In addition, risk factor prevention approaches are inappropriately researched or adapted to the Somali context (e.g., relevance of traditional messaging around exercise for pastoralists).

SRCS has strong volunteer networks that have a key role in communicable disease care and disease surveillance. Volunteer CHWs support NCDs in pilot facilities through the Continuity of Care project (see description in Box 6). The project also consists of a peer support component where people support each other in self-care, and medicines adherence among other things. Groups are self-organised but

supported by medical personnel and CHWs, who do follow-up of clinical care. One respondent noted the importance of this initiative in changing people's perception of the condition: "Initially it was very difficult for patients to speak out and talk about their status – they did not like even to tell their own people. But now, when we attend events, they are willing to talk about their experiences." (RCRC). This bottom-up approach helps SRCS identify the real needs of communities and advocate for the necessary resources. One respondent provided an example of how NCDs started to emerge and be noticed within the SRCS. SRCS implements a home-based care component as part of the HIV program, to reduce access issues due to stigma. They instituted a policy where volunteers would be trained to help anyone who is housebound. As part of this training, they realised many of these patients had had a stroke, highlighting the importance of addressing NCDs.

Other INGOs, such as the IRC, reportedly used a CHW approach linked with their PHC centres. The CHWs, selected from the community, provided health education, awareness raising and sensitisation, limited screening (specific awareness days), and referral for selected NCDs (diabetes and hypertension). Their efforts follows a new CHW curriculum developed with the MoH. People's health issues that are identified (beyond the basic screening for diabetes and hypertension) are referred to PHC centres, e.g., asthma.

An assessment of NCD capacity at selected hospitals in Somaliland in 2023 reported that facilities lacked community engagement activities.[73] One respondent confirmed this by noting that the historic focus on communicable diseases resulted in a complete absence of community structures or forums that could advocate for NCDs across the country.

SOMALILAND
SCRS mobile health clinics travel to rural villages in Somaliland.
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Safe and scalable care

The national public health care system across Somalia, from community to tertiary level, is defined by the EPHS. The package was adapted in 2020 to include NCDs.[65] The assessment of NCD capacity in the healthcare system is limited to an unpublished pre-print from 2023. The document shows that none of the hospitals in Somaliland met the WHO-PEN standards.[73] However, significant capacities existed in other areas with hospitals having adequate quantities of basic equipment, first-line NCD medicines and sufficiently staffed laboratories. Overall, there is a lack of advanced diagnostics, expertise and training of laboratory staff, and outdated guidelines and referral systems. Imaging and laboratory services are the main cost drivers. NCD care does not routinely include health education and awareness raising,[74] which is linked to low levels of NCD health literacy amongst the general population. There is no existing assessment on the current capacity of the PHC system to address NCDs, while key stakeholder interviews provided some insights (see page 33).

Respondents highlighted that the service delivery would be similar across the country, including in Somaliland, with only some differences in the specific preferred treatments and a somewhat lower capacity of facilities, including regional hospitals, in the South due to increased volatility. Others argued that the ongoing armed conflict in the South/ Central region impacted the scope of work significantly, for example with a much less developed CHW network or in terms of prioritisation (see below).

The private sector is the largest service provider in the country, with respondents suggesting it accounts for 70% of all services provided. The WHO Country Cooperation Strategy 2021-2025, cites this share of private sector service provision to be much lower at 40%.[58] This was seen to apply equally to NCDs. When probed for reasons, one respondent argued that the inconsistency of supply and the historic reliance on the private sector (in health and beyond, e.g. education), led people to believe it has more specialists and advanced equipment. A household survey from 2020, found that most people sought care from private facilities followed by government hospitals, pharmacies, and health centres.[71] Public health facilities often have insufficient workforce, though people seek private sector care even if specialists are present (e.g., central public hospitals). Public hospitals reportedly play a more significant role for internally displaced persons (IDPs).

International and national NGOs, which play a key role in delivering services, typically implement PHC-

centred health service delivery. Some organisations support hospitals in parallel, such as ICRC or Pharo Foundation. INGO approaches often centre around capacity building, provision of medical supplies, and - at times - incentives for healthcare staff. Several respondents flagged that most INGOs do not implement NCD care: 'NCD is a component of EPHS, but organisations seldom try to implement it.' Exceptions that were mentioned include the International Rescue Committee, Save the Children, and International Medical Corps. The absence of focus is more at the governance and financing level rather than the day-to-day clinical reality, as highlighted by one respondent: 'NCDs are clinicians' normal business, but are a low priority because communicable diseases are so common.' Another respondent from the RCRC Movement highlighted this as an opportunity to enhance NCD services, stating 'If we receive a wounded patient, they may have NCDs and we should address this: we can't just say NCDs are not important!'

One respondent argued that the primary NCD care gap is around treatment itself, while previously the primary issue was around diagnostics. Primary and secondary prevention was another key gap, including referral and medication. Respondents were vocal about the virtual absence of certain services, including palliative care and cancer treatment. One person put it bluntly as 'anyone [living with cancer] capable of travelling goes abroad; if not they usually die' (INGO). Private hospitals may provide some - though insufficient - palliative care and rehabilitation services. Mental health services are equally missing from primary care delivery, including from the SRCS and INGOs, who refer those patients to higher-level facilities. This is further complicated by the significant stigma associated with mental health conditions.

Beyond specific services across the continuum of care, multiple respondents raised issues of access. The underfunding and understaffing of the PHC system mean that facilities, especially in rural and conflict-affected areas, are struggling to provide the expected EPHS services. People often arrive at facilities with existing complications, highlighting the delay in care seeking. Even existing patients faced major issues around maintaining continuity of care. Respondents flagged the high number of people lost to follow-up, especially when referred to other facilities. 'Patients really do come when it is too late and we lose many of them. Public hospitals may lack capacity for NCD care, with one respondent suggesting that the only referral option for complicated cases are private hospitals - which are unaffordable. While access to care is a key issue around the country, it was emphasised that areas controlled by non-state armed groups may have 'no access to care at all', beyond small pockets where international organisations operate.

The program scope is based on the EPHS, while respondents acknowledged that SRCS facilities may not implement the full package due to resource limitations. NCDs are one component that is - with few exceptions - not addressed. Exceptions include screening and treatment for hypertension and - partially - diabetes screening and medicines or equipment (e.g., glucometers) and some epilepsy drugs. Healthcare professionals and CHWs provided basic health education. The SRCS is currently implementing a pilot project of a more comprehensive NCD model of care in two facilities, with support from DRC (see Box 6). Some organisations, such as the SRCS and ICRC, noted that despite an awareness of NCD service gaps, implementation is hampered by significant sustainability concerns. For example, the existing treatment gaps even at regional hospitals were mentioned.

BOX 5: International Rescue Committee: Model of care

IRC has been integrating NCD services into existing PHC services since 2016, with capacity-building based on WHO protocols to enable health staff to screen, identify, and treat NCDS. Medicines are provided free of charge to patients for 'common' NCDs during their three-monthly check-ups. Complicated cases are stabilised and referred to hospitals. Facilities are supported by CHWs, who conduct house visits, provide educational messages, and refer to facilities. IRCs focus is on the most vulnerable populations, especially IDPs, who are unable to access private sector care. In 2021, a 'sustainable community engagement' NCD project was initiated in one region to improve engagement with communities as well as support health system strengthening (see governance on page 28). The IRC example provides a strong case for the feasibility of providing essential NCD services in Somalia through a PHC-based approach while also engaging in health system strengthening. But it also highlights the sustainability challenges of funding.

