

Noncommunicable diseases and post-conflict countries

Bayard Roberts,^a Preeti Patel^b & Martin McKee^a

In September 2011 world leaders attending the United Nations high-level meeting on noncommunicable diseases recognized that these diseases are one of the major challenges to international development. However, among the wide-ranging discussions at the meeting, one topic received scant attention: the issues facing countries emerging from armed conflict. This mirrors the virtual absence of noncommunicable diseases on the agendas of leading global institutions engaged in humanitarian and reconstruction efforts in conflict-affected countries.¹ We argue that this is an important gap that can, and must, be filled.

The post-conflict phase begins when there has been a prolonged cessation of armed hostilities or signing of a peace agreement. It is characterized by increasing peace and stability (although insecurity and violence may still exist in certain regions) and countries involved often attract large-scale development aid and private investment. The period of post-conflict status may last between approximately five and 20 years.

A combination of shifting geopolitics and global economic and demographic development is changing the type of countries affected by conflict. They are increasingly countries with higher incomes and life expectancy, and thus a higher burden of noncommunicable diseases.² For example, the years of life lost from noncommunicable diseases in Libya are three times higher than from communicable diseases. Similar patterns can also be seen in, for example, conflict-affected countries in the Balkans, the Caucasus region and Sri Lanka. In marked contrast to conflicts in much poorer countries, many people with noncommunicable diseases in these countries have survived because they have had access to long-term treatment but they are then left vulnerable in times of conflict.²

The most obvious area of concern relates to mental health, resulting from exposure to violent and traumatic

events, forced displacement, impoverishment, uncertainty and isolation. Not surprisingly, surveys reveal very high levels of mental ill-health in countries emerging from conflicts.³

Rather less attention has been paid to the ways the post-conflict environment increases risks of other noncommunicable diseases. First, high levels of psychological distress contribute to harmful health behaviours, such as hazardous drinking and increased smoking, which in turn increase the future burden of noncommunicable diseases. Second, post-conflict countries commonly experience rapid urbanization, also associated with increased alcohol and tobacco use, as well as higher levels of obesity and reduced physical activity. Third, tobacco, alcohol and food companies often take advantage of weakened post-conflict trading systems.

This toxic combination of stress, harmful health behaviours and aggressive marketing by multinational companies in transitional settings^{4,5} requires an effective policy response,⁶ but often the state has limited capacity to do this. For example, Afghanistan has no national policy, strategy, targets or coordinating body for noncommunicable diseases. With the exception of the European Commission, none of Afghanistan's donor partners have prioritized preventive or curative services for noncommunicable diseases in their programmes.⁷ This policy vacuum provides an open door for multinational companies to influence policies in ways that undermine efforts to control tobacco and alcohol use or improve unhealthy diets in transitional countries.^{4,8}

Health systems in many post-conflict settings have difficulty responding to existing noncommunicable diseases. For example, Somaliland has no psychiatric professionals or related medications available in primary or secondary health services, despite the conflict ending almost two decades ago.⁹ Services for other noncommunicable diseases are also extremely limited – hypertension

is largely untreated in Iraq despite it having some of the highest levels in the region.¹⁰ In many post-conflict countries, noncommunicable disease care is mostly provided by the private sector, with high costs excluding poor people or placing them at risk of catastrophic expenditure. In countries where poverty levels are often already extremely high (and often magnified by the conflict), such expenditure creates a vicious cycle whereby poverty and disease continually reinforce one another.⁶

The challenges of addressing noncommunicable diseases in post-conflict countries are many and complex, particularly in countries with high levels of infectious disease, i.e. facing a double burden of disease. However, the post-conflict period can provide a window of opportunity to undertake fundamental reforms to better address the population's health needs. While existing humanitarian guidelines provide minimum standards for health services for some noncommunicable diseases, more substantive support is required to address their underlying social and environmental determinants, to support governments to enact and enforce preventive legislation and policies, and to provide comprehensive services to treat them.¹¹ The declaration of the United Nations General Assembly on noncommunicable diseases reiterated the Member States' commitment to tackling this global epidemic. It is essential that populations recovering from conflict are included in this commitment. ■

References

1. *World development report 2011: conflict, security and development*. Washington: The World Bank; 2011.
2. Spiegel PB, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet* 2010;375:341–5. doi:10.1016/S0140-6736(09)61873-0 PMID:20109961
- ... full reference list available at: <http://www.who.int/bulletin/volumes/90/11/11-098863>

^a European Centre on Health of Societies in Transition, London School of Hygiene and Tropical Medicine, 15–17 Tavistock Place, London, WC1H 9SH, England.

^b Department of War Studies, King's College London, London, England.

Correspondence to Bayard Roberts (e-mail: bayard.roberts@shtm.ac.uk).

References

1. *World development report 2011: conflict, security and development*. Washington: The World Bank; 2011.
2. Spiegel PB, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet* 2010;375:341–5. doi:10.1016/S0140-6736(09)61873-0 PMID:20109961
3. Roberts B, Damundu EY, Lomoro O, Sondorp E. Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan. *BMC Psychiatry* 2009;9:7. doi:10.1186/1471-244X-9-7 PMID:19261192
4. Gilmore AB, McKee M. Moving East: how the transnational tobacco industry gained entry to the emerging markets of the former Soviet Union-part II: an overview of priorities and tactics used to establish a manufacturing presence. *Tob Control* 2004;13:151–60. doi:10.1136/tc.2003.005207 PMID:15175532
5. Leon DA, Shkolnikov VM. Social stress and the Russian mortality crisis. *JAMA* 1998;279:790–1. doi:10.1001/jama.279.10.790 PMID:9508158
6. *Global status report on noncommunicable diseases 2010*. Geneva: World Health Organization; 2011.
7. *Noncommunicable diseases in Afghanistan* [Policy brief]. Washington: The World Bank; 2011.
8. Bakke O, Endal D. Vested interests in addiction research and policy alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. *Addiction* 2010;105:22–8. doi:10.1111/j.1360-0443.2009.02695.x PMID:20078460
9. Syed Sheriff RJ, Baraco AF, Nour A, Warsame AM, Peachey K, Haibe F et al. Public-academic partnerships: Improving human resource provision for mental health in Somaliland. *Psychiatr Serv* 2010;61:225–7. doi:10.1176/appi.ps.61.3.225 PMID:20194397
10. Webster PC. Iraq's health system yet to heal from ravages of war. *Lancet* 2011;378:863–6. doi:10.1016/S0140-6736(11)61399-8 PMID:21898919
11. Maher D, Ford N. Action on noncommunicable diseases: balancing priorities for prevention and care. *Bull World Health Organ* 2011;89:547. doi:10.2471/BLT.11.091967 PMID:21836749