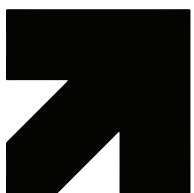




IRC PAVING THE WAY ON NON-COMMUNICABLE DISEASES IN HUMANITARIAN & FRAGILE SETTINGS



WHY ARE WE TACKLING NON-COMMUNICABLE DISEASES?

Non-communicable diseases (NCDs) are long-term conditions that cannot be passed from one person to another. The main NCDs are diabetes, hypertension, heart disease, stroke, asthma and cancer. According to the World Health Organization (WHO), [15 million people](#) die prematurely before the age of 70 from NCDs every year, and [85%](#) of these deaths occur in low- and middle-income countries (LMIC). NCDs now represent the leading causes of death and disability worldwide including in many crisis-affected areas where the impact of the crisis on the health system can severely impede timely diagnosis and treatment.

Numerous factors influence the increased prevalence of NCDs including widespread exposure to unhealthy diets, limited physical activity, smoking, alcohol consumption, and the fact that many countries are experiencing a demographic transition, resulting in an aging population and increased life expectancy. Globally more than [1.9 billion adults are overweight or obese](#). Furthermore, [80% of the world's smokers \(1.1 billion people\) live in low- and middle-income countries](#). Crisis-affected populations are at risk of exposure to a combination of trauma and daily stressors including mental health conditions which can exacerbate NCDs. In some settings, refugees largely live in urban areas rather than camps, which can further contribute to risk-factors related to diet, physical activity and tobacco use.

Humanitarian response has traditionally focused on treating and preventing communicable diseases and physical trauma. Increasingly, however, humanitarian agencies, academics and governments have been challenged with how to effectively tackle NCDs in these situations. In emergencies, screening, diagnosis and treatment of these chronic diseases prove immensely difficult. Services are often easily interrupted or inaccessible due to the mobile nature of crisis-affected populations, the disruption of healthcare services, and dysfunctional health systems. Despite these challenges the IRC is providing care for crisis-affected clients living with NCDs, integrating NCD programming into recovery and development efforts across different contexts, undertaking research projects and developing innovative approaches to improve the quality of care for the people we serve.



PROVIDING CARE FOR PEOPLE WITH NCDs ACROSS THE ARC OF A CRISIS: IRC'S MODEL

Emergency Response

The IRC aims to address NCDs at the onset of a crisis and throughout the recovery period. We work to identify patients who have already been diagnosed with NCDs and ensure they receive uninterrupted treatment and avoid developing complications; help people prevent NCDs; and strengthen health systems to address this growing burden of disease. The IRC facilitates the use of diagnostic and treatment services by setting up laboratories and strengthening staff capacity to manage NCDs at primary health care facilities. We work in diverse settings, from fragile contexts serving internally displaced and conflict-affected communities in Democratic Republic of Congo, South Sudan, Myanmar, Libya, Yemen, Central African Republic, Nigeria, Syria and Somalia, to long-standing Syrian, Burmese, Somali, Sudanese and South Sudanese refugee populations in camps in Chad, Jordan, Thailand, Tanzania and Kenya, to acute onset refugee situations in Colombia, Uganda and Bangladesh. The IRC works within contexts that experience cyclical shocks and crisis. The path from emergency to recovery is non-linear and often requires development and humanitarian efforts at the same time. The IRC therefore carries out the direct implementation of service while strengthening the capacity of host-country institutions to provide quality services to affected communities.

People living with NCDs are more susceptible to severe & fatal COVID-19 infection & associated complications

As part of its response to the COVID-19 pandemic, the IRC adapted its NCD programs to ensure continuous care with limited risk of exposure at facilities by providing people with a 90 day supply of medication when possible, linking patients with the community health system for follow up and support, and utilizing remote/virtual health services to monitor patient conditions.

Primary Care Facilities

After the initial emergency phase, we focus on improving the primary health care response and implementing the most effective public health measures to ensure continuity of care and prevention of secondary complications. At primary health care facilities, we prioritize addressing conditions that cause the highest burden of disease such as hypertension, diabetes, asthma, epilepsy, chronic obstructive pulmonary diseases and chronic heart disease. Much of the NCD work at IRC-supported health facilities in Jordan, Kenya, Chad, Libya, Somalia, Syria, Thailand, Uganda and Yemen is focused on ensuring access to services through the provision of diagnostics and medicines at the health facility level. We also work to increase demand for services by engaging communities using client feedback and responsiveness mechanisms, and by ensuring high quality services.

In 2020, the IRC primary care facilities in 15 countries delivered an estimated 978,000 consultations for NCD related conditions. These included 103,000 consultations for hypertension, 73,000 for diabetes, 26,000 for asthma, 27,000 for epilepsy, 3,000 for patients with COPD, and 1,700 for people with cancer.

Community-level support

The IRC aims to promote the adoption of healthy behaviors at the individual, family and community level that can prevent disease and the need for treatment, particularly in more stable settings. We integrate NCD care and support into community



health programs; we link individuals living with NCDs and their families with economic opportunities to ensure the costs of prevention and treatment do not overwhelm limited family resources; we provide individuals with the skills to prevent NCDs and adhere to treatment; and we work with communities to foster an enabling environment for patients to adopt healthy behaviors.