SRCS also runs two hospitals in Mogadishu and three national rehabilitation centres, supported by Movement partners. Rehabilitation centres provide services including for NCD patients, such as post-stroke rehabilitation. The teams may also provide advice around palliative care, while no formal palliative treatment approach exists. One unique project implemented by SRCS is a fistula care project at the hospital in Mogadishu, the only one of its kind in the country. It includes a comprehensive referral system for CHWs, including covering travel costs.

BOX 6: SRCS Continuity of Care project

The Continuity of Care project focuses on a more comprehensive model of care for NCDs, centred around community-based efforts. It is implemented in two facilities from the SRCS and builds on a similar project implemented in Kenya. It focuses on diabetes (including gestational diabetes) and hypertension screening and treatment. The project consists of training healthcare professionals and CHWs, support of medicines and equipment, the development of SOPs and community care guidelines, and a peer support component. The CHW component has trained 15 volunteers and a community health specialist per facility to provide basic health education and awareness raising around NCDs. Volunteers are further screening people and providing referrals to the adjacent PHC centre or hospitals, for more severe cases. Peer support groups are inviting people to share their lived experiences and support each other. This pilot may be scaled up, although resource availability (especially around capacity building and medical supplies) and organisations' thematic areas (e.g., DRC has NCDs as a thematic area) may present barriers.

Beyond the facility where the pilot is being implemented, the project reaches 10+ other centres with a less comprehensive package. This includes the provision of treatment guidelines (on diabetes, hypertension, COPD, and asthma), provision of clinical management training on NCDs, and support on simplifying case management. These centres are not supported with treatment and medicines.

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Access to countermeasures

In Somalia, the drug supply chain for NCDs faces significant challenges in providing continuity of supplies, especially in conflict areas. The Ministry of Health delivers medicines monthly to clinics. The system for providing essential medications follows EPHS and EML guidelines but is often customised per region based on known health needs and the lists do not include a full range of NCD medications. Currently, only one treatment option is covered for diabetes (oral hypoglycemics) and asthma (inhalers). No treatment for Type 1 diabetes is included and there are significant gaps in the national cold chain, such as a lack of appropriate storage in the customs area. Solar-powered fridges exist at the PHC level but guidelines forbid their use beyond vaccines. These policies vary across organisations; for example, while the SRCS does not prescribe insulin it offers patients the option to store their insulin at the facility and do their injections there.

SRCS is advocating with other partners to add NCD drugs to medical kits. The national public supply chain consists of a national warehouse and supply chain management system. The most significant obstacle is the procurement of medical supplies with Somalia lacking a formal regulatory framework, such as an agency to monitor drug quality and imports. As a result, most medications are sourced internationally, creating delays due to extensive paperwork and transportation logistics. Only a limited selection of supplies, such as glucometer strips, are available from the local market.

Other actors run parallel supply chains, including ICRC, UNICEF, and SRCS. If insulin is included by actors, there are significant patient-level storage challenges, more frequent follow-up care. Within the RCRC Movement, multiple partners are collaborating to address the supply chain issues. The SRCS does not currently provide NCD medications, with few exceptions. Respondents noted that many people living with NCDs are not taking prescribed medicines as intended, due to affordability issues.

Emergency coordination

The Health Cluster in Somalia is the primary coordination mechanism for emergencies in Somalia, while primarily focused on infectious disease outbreaks. The Health Cluster section of the current Somalia HRP emphasises[75] (i) 'lifesaving' interventions for those affected by emergencies delivered in close proximity, (ii) strengthening of referral pathways to ensure access for pregnant women, malnourished children with complications and survivors of sexual and gender-based violence, and (iii) the prevention and response of disease outbreaks, including the delivery of care as defined by the EPHS. Despite the reference to the EPHS, NCDs are not explicitly mentioned in the plan. Similarly, respondents perceived the response plan as verticalised, with NCDs being neglected. The WHO NCD kit was received for some specific emergencies in the past, highlighting the absence of NCDs in the public system. Importantly, the frequent nature of emergencies was seen as diverting attention away from health system strengthening, especially around NCDs. The Health Cluster operates nationally with decentralised clusters per federal state. However, the degree to which they are active varies and implementing actors, including the SRCS, are usually not involved due to the security concerns described above.

Humanitarian actors described various strategies to prepare for acute emergencies within the wider response. Frequently mentioned were a mix of pre-positioned emergency supplies and the use of mobile clinics, to address a variety of potential scenarios. The SRCS highlighted a similar approach, centred around the ongoing service provision at PHC centres. SRCS's emergency preparedness approach consists of maintaining emergency stock and including a contingency fund within long-term programming. Mobile clinics were part of preparedness efforts for rapid response. These crisis modifiers allow for quick access to funds before accessing other rapid funding mechanisms, such as the Disaster Relief Fund. It has also built its capacity with mobile clinics to increase the ability to respond quickly and flexibly. These clinics respond to emergencies as well as maintain essential healthcare services. These responses do not necessarily include NCDs, given their absence from normal programming. However, one respondent noted that SRCS does consider including NCDs as part of cross-cutting issues in its disaster response management efforts.

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KEY MESSAGES

Policy messages

- NCDs are a key need but are left behind. Current programming priorities of many health actors are frequently not informed by robust data on needs, but are driven by historical priorities (e.g. Maternal-child health)
- Strong advocacy is needed to ensure NCDs become a core component of PHC. Humanitarian actors - and humanitarian donors - can carry out such advocacy; although they also need to be considered as 'recipients' of these advocacy messages.
- Stronger political will and leadership is needed to address NCDs as 'silent' killers across all the 5x5, the continuum of care, and cross-cutting topics (e.g., disability). NCDs should further be recognised as a key component of the UHC agenda.
- The EPHS is the key normative resource guide for the integration of NCDs and should be the basis for NCD service delivery by health organisations. For SRCS to provide these services, resources will be needed from the wider RCRC movement.
- Support the MoH to strengthen strategic planning capacity and in the development of guidelines.

Operational messages

- All partners should push for strengthening patient-level data so that adequate monitoring can be put in place (e.g. using the WHO health-facility indicators). Having this data is critical for advocacy and resource mobilisation.
- The CHW home visit initiative provides a strong example of a comprehensive model of care that takes into account people's vulnerability. Actors should considering learning from or scaling up similar programs.
- NCD services should be anchored in the community, and healthcare staff should receive support to contribute to these efforts.
- Treatment needs to be affordable with a minimum or no co-payment to ensure access for those most at risk of not receiving care.
- NCD training for CHWs and healthcare workers in the public sector is essential.
- Given the lack of MoH treatment for type 1 diabetes, and the evident vulnerability and low life expectancy of this group, SRCS or movement partners should consider supporting insulin provision.

SYRIAN ARAB REPUBLIC*

Total population	~24 million[76]
Population in need of humanitarian aid	16.7 million in 2024 per HNO[76] (70% of total population)
NCD burden	75% of deaths (2019)[2]
Risk of premature NCD death	22% (2019)[2]
Top 5 NCDs (all-causes of death ranking)[4]	1. CVD (1) 2. Neoplasms (3) 3. Diabetes and CKD (4) 4. CRD (6) 5. Digestive diseases (7)

Background

The Syrian war, beginning in 2011, has resulted in a devastating humanitarian crisis, with the conflict quickly escalating into a complex civil war involving numerous factions, foreign powers and extremist groups. The violence has led to the displacement of over half of Syria's pre-war population, both internally and as refugees in neighbouring countries. This massive displacement and the destruction of infrastructure has severely impacted the country's national healthcare system. As a result, millions of Syrians now lack access to basic medical care, with their suffering intensified amidst the ongoing conflict. Prior to 2011, the country had among the best regional health indicators and had strong national production capacity that covered 90% of the country's medicines needs.[77] Since then, health indicators have drastically worsened, attacks on healthcare facilities are frequent, aid convoys are blocked, and large parts of the population lack basic services.[77] Estimates show that around 70% of healthcare workers have left the country and nearly 50% of facilities have been destroyed or damaged.[78] Much of the national pharmaceutical manufacturing capacity has halted or been impacted by sanctions.[79]

The country has seen shifting territorial control since the start of the civil war in 2011, with a complex set of actors and proxies active in the country.[80] The main division of the country has been between the Damascus government-controlled area, covering around two-thirds of the country, North-West Syria that has been controlled by various 'opposition' groups since 2011, in Idlib mainly Ha'yat Tahrir al-Sham (HTS), in Northern Aleppo an umbrella of armed groups backed by Türkiye under the Syrian National Army (SNA), and North-East Syria (NES) has been controlled by the Kurdish-led Syrian Democratic Forces.

The recent fall of the Assad regime at the end of 2024 has led to drastic changes. Apart from tensions in the North between the Kurdish led Syria Democratic Forces (SDF) and the Turkish backed SNA, the conflict stopped when HTS and other armed groups gradually defeated the Assad regime and took over the capital Damascus. A new government was initiated in March 2025. However, the 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. Over half the population – around 14 million people – have been displaced, either within Syria (before the events at the end of 2024 this figure was ~7.4 million) or as refugees in neighbouring countries (~6 million). The escalation of hostilities at the end of November 2024 resulted in another 1.1 million people internally displaced out of which, in January 2025, approximately 627,000 people remained newly displaced, while nearly 523,000 people have returned to their areas of origin, mainly in Hama and Aleppo governorates. 90% of the population live below the poverty line and 70% are thought to be in need of humanitarian aid.

* This case study was finalised in November 2024, before the fall of the Assad regime in early December 2024. Parts of the report may become outdated given the rapidly evolving situation.

SYRIAN ARAB REPUBLIC	
National NCD policy and legislation?	Partial implementation of tobacco, diet, and alcohol-reduction measures.[81]
National NCD strategy/ action plan?	No national strategy available.[81] NCD action plan currently in development with WHO (April 2024)
NCDs included in the national care package?	No national essential care package identified. An essential health service package was developed with WHO support for North-West Syria, which covers key NCD services (including at primary care level).[82]
NCD unit in health ministry?	Yes (Directorate and Department)[83]
National NCD clinical guidelines exist?	Yes (including diabetes, CVD, CRD)[81]
EML includes NCDs?	Yes (2019)[84]
NCDs included in the information system?	Partially.[81] Last STEPS survey was in 2003
Regular NCD access and quality assessments?	WHO Country Cooperation Strategy includes M&E plan (NCD indicators on the development of a multi-sectoral plan and tobacco surveys)[85]

in place/ existing partially set-up not in place/ existing

Data collection for this case study was done before the latest events and fall of the Assad regime and centres around the situation in former government-controlled areas, unless otherwise stated. The situation in NES is discussed in a separate box (see Box 8).

Information on the health of Syrians in the country is very limited, especially for internally displaced populations, due to a lack of population-based data.[77] Pre-war studies on the NCD burden showed a prevalence of 15% for diabetes in Aleppo[86] and 8% for asthma nationally.[87] Additional insights are offered by reviewing information from Syrian refugee populations in neighbouring countries. In Jordan and Lebanon, prevalence rates of diabetes were around 5-6% in 2019, while half of all Syrian refugee households reported a member living with a chronic disease.[86,88] Population awareness about NCDs seemed to vary by condition with better knowledge reported around diabetes and hypertension[89] than around some cancers.[90] Even before the war, some publications flagged issues with the robustness of health data.[91] In the absence of high-quality data, humanitarian responses are often led by top-down and donor-driven approaches rather than being based on existing needs.[77]

NCD response

Governance

Under the Syrian Constitution, healthcare provision is a state responsibility. It is implemented through the 14 governorates who hold the financial and organisational responsibility. NCDs are reportedly seen as secondary in importance, relative to trauma and infectious diseases,[79] although they were officially recognised already in 2006 as part of the 10th Five-Year Plan.[91]

Key achievements in the country regarding NCDs include the establishment of an NCD department, development of clinical guidelines, and implementation of various NCD programs. The clinical guidelines are at times outdated, and are available for CVD (last updated: 2007), diabetes (2015), COPD (2023), and cancer (2023). There were some reports of a 2023 update of the diabetes guidelines as a joint effort between the MoH and ICRC. The Arabic mhGAP is used for mental health services. However, even where guidelines exist, up-to-date hard copies are often not available at PHC centres and guidelines are primarily used in government-controlled areas.

A national essential service package exists and was recently updated by the MoH and WHO, including through a costing exercise. It aims to standardise the level of care across the country and types of PHC centres by detailing essential medicines and equipment lists, human resources, and infrastructure needs. However, the package is not fully implemented or sustained at the PHC level because of the lack of human resources and large-scale destruction. A separate NCD model of care was employed in North-West Syria, with the WHO developing an EPHS for the region in 2016-17.[92] The project was financed by various international donors (including Japan, FCDO, and ECHO) and implemented by local NGOs. It is unclear to what extent this project is currently implemented.

One study flagged a general lack of institutional commitment towards NCDs and uncoordinated response and leadership, even prior to the war,[91] and this was borne out by the research for this case study. Currently, no national NCD strategy or action plan exists, despite some ongoing efforts to develop them (see mapping in the table above). This lack of prominence of NCDs in policy has been echoed in previous studies, where humanitarian actors voiced concerns about unclear prioritisation processes, non-transparent resource allocation, and a lack of strategy for NCD integration in primary care.[77] Key challenges have also been noted around the mismatch in stakeholder priorities and the conflict's impact on trust, leadership ability and power dynamics. Some humanitarian actors reported this affecting the degree of coordination with the MoH due to fear of repercussions.[77] These challenges were especially pronounced in opposition-controlled areas, where local directorates of health (DoH in each governorate) often provided (informal) leadership.[77] The Health Cluster objectives in the 2024 Syria HRP[93] focus around (i) increasing access to live-saving and -sustaining health services for those most vulnerable, (ii) strengthening the health sector capacity around disease outbreaks, and (iii) strengthening the health system capacity for continuity of care, community resilience, and to respond to IDP movements. The plan does mention outpatient NCD care and the provision of dialysis materials, although NCDs are not mentioned as a separate category, unlike mental health.

Various humanitarian actors reported working closely with the MoH, including the WHO and RCRC movement partners such as ICRC and the Syrian Arab Red Crescent (SARC). However, these actors were registered in Damascus and thus had a lesser role in NES. In previous studies, humanitarian actors have identified a tension between the need to provide acute responses and the need for longer-term health-system strengthening efforts in the face of short-term funding cycles.[77] One respondent confirmed this persistence of an 'emergency response mentality', while acknowledging that actors are more aware of the protracted nature of conflicts. They linked this changing nature of conflicts to the need for greater localisation, as local actors are better placed to sustainably drive key initiatives (such as strengthening health information systems).