Box 1: Community Health Worker approach to supporting NCD patients

Community Health Workers (CHWs) are a valuable asset to health systems in fragile contexts, including for the delivery of child health services and reproductive health promotion. Since 2017, the IRC programs in Kenya, Libya, Somalia, Syria, , Uganda, and Thailand trained CHWs to support NCD patients in displaced populations. They visit patients in their homes to advise them on topics including medication adherence, healthy behaviors, and signs and symptoms of complications. CHWs also trace NCD patients who have stopped attending clinic appointments to help improve continuity of care.

In 2019, the IRC developed videos and simple protocols to improve CHWs' knowledge and understanding of NCDs. In the future, this new approach could be scaled up to further demonstrate its effectiveness.

DRIVING INNOVATION IN NCD CARE

Collaboration to drive innovation and change

Since 2015, the IRC has been leading and collaborating with partners to strengthen NCD response in humanitarian settings. As a founding member of the Informal Working Group on NCDs in Humanitarian Settings, we believe that a partnership approach is vital to building and promoting best-practices, evidence, and innovation. As part of this commitment to collaboration, we actively engaged in NCD guideline and indicator development, including updating the NCD section of the Sphere guidelines. Since 2015, we have also participated in a range of relevant NCD symposia and worked with others to advocate for unified guidelines, improved data, and universal access to insulin in complex emergencies. The IRC is now working with partner organizations to develop a package of materials to improve NCD care in humanitarian settings. These include guidelines and protocols for healthcare staff and community health workers and self-care guides for patients with epilepsy and cardiovascular diseases. These materials are being tested in refugee and emergency settings to ensure they are suitable for humanitarian and low-resource settings. We also ensure materials are open access so they can be used by other organizations.

Contributing to evidence on effective NCD interventions in humanitarian settings

The IRC is working to strengthen the evidence base on how to effectively address NCDs in low resource settings with a focus on examining the burden of NCDs, the effectiveness of interventions that include new tools and diagnostics, the cost of treatment, optimization of drug distribution, implementation of programs, including the value added of m-health and electronic medical records in low and middle income settings (including humanitarian and fragile contexts). In addition the IRC aims to look at access to healthy food in humanitarian settings, and epidemiological methods of assessing prevalence of NCDs in crisis settings. Research will also evaluate systems and policies including shifting tasks among health workers and the impact of community level follow up of NCD patients.

The IRC's funded NCD research projects have included a study funded by OFDA to describe current models for NCD management through primary health care in two complex

Box 2: Linking NCD care to economic recovery and cash programming

The impact of NCDs on socioeconomic development is well known. In low-resource settings, for example, health-care costs for NCDs can quickly drain household resources and drive families into poverty. The exorbitant costs of NCDs can include lengthy and expensive treatment, loss of breadwinners and the exclusion of refugees and migrants from national health systems requiring out of pocket payment. These chronic illnesses force millions of people into poverty every year and stifle development. While services provided at IRC-supported health facilities are free, treatment-related costs are still incurred by patients both directly and indirectly. IRC's health and economic recovery and development (ERD) teams work together to make cash available at the onset of a crisis and thus increase accessibility of healthcare services. IRC's NCD program guidance advocates for integrated health and ERD for improved patient outcomes.

emergency settings in Syria and the Democratic Republic of Congo. Another study, funded by R2HC, is underway in refugee settings in Jordan using a participatory approach and community care model to improve access to medical care for hypertension patients. In Hagadera refugee camp in Kenya, the IRC collaborated with a London School of Economics graduate student on a diabetes costing study including a comparison of resource requirements for complicated and uncomplicated diabetics. Furthermore, in 2019 the IRC initiated and facilitated research on the feasibility of NCD prevention initiatives in Bidibidi refugee settlement, Uganda. The IRC is now leading a study among refugees in Thailand assessing the cost effectiveness of integrating an evidence-based mental health intervention into routine care for people living with hypertension, diabetes, and epilepsy. Finally, assessments have been executed in Yemen, Libya, South Sudan and Sudan to determine the utility of the [WHO NCD emergency health kits](#).

Integration of NCD care within health and other sectors

To more effectively drive positive outcomes for all clients, the IRC examines linkages between NCDs and other areas of work related to health, safety and economic well-being. At the same time, there is an emphasis on developing gender sensitive and inclusive programming targeting marginalized and vulnerable populations. Through an evidence-based approach, the IRC can recognize and address linkages among NCDs such as pregnancy-induced hypertension and gestational diabetes mellitus while also addressing the health needs of women with pre-existing NCDs. In children, the focus is on ensuring malnutrition treatment and prevention efforts are linked with programs addressing childhood diabetes. Efforts promoting environmental health consider the impact on patients with chronic respiratory diseases while linkages with economic recovery and development programming are being further explored given the positive evidence tied to this approach and the IRC's commitment to cash programming in humanitarian settings.

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International Rescue Committee

122 East 42nd Street
New York, NY 10168-1289
USA

Rescue.org