BOX 7: Syria - which NCDs?

The national NCD programme of the MoH covers 16 conditions (including diabetes, COPD, CVD, sickle cell disease and kidney disease). Implementing humanitarian actors reported focusing on a smaller subset of NCDs, typically including diabetes, CVD, and COPD. Some organisations provided broader community-based risk messaging that included cancers, due to the overlap of risk factors.

SYRIA
SARC medical outreach team nurse checking the health of a child in Quneitra after the family arrived in Syria due to displacement by the Lebanon Crises.
© SARC

Financing

In government-controlled areas, primary care facilities are in theory government subsidised to provide services for free.[94] However, outpatient services and medicines are often paid out-of-pocket by patients.[78] There is no national health insurance system, although some individuals working for public institutions are covered by insurance policies.[78]

Lack of financing was voiced as a key gap for improving NCD care in the country, including from RCRC movement partners. SARC mentioned looking for funding opportunities, including partnerships with DRC. This was echoed by a published study, where Syrian NGOs reported issues with obtaining donor funding for NCDs.[77] In contrast, one respondent noted that their NCD programs were generally seen as cost-effective given their focus on filling specific gaps and working closely with the MoH. One INGO noted that the majority of its health funding was non-earmarked, allowing it to implement NCD programs as part of its PHC service package.

Collaborative surveillance

In the government-controlled areas, there were reportedly no functioning electronic medical record systems or NCD registries. Respondents highlighted the disconnected nature of health data, with various partners holding part of the information. In non-government-controlled areas, including North-West Syria, the implementation of a unified system was hampered by the lack of capacity from the local health authority (LHA) and data-sharing sensitivities. One respondent noted that the WHO would be best placed to lead on implementation of the unified system, but has not done so to date.

The SARC healthcare facilities use an organisation-specific HIS including selected NCD data. A separate data collection system exists for the Community-Based Health and First Aid (CBHFA) component which collects data on pen-and-paper before manually transferring it to an Excel sheet. The two systems have little interoperability but the CBHFA team is meeting monthly with the health team to manually share data, for example around the number of patients who need medicines. The SARC is currently working on implementing DHIS2, which includes CBHFA, for launch in 2025. SARC data systems do include NCDs as part of their needs assessments. For example, during the earthquake in North-West Syria in February 2023 this included data on whether people have an NCD and if they were previously displaced.

One INGO respondent described a well-established organisational HIS, covering a detailed diagnosis, including NCDs, avoiding duplication, and providing detailed treatment insights (e.g., prescriptions, treatment adherence). Their system, while non-representative, confirmed NCDs as a major health priority, with both diabetes and hypertension being within their top ten list of consultations.

Community protection

The MoH and its partners, such as the ICRC, are not involved in primary prevention or screening efforts. This was linked to the already vast existing needs and the system's inability to deal with patients that would be identified through population screening initiatives. Small-scale screening programs do exist, such as for symptomatic relatives of PLWNCDs. 'The needs are already huge, so if you start doing screening and mass diagnosis, when we know that we can only treat the tip of the iceberg, this is difficult ethically.' (RCRC). Public health practitioners and humanitarian organisations acknowledge that primary prevention is not a priority during active conflict. Existing guidelines do acknowledge that NCDs can be integrated into existing community health programs.[95]

SARC's CBHFA program in Syria addresses various health issues, not just NCDs, based on community priorities. It operates in the most vulnerable areas, such as those with high numbers of IDPs, across all 14 governorates. The program focuses on NCD risk factors such as smoking, alcohol, physical activity, and diet with volunteers going door-to-door to check blood pressure, weight, and BMI, and provide messages or referrals. However, referrals are complicated by a lack of capacity at the receiving centre or the inability of people to reach centres, especially in 'neglected' areas. Specific advocacy campaigns were mentioned such as a breast cancer awareness month, where free mammograms are offered in certain clinics.

CHWs - termed community health promoters in SARC - have strong relationships with the community as each CHW is assigned 100 households for three years. They are further responsible for providing follow-up for people who are referred back from facilities.

Other INGO respondents also noted that CHWs provide simple educational messaging, such as informing communities about the role of diet in diabetes self-care and women about breast cancer risk.

BOX 8: North-East Syria

In NES, despite its relative stability, the population is highly vulnerable, with much of the region's infrastructure destroyed (e.g., water supply, banks, airport) and all of its borders closed. Multiple respondents noted the LHA's limited technical (e.g., non-medical staff leading programs) and financial capacity (e.g., its budget being smaller than that of a single NGO). Due to the region's political sensitivity, only a few actors are left to cover the vast humanitarian needs.

As of November 2024, service provision in North-East Syria was largely provided by national and international NGOs (e.g., Save the Children, Oxfam, Relief International, MSF, IRC, Medical Relief for Syria, SAMS, amongst others), though the number of actors decreased due to funding cuts. Organisations are divided by a 'wall' between those registered and non-registered in Damascus. For example, SARC's operation in NES is limited to IDP camps and 'security boxes' given its Damascus-based registration. Actors' coordination is complicated by the absence of a UN Cluster system, which has been substituted with an informal coordination mechanism, the 'NES Forum'. One respondent mentioned that the WHO is rarely at coordination meetings due to political sensitivities of being seen to work beyond the Damascus-controlled areas.

Respondents emphasised that NCDs were typically integrated into the PHC response through mobile or fixed clinics, with few exceptions of vertical programs in specific IDP camps. Priority NCDs included CVD and DM while sometimes covering COPD, mental health, or epilepsy. Other services, such as cancer care, are not covered. However, programming approaches are non-standardised and have significant variations. Organisations used either their own clinical guidelines or those developed by the WHO or in North-West Syria. Previous attempts to develop a standardised basic service package were hampered by the lack of capacity from the LHA and the political sensitivity of working on NES-specific guidelines. Others noted donors' influence on NCDs, citing specific proposal rejections from humanitarian funders due to NCDs being considered a 'development issue' rather than a humanitarian priority.

Due to these reasons, the provided services depend on the specific actor. NGOs generally focus on medicines, consultations, and cohort management as well as include a CHW component focusing on health education and referral, including around NCDs. This service provision is complemented with technical and financial support (e.g., covering salaries) and training. Actors' ability to sustainably procure medicines strongly influences service provision. International procurement is often prioritised due to quality concerns about locally produced medicines. Humanitarian actors' operations explicitly attempt to reach the most vulnerable members of the displaced and host population. Vulnerability is understood as those furthest from larger cities or identified through dedicated vulnerability scoring tools. Some actors reported providing improved care in some areas when compared to what was available pre-war (e.g., covering more medicines).

Data was a key concern, especially as basic population estimates are unavailable. Humanitarian actors implemented their own data systems, with few data-sharing processes in place. These were sometimes well-established cohort management systems, which included fully digitalised data, details on prescriptions and medicines usage, and duplication checks.

Organisations mentioned emergency preparedness as a top-of-mind concern, specifically flagging contingency stock planning, short-term financing back-up, and maintaining an 'extra mental capacity'.

Safe and scalable care

Primary care facilities are provided by the government in the areas it controls. However, since around 2010 the government has reduced its role in the provision of healthcare services, giving an increasing space to the private sector.[91] The high quality of the pre-war healthcare system influenced people's expectations of being treated by specialists in hospitals and receiving branded medicines.[77] These reportedly reduced the acceptability of primary-level NCD care. The service delivery is further complicated by the impacts of armed conflict, unpredictability, political discord and infrastructure collapse, which result in rapid population movement and rapidly changing needs.[77]

The MoH programme covers about 16 different NCDs, including a free national programme on diabetes, financed through annual budgets. Other NCDs are CVD, sickle cell, and kidney disease.

It manages some NCDs at the primary care level (NCD clinics) led by an internist who provides consultations and medicines prescriptions. There are about 1,370 such clinics. Specialised centres, such as diabetes treatment centres, have additional lab capacities (e.g., HbA1C, tests for kidney complications) and specialist physicians. The main gap and unmet need in current services was seen around dealing with complications of chronic diseases (e.g., kidney disease) and specialised services (e.g., cancer). One respondent linked the lack of focus on cancers to people's delayed care-seeking, and arriving at facilities with late-stage cancers. People are struggling to access services, which are limited, expensive, and centred around the capital. The gap is worsened by the decrease in local pharmaceutical production capacity, as discussed below. However, gaps in care provision exist even for conditions that are relatively less complicated to treat, such as diabetes. Despite MoH being the main provider, it has registered only 200,000 diabetes patients in its system, which is far below the estimated prevalence rate. Of these registered patients, around 40% were insulin-dependent, which suggests that people use government facilities primarily to access insulin free of charge. People on oral medicines have more treatment options, including private facilities and pharmacies. Another respondent confirmed that patient numbers were directly related to the availability of specific services or medicines, with other organisations referring to those perceived to have the greatest capacity in a given area.

SARC provides basic NCD treatment in its clinics and mobile units, including support for DM, CVD, and COPD. However, it does not act as a full primary care provider for PLWNCDs as it covers only a simplified service package when compared to regular MoH clinics. SARC clinics prioritise medicines supply, while some centres have equipment and diagnostic capabilities. Even those centres cannot provide the regular testing required by PLWNCDs (e.g., yearly eye exams). Centres do not offer specialised services such as for cancers, due to financing challenges. SARC runs several hospitals and refers patients with complications, such as those needing surgery, to SARC or government hospitals, which are free of charge. SARC does not cover referrals to private hospitals. SARC does have a rehabilitation facility, the Shabaa physical rehabilitation centre, that may also provide services to PLWNCDs (e.g., amputations, prostheses). One dialysis clinic exists in Damascus and is jointly operated with the MoH. While its services were originally provided free of charge, it shifted to an out-of-pocket payment mechanism due to funding issues. SARC hopes to implement a more comprehensive package, including a community-based component, through a pilot program in partnership with the DRC.

Humanitarian actors emphasised their focus on complementing the existing system and filling gaps, rather than establishing parallel systems. This typically manifests itself in the provision of specific support (e.g., certain medicines) or a focus on hard-to-reach areas. Actors generally focused on the provision of treatment for identified patients and the prevention of secondary complications, while some did outline efforts of community-based care or primary prevention. NGOs normally receive six-month contracts from the MoH to work in hard-to-reach areas and cover essential services. According to respondents, a shift in humanitarian actors' approaches, to move more towards a comprehensive service provision, was seen in 2018. This mirrors reports by other authors denoting a similar shift in Syria and regionally.[96] Systematic attacks on healthcare facilities influenced organisations' presence over the past few years and led to several facility closures. Exceptions to this approach exist, with one INGO providing comprehensive cancer services in North-West Syria, including diagnosis, pathology services, and treatment (including surgery and chemo). Cases that could not be treated are referred to Türkiye, but this pathway has become more difficult and time-consuming due to the country's stricter entry requirements. The INGO is reportedly planning to expand its treatment capacity and has initiated a residency program for oncology specialities, as the lack of trained medical professionals was a key gap in cancer care.

SYRIA
A doctor with SARC mobile health unit offering primary health care services to a mother in Al-Hamidiyah.
© SARC

Access to countermeasures

Access to and funding of medicines is seen as a major gap in delivering quality NCD care in Syria. The MoH runs a free national programme on diabetes, financed through annual budgets, alongside 16 other NCDs (including CVD, sickle cell disease, and CKD). However, assessments of the availability of NCD medicines, specifically for diabetes, showed large gaps in public healthcare facilities.[79,94] For example, the first-line treatment metformin was available in only 40% of surveyed facilities,[79] forcing patients into unsustainable coping mechanisms, such as skipping doses or stopping taking medication entirely.

Limited insulin supply was estimated to put 60% of insulin-dependent patients at risk.[78] Other NCDs face even greater unmet needs with cancer and chronic kidney disease mentioned as two examples where local production is lacking and imports are difficult due to sanctions. Issues with NCD medicines procurement were seen as one of the primary challenges for humanitarian actors to provide NCD services. Even INGOs with strong supply chain capacities reported that due to frequent stock-outs only 60% of patients arriving at the facility could be provided with medicines.

Respondents contrasted this with the pre-war reality, where the vast majority of pharmaceutical needs were covered from within the country. This changed drastically due to the war and ongoing sanctions, with humanitarian organisations procuring most medicines internationally, often from Türkyie. Even medicines that continue to be locally produced by some actors, such as oral medications for hypertension and diabetes, are challenged by inflation, sanctions, the cost of raw materials, and the impact of active conflict. For example, one local producer was caught in crossfire in 2016 leading to a loss of around 80% of its production capacity.

ICRC was mentioned as a key NCD supply chain actor that has supported both the MoH and the SARC since 2018, providing the MoH centres with diabetes and other specific medicines (e.g., statins). Initiated during the emergency phase, ICRC donated insulin to address the vast shortages in the country. The collaboration has since been formalised and expanded to cover laboratory devices, the development of health education materials, and capacity building. The ICRC currently covers about 20-30% of the MoH's insulin supply. ICRC procures insulin internationally due to quality concerns and limited local production. ICRC's support to SARC covers 10 centres and mobile clinics with oral medications. Previously this included insulins, which have since been taken over by the DRC. Most people living with diabetes rely on the national MoH program as SARC's reach is limited in comparison. ICRC also supports functional physical rehab centres and estimates that around 50% of amputations are because of poor management of diabetes.

The WHO also provides support to NCD and mental health medicines procurement, while one respondent noted that its role had been minimal in this area over the past years.

Emergency coordination

The country frequently shifts from chronic conflict to acute crises, like the 2023 earthquake and the arrival of refugees from Lebanon in October 2024, displaced by the war with Israel. After 12 years of the Civil War, healthcare professionals are highly skilled in preparedness. The government now has some emergency planning, such as deploying mobile clinics with rotating staff across 24 villages during the 2023 earthquake - as a first for the MoH. There is no publicly available National Emergency Preparedness Plan. For NCDs, preparedness efforts are limited to specific initiatives, such as contingency supplies, which include 100,000 insulin vials.

SARC's health emergency program began in early 2024. While NCDs are not currently part of SARC's emergency preparedness plans, a new multi-hazard contingency plan and an emergency health plan are being developed that will include NCDs. Historically, crises focused more on communicable diseases, with NCDs often addressed incidentally, such as during the 2023 earthquake in North-West Syria when mobile health units (MHUs) brought NCD medicines to shelters. Other movement partners support the SARC, and MoH, with emergency supplies or short-term donations.

WHO is supporting emergency responses, for example during the 2023 earthquake, including the deployment of mobile health teams that provide essential services, including NCDs. One respondent highlighted WHO's strong role in responding to disease outbreaks while flagging its limitations in supporting a HIS and around capturing data beyond output indicators.

KEY MESSAGES

Policy messages

- Funding is the primary gap: it is the main issue that needs to be addressed.
- NCDs are underserved and out-of-sight in Syria; they should be a focus of international organisations, donors, and the government. NCDs are not 'just' an illness; lives are lost due to the non-availability of NCD care. This can be prevented.
- Investments in NCD care should ensure a minimum standard of access to treatment of complications and secondary prevention, before focusing on primary prevention.
- NCD care should be integrated into the basic service package.

Operational messages

- Community engagement and MHPSS components are missing across Syria – there is a huge unrealised need and advocacy gap.
- There are some efforts to build the capacity of national health workers around the family medicine approach for UHC - this should be scaled up. This includes sub-national or de-factor authorities, such as the need to strengthen the capacity of the LHA in NES to ensure sustainability.
- RCRC should continue to explore potential ways to reach all areas of Syria with the greatest need or vulnerability, including opportunities to work beyond government-controlled areas.
- The barriers to provision of basic cancer services are lower than commonly perceived; managing solid tumours is relatively affordable but requires workforce capacity building, a referral system, and access to surgical care.
- Sanctions strongly affect the import of raw materials and procurement of medicines. There is a need to advocate for a stronger consideration of the population health impacts of all sanctions.
- Implementing actors should, wherever possible, procure locally and strengthen the existing national manufacturing capacity - for example, from producers that meet national quality standards.

FINDINGS AND KEY RECOMMENDATIONS

This section summarises the findings across all four case studies (Afghanistan, Lebanon, Somalia, and Syria). It identifies common themes with regards to the status quo of NCD prevention and care in protracted humanitarian crisis settings. All four case study countries fall under the banner of 'protracted humanitarian crisis', while there are significant areas of overlap and differences between them. These contextual factors are picked up here to guide the discussions on strengthening NCDs in each country as well as informing global efforts to address NCDs in crises. Synthesising the case study findings, each part of this section concludes with a list of suggestions for implementing humanitarian actors looking to strengthen their efforts to support people living with NCDs in protracted crises.

Governance and leadership

Each of the four case study countries describes governance mechanisms relevant to NCDs at the national level, ranging from an NCD department (e.g., Afghanistan) to small NCD-focused units (e.g., Somalia). Technical working groups often play a key role in operationalising and driving NCD-related work. Given the protracted nature of these four crises, governmental priorities are heavily influenced by funding availability and the interests/focus of implementing agencies - in some contexts (e.g. Afghanistan) there is a relative lack of long-term health system investment, and instead a predominantly short-term focus (acute emergency mindset). This reflects the importance of humanitarian financing in the overall funding for healthcare. In protracted crises, governance structures are often complicated by intricate power dynamics where different actors hold the de-facto authority and legitimacy. Thus, to ensure sustainability and context-appropriate approaches, humanitarian actors have to engage with de-facto authorities. For example, in North-East Syria the local health authorities are the primary health authority, despite their political isolation and limited capacity.

In all four countries, there is an essential package of health services that is provided at the primary care level, which all include NCDs to some extent. However, in Somalia and Afghanistan the scope was limited with a focus primarily on hypertension care and maternal and child health-related NCD care. Where packages exist, they are rarely fully implemented due to lack of financial and human resources at central level, and weak health system governance (district-level MoH services and non-government actors are not consistently required / requested to deliver this care). Despite a notable growth in governments' recognition and interest in the role of NCDs in each of the case study countries, specific actions may be hindered by a lack of capacity and funding.

There is a level of consistency in the international humanitarian response across these four protracted crises, underpinned by UNOCHA-assured response mechanisms. All four case study countries have ongoing humanitarian emergencies and an Humanitarian Response Plan (HRP) in place which supports ongoing resource mobilisation to fund humanitarian response, though often excluding NCDs.

LEBANON
NCD Open Day
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Recommendations for RCRC and implementing agencies:

- Where it exists, the essential package of health services is the key normative framework for the integration of NCDs and should be the basis for actions by health organisations.
- Where NCDs are not included in the essential package of health services (as is the case in Afghanistan), this should be advocated for by challenging the narrative around 'ongoing crisis' that is directing attention only to acute health needs. In parallel, it is important to promote a minimum package for NCDs to be implemented by humanitarian actors.
- Where NCDs are included in essential packages of health services but not fully implemented, humanitarian actors - and humanitarian donors - can advocate for full implementation. At the same time, these actors need to be considered as 'recipients' of advocacy messages, as they do not always appreciate the extent of the NCD burden and consequent need for action.
- Leadership capacity needs to be ensured at all levels, including within the implementing NGOs, national RCRC societies, cluster system, and health authorities. In contexts where there is marked lack of leadership capacity, can RCRC find entry points to build the health leadership / management capacity at different levels within the health system?

Example: Changing NCD leadership in Somalia

The Somalia case study exemplifies that the political will to address NCDs does not require NCDs to be the leading cause of death. In the last few years, the government has been paying increasing attention to NCDs, often triggered by anecdotal evidence and increasing discussions of NCDs on social media platforms.

Within a few short years, the country has made great strides around NCDs, featuring a dedicated unit in the MoH, their inclusion in the national essential care package, the initiation of an NCD technical working group, and ongoing work to develop an NCD strategy. These efforts are a key starting point in advancing NCD integration, while their translation into affordable NCD care requires continued efforts.

Humanitarian organisations are not only key to ensure the inclusion of NCDs in all policies but can also work with country leadership to support national funding requests and messaging.

SOMALILAND
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Financing

The financing of NCD services in all four case study countries comes from multiple sources, representing a mix of national funding streams and international assistance. Funding streams include a combination of:

1. humanitarian funding obtained through the HRP / flash appeal mechanism, mainly channelled to implementing partners, and in some cases to governments;
2. long-term development assistance channelled primarily through government; and
3. domestic (governmental) funding is raised through a variety of mechanisms, including cost recovery through out-of-pocket payments

However, in each setting a large proportion of health care is private (in Lebanon, for example, until recently the publicly funded primary PHC centres were less frequently used by the host population). As a result, in all four settings the majority of the actual costs of care are covered by out-of-pocket payments. This reflects breakdown of public systems (due to the crisis), leading to a consequent burgeoning of private healthcare, as well as pre-existing health system challenges including pluralistic and highly privatised systems. Either way, the impoverishment of the population - whether historic or due to more recent economic collapse and loss of financial opportunities - renders healthcare, especially chronic care for NCDs, unaffordable to significant proportions of the population. Wealthier individuals are often able to maintain a standard of NCD care, including through seeking care abroad, while the majority of the population is left behind. This especially affects people living in rural areas or those already marginalised. The public healthcare system plays a key role in covering their needs across all four settings, while its ability to fulfil this role is hampered by underfunding and non-availability of medicines. Humanitarian actors' NCD funding was often sporadic and project-based, while some organisations - with integrated care approaches - were able to use health funding to provide NCD care as part of their PHC services.

Recommendations for RCRC and implementing agencies:

- Funding for humanitarian response in general, and for NCDs within that, is the primary gap. This requires advocacy towards humanitarian and development donors, supported by robust, up-to-date data from needs assessments and activity reports that implementing agencies (including RCRC) are best placed to provide.
- Implementing actors should challenge narratives around NCDs as 'development issues', especially with humanitarian donors.
- Can RCRC find ways to financially support the most vulnerable in accessing care, or otherwise to organise and cover the costs of referrals?

Example: Financing NCDs in Lebanon

NCDs in Lebanon - and healthcare services more broadly - are financed through diverse channels, including a large out-of-pocket component and international donor commitments. At the same time, the relatively strong MoPH leadership capacity ensures a more coherent implementation - despite the layered funding system. Implementing actors' financing in Lebanon also exemplifies the uniqueness of protracted crises, with both development and humanitarian financing channels being used. Respondents in this project generally perceived their funding as flexible (e.g., from ECHO), enabling work on systems strengthening and crisis response activities simultaneously. Another noted the role of donor-earmarking around target groups and its limitations towards responding effectively to evolving situations and shifting needs. Despite the existing leadership, NCD efforts in the country often rely on project-based and short-term funding, especially efforts beyond diabetes and hypertension. This leaves people living with these NCDs at risk of discontinuation, including a recent example where including a recent example where a large supply chain NGO lost its funding and had to shift thousands of patients to other actors.

Community protection and engagement

Functions performed by CHWs and community volunteers vary substantially across the four crises, spanning community engagement, health promotion and screening, and community health service delivery including treatment support. CHWs are often at the forefront of implementing actors' community-based efforts, building connections with local communities. However, existing community service models often centre around communicable diseases and surveillance (e.g., WASH messages, disease reporting), while

NCDs are typically only addressed sporadically or as part of other messaging efforts (e.g., smoking during pregnancy). Some exceptions exist, especially where NCD prevalence is higher or when implementing actors consider NCDs as part of their agenda. In one case, CHWs were involved in NCD screening, but without assurance of access to care for those screened positive.

Recommendations for RCRC and implementing agencies:

- Community health service delivery provided by RCRC national societies includes many examples of good practices that should be shared with other implementing partners and WHO (e.g. in Somalia).
- Beyond health promotion and health education, CHWs can take on valuable additional responsibilities, which could be further explored in some of these contexts. This includes active case finding and referral, home-based care for vulnerable patients, and therapeutic education for PLWNCDs, focusing in particular on how to deal with service disruption.
- By contrast, NCD screening in humanitarian contexts is generally not recommended unless the following are already well established (at community or primary care level): treatment and follow-up of diagnosed patients, identification and referral of complications; therapeutic education, health promotion, and active case finding.
- The role of CHWs in channelling community feedback - both for accountability and to improve service design and delivery - could be much more developed. This is especially important for chronic diseases, where engagement with populations over time is critical.

HAZRAT ABU BAKAR SEDIQ BHC, HERAT, AFGHANISTAN
ARCS's Herat branch BHC. Doctor monitoring a patient's blood pressure.
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Example: Community health in Afghanistan

Community health workers are the primary community-based mechanism used across the four case study countries. In Afghanistan, CHWs are defined as part of the basic service package guidelines and are a well-established component of communicable disease prevention and care. NCDs are not typically included in their roles, with the exception of some INGOs or when NCDs are addressed as part of other priorities (e.g., smoking during pregnancy).

The expansive network and well-established concept of CHWs present a key opportunity for extending NCD care in the country. However, expanding their role for NCDs is hampered by the lack of primary level capacity to treat NCDs, especially in rural areas, and the risk of overburdening CHWs.

Countermeasures (medication supply)

Reliable access to quality medication was a critical gap in all four protracted crises, caused by availability issues and the high cost of medicines. Given the often significant role of the private sector in protracted crises and the large share of out-of-pocket payments, access to medicines was often directly linked to people's ability to pay for them and their proximity to cities. Access to NCD medicines is an issue for the vast majority of PLWNCDs in protracted crises, while barriers are further increased for medicines that require special infrastructure, such as insulin cold chains.

The national EMLs often only include limited NCD medicines and diagnostics equipment, such as in Somalia. Even when included, procurement is often done internationally - especially by humanitarian implementers - due to quality concerns and limited in-country production capacity.

Recommendations for RCRC and implementing agencies:

- Where cost of medication is a paramount barrier to NCD care, national societies should consider implementing medication provision programmes.

- Given the frequent lack of reliable treatment for T1D, and the evident vulnerability and low life expectancy of this group, movement partners should consider supporting Insulin provision in contexts where Insulin is unavailable outside of central locations.
- Implementing actors should advocate for the expansion of NCD medicines and equipment in national essential medicines and equipment lists, where absent or limited.

Example: Supply chains and sanctions in Syria

Medical supplies, especially medicines, are often a primary concern for PLWNCDs in crises and are often prioritised by humanitarian implementers. In Syria, several actors have been complementing the government's supply chain for NCD medicines. Their approaches varied based on the evolving nature of the crisis: during the initial response in the Syrian war, medicines donations were prioritised, but this shifted to a formal partnership between actors and the government over time. Implementers often focus on specific gaps with regard to the highest needs, for example the ICRC covering 20-30% of the MoH insulin supply. These efforts are essential in addressing supply gaps and maintaining essential care. However, in Syria, even NGOs with strong health supply chain capacities report frequent stock-outs.

This highlights the need for implementers in protracted settings to engage with system-level barriers. For example, in Syria two of the main limiting factors are ongoing sanctions and the limited local pharmaceutical production capacity. The country produced around 90% of its medicines locally before the war. Working at the system level may be beyond the expertise or mandate of specific organisations, yet actors may find specific entry points to ensure sustainability. As one example, implementers should endeavour to work with national quality standards rather than procuring internationally under the pretense of 'quality concerns' around locally-produced medicines.

Collaborative surveillance and public health intelligence

Data issues and gaps are key themes across all four case study countries. While Lebanon has a relatively stronger data collection system that includes NCD data, issues of quality and coverage limits its useability. In contrast, NCD data is virtually absent from the national HIS in Somalia and Afghanistan, while health data in Syria is largely siloed and managed by different actors.

Some of the national societies - as well as other humanitarian actors - have supported NCD data collection and effectively promoted patient-level data collection so that adequate monitoring can be put in place (e.g. using the WHO health-facility indicators). However, this data is often kept at the organisational level due to NCDs not requiring reporting to national health authorities. Similarly, needs assessments rarely included NCDs, with some exceptions during specific disasters or crisis events in Lebanon and Syria.

The absence of NCDs from needs assessments and routine HIS data collection renders people living with NCDs often invisible, contributing to the exclusion of NCDs from funding calls / flash appeals, donor priorities, and hence service delivery. As such, collecting relevant and targeted NCD data can become a catalyst for changing the system's continuous exclusion of NCDs as a health priority.

Recommendations for RCRC and implementing agencies:

- By virtue of their proximity to primary care services, and the trust they enjoy, national RCRC societies should consider supporting or advocating for patient-level data collection and collation on NCDs in each context, as this can be critical for advocacy and resource mobilisation.
- Several implementing actors have experiences with strong organisation-level NCD data collection and cohort management systems, which can be used to advocate for expanding NCD data collection within the national HIS.
- People living with NCDs are often well aware of who provides what services. As such, the absence of NCDs in existing data collection systems may be a sign of gaps in NCD service delivery rather than the absence of need.

Example: NCD data in Somalia

Data is essential for the NCD in crises agenda and for ensuring quality care. This has emerged as a key theme in this project as well as in previous research. However, the case studies clearly exemplify that the areas requiring attention can vary widely. In Somalia, there have been some efforts to integrate simple NCD data into the HIS. The primary challenge lies less with defining and reporting indicators and more with data quality and standardisation. Respondents flagged that there are major issues around the duplication of patients in the system (e.g., multiple entry points, data collected per visit not per patient, and people having multiple ways of spelling their name). At the same time, detailed data collected at the facility level is often lost during the aggregation process, such as by covering NCDs under the category of 'other' diseases.

Another clear pattern that emerged from the Somalia case study is that demand follows supply. For example, one respondent's organisation reportedly had few NCD consultations recorded, despite a well-established data collection system. This could be for many reasons, but may include a lack of continuous NCD services and medicines, leading people to seek care elsewhere. Organisations should thus be cautious when interpreting internal NCD data, as it may be rather a reflection of the organisation's historic priorities and what it is known for in the community, rather than actual need. This is especially pronounced when NCDs are also excluded from needs assessments.

Safe care delivery

Care delivery models, and the types of provider, varied across these four case studies. Lebanon represents one end of the scale with a highly pluralistic and privatised health care system; Syria has a mixed system but with a higher proportion of care delivery provided by the state. Afghanistan's system is more centralised but a significant proportion of service delivery is provided by humanitarian actors, which is also true (to a lesser extent) in Somalia. National societies have often been involved in NCD service delivery (community and PHC level), and this is well recognised and valued by partners (e.g. WHO Afghanistan). However, few implementing actors provide all services needed by PLWNCDs, requiring patients to navigate and identify multiple service providers. For example, in Afghanistan medicines may only be available for hypertension but not for diabetes at the PHC level, which then have to be purchased privately. Similarly, with many NCD services being run as part of pilots or specific projects, the presence of NCD services may vary even within organisations. Certain aspects of the continuum of care were virtually non-existent across all four settings, including palliative care and secondary prevention.

NCD care delivery tends to focus on (1) diagnosis and care for chronic conditions that can be managed relatively easily in primary care (e.g. hypertension, type 2 DM) and (2) management of acute complications at hospital level. In general, access to care is much more limited in rural settings - in Afghanistan this disparity is extreme. Care for more complex conditions such as cancer is generally very inaccessible (one exception for example being parts of North-West Syria where this is supported by SAMS).

In most humanitarian contexts, care for complex conditions / paediatric cancer / cancer requiring systemic therapy requires out-of-province or out-of-country referral. Implementing actors have often put in place these referral mechanisms to higher-level facilities, but their use in practice is extremely difficult due to travel and financial restrictions. Provision of mental health services is highly variable and is often not integrated, despite the evident need among many populations (such as the mental toll of war on PLWNCDs).

Recommendations for RCRC and implementing agencies:

- National societies can play a valuable role in NCD service delivery. Extending access to people living in rural areas should be a priority for national societies, in contexts where rural NCD care provision is almost absent (e.g. Afghanistan). Technology is beginning to provide an opportunity to strengthen NCD care in rural areas (e.g., using m-health in data-gathering and care algorithms for CHWs).
- Mental health needs to be seen as an integral part of NCDs, mainstreamed across all aspects of humanitarian responses.

- Cancer services are feasible, although this requires separate attention from the core focus on integrating chronic NCD services into PHC. Cancer care requires building workforce capacity, functioning referrals, a few core medicines (e.g. Tamoxifen) and basic surgical capacity as a minimum.

Example: Accessing NCD services in Afghanistan

In Afghanistan, access to NCD care varies geographically. People living close to cities may have relatively good access, even to specialised services (e.g., rehabilitation), especially if able to pay for private care. In comparison, those living in more remote areas have little to no options. At the same time, humanitarian implementers typically focus on the hard-to-reach populations, which may mean that certain communities - even if in remote regions - have access to good quality NCD care. This depends strongly on the specific organisation's mandate and priorities, leading to significant variance in what care is provided.

To compound this, there is a lack of capacity nationally to lead NCD programs and ensure standardisation across actors and comprehensive service coverage. Similarly, the basic package of health services does not currently include NCDs, while some implementers reported going beyond services defined in the package to implementing a "BPHS+". This may be encouraging, highlighting that implementers can address existing NCD needs even without their explicit integration in existing strategies or basic care packages.

With people often arriving at facilities late with complex care needs, referrals become essential. However, even organisations with well-established referral pathways had many defaulters, most likely due to the prohibitive cost of transport. This raises questions of how people can be best supported, especially if travelling to urban centres is not feasible.

DEH BALA, NANGARHAR, AFGHANISTAN
ARCS's Nangarhar branch mobile health team. Doctor conducting a blood pressure examination of a patient.
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Emergency coordination

In all four countries, the fact that there is an ongoing internationally recognised humanitarian crisis means that the cluster system is in place, and thus humanitarian emergency coordination is provided by WHO in conjunction with the governments (mainly the MoH). A number of key health actors do not participate in the Health Cluster; and the Health Cluster is absent in contested areas (e.g. NE Syria and Somaliland) which means that informal coordination mechanisms fill those gaps (e.g., North-East Syria NGO forum).

Even when the cluster system is active, NCDs are typically absent from its agenda, which may be due to historical priorities, lack of data, or the existing expertises within the cluster agencies. This relative lack of coordination may partly explain the variability in services provided by humanitarian implementers (such as different approaches to the provision of NCD care, and variable support to delivering essential care packages). Furthermore, there is little sharing / pooling of NCD data, from surveillance, assessments or HIS, and actors are often collecting quite different (and incompatible) data. Implementing actors may need to consider working closely with and supporting de-facto authorities in specific regions, as they may be the only pathway towards building sustainable NCD care and implementing health system strengthening efforts (e.g., including NCDs in HIS).

Recommendations for RCRC and implementing agencies:

- Can RCRC use its position of relative credibility to bring more health actors around the table in existing coordination mechanisms?
- Can movement partners use the observations from national societies to push for more alignment at the level of the global Health Cluster / informal NCD Technical Working Group?
- Can implementing actors advocating for NCDs in humanitarian settings identify entry points to integrate NCDs into Health Cluster agendas?
- Can existing coordination mechanisms be leveraged to strengthen the alignment of how NCD data is collected and shared across actors?

ALEPPO, SYRIA
A medical team provides medication to patients with chronic diabetes who were unable to take their medication with them when they left their homes during the earthquake that struck the country in February.
© ICRC/Ammar Saboh

Example: Emergency coordination in Syria

The four country case studies are all classified as protracted humanitarian crises, and all have the IASC cluster system in place with the health coordination led by the WHO. The Health Cluster coordinates closely with the country's health authorities, which means that disputed territories or non-state-controlled areas are often left behind. For example in Syria, the cluster system was not active in the North-East of the country at the time of this analysis, due to political sensitivities with regard to non-government-controlled areas. This meant that actors often established separate - informal - coordination mechanisms, such as the North-East Syria NGO forum. However, the legitimacy and capacity of de-facto authorities varied widely and shapes how implementing actors can or cannot engage with them.

While informal coordination mechanisms can play a key role in filling the gaps, they are often unable to fulfil all the functions of the cluster system. For example, in North-East Syria there was a lack of standardised data collection and sharing, due to no single NGO being able to take this on and to data-sharing sensitivities.

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