

Humanitarian health financing for noncommunicable diseases

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NCDs and humanitarian crises

1. Noncommunicable diseases (NCDs), including cardiovascular disease, cancer, chronic respiratory diseases, diabetes are on the rise. (1) They account for around 74% of deaths globally, 77% of these deaths are in low- and middle-income countries (LMICs) which include countries with the highest burden and risk of humanitarian crises. Eight-five per cent of premature deaths (deaths under the age of 70 years) from NCDs were in LMICs. (2)
2. In 2019, over 1.28 billion adults between 30 and 79 years of age were living with hypertension, the vast majority (82%) in LMICs. In terms of diabetes, in 2021 it was estimated that there were over half a billion people (men, women, and children) living with diabetes worldwide with projections showing a doubling in numbers to 1.3 billion by 2050. Eight per cent of those living with diabetes are currently living in LMICs, and it is these countries that are projected to see the most dramatic increase in prevalence over the coming 25 years. (3,4) In turn, prevalence of chronic kidney disease (CKD) is also increasing often as a consequence of late management of risk factors including hypertension and diabetes, including in LMICs, posing a challenge due to growing demand for interventions such as kidney replacement through dialysis. (5,6)
3. One in eight people live with a mental health condition, the most common being anxiety and depressive disorders. COVID-19 has had a marked impact on the mental health of affected populations. (7) A range of mental health conditions coexist with NCDs, and they share many risk factors, including tobacco use, unhealthy diet, physical inactivity, and harmful alcohol use, as well as childhood adversity. Mental health conditions may also affect provision of and adherence to NCD care. People with severe mental health conditions die on average 10–20 years earlier than the general population, largely because of untreated NCDs.
4. LMICs include countries with the highest burden and risk of humanitarian crises. Indeed, more than half of those living in extreme poverty live in countries classed as fragile and conflict affected settings (FCVs). People living in FCVs face numerous health needs, including from NCDs, particularly given the high prevalence of hypertension, diabetes, and other NCDs and the need for ongoing access to treatment and health services to ensure optimal management. FCVs experience significant disruption of health system governance, delivery, complex, fragmented resourcing needs, increased demand and vulnerability including to multiple public health crises.
5. Humanitarian crises are affecting more people than ever before. They last longer and are more complex. These crises are often driven by intersecting threats from one or more of conflict, climate change and socioeconomic vulnerability. Three quarters were in countries facing two of these vulnerabilities. (8–11) Countries that receive humanitarian aid often end up in a spiral of crisis with weak governance and institutions limiting their ability to exit out of this cycle.

6. In 2024, over 299 million people were in need of humanitarian support. Over half of whom (165.7 million) are predicted to require emergency assistance for health needs including for NCDs. Four in five of those in need of humanitarian assistance were living in countries affected by protracted crises. Eighty-three per cent of those in need were living in countries that had required humanitarian support for five or more consecutive years. (10). Over half those in need over the past five years live in 10 countries.¹ (8)
7. Forced displacement is a feature of the current humanitarian landscape with over 107 million people, more than 1% of the world's population, displaced. (10)
8. Estimates suggest that climate change and natural disasters may lead to over 1.2 billion people displaced by 2025. (12) This is exemplified by the Small Island Developing States (SIDS), which account for two thirds of countries with the highest relative annual disaster losses. They suffer an estimated annual losses of US\$ 0.5–US\$ 1 billion in the Caribbean due to infrastructure damage, with climate change further increasing the intensity and frequency of disasters, contributing to high levels of debt. This is in turn affecting progress towards the SDGs and indeed posing an existential question for the islands. (13)
9. **Given the scale of humanitarian crises today, the diversity of contexts affected, and the trends in those living with NCDs, the numbers of people living with NCDs in countries affected by crisis are likely to be high and to increase substantially over the next decade.** With low levels of investment in the management of NCDs as part of health system strengthening and universal health coverage interventions in low- and lower-middle income countries (L-LMICs) affected by conflict further increasing the likelihood of dying prematurely from an NCD.
10. WHO estimates that almost everyone affected by a humanitarian crisis will experience psychological distress with one in five people experiencing conflict over the last 10 years having a mental health condition. (14) Further, 1 in 11 people experience a severe mental health condition and are thus at risk of experiencing violence, abandonment or other human rights violations during crises. Many of these people have both NCDs and mental health conditions.
11. People living with NCDs and mental health conditions are more vulnerable to the effects of a crisis including increased morbidity/disability, as well as disruption of health and social care services and access to commodities. Disruption of services has both a direct impact on the health of those living with these conditions but also an impact on economic productivity, quality of life with increased risk of being driven into poverty either through the need to manage costly complications such as from advanced renal disease or blindness but also on their earning potential due to disability or absenteeism.
12. For refugees, access to health services depends on the availability and affordability of health care in countries of origin, transit, and destinations and on the type of migratory journey undertaken. While refugees share similar barriers in accessing NCD and mental health services as per the local population, they also face specific barriers due to ethnicity, and a lack of linguistically and culturally sensitive information increasing their vulnerability. Policies may create legal and structural barriers resulting in exclusion from health care due to lack of insurance or discrimination within policies. (15)

¹ Afghanistan, Democratic Republic of the Congo, Ethiopia, Lebanon, Somalia, South Sudan, Sudan, Syria, Ukraine, Yemen.

13. The political mandate for addressing NCDs in humanitarian settings has evolved over the last 10 years with recognition of the importance NCDs in humanitarian emergencies as part of the Political Declaration of the UN High-level Meeting on NCDs in 2018. In addition a number of Executive Board and World Health Assembly (WHA) resolutions and decisions have been agreed including EB148/7 Annex 9 and WHA75/10 Add 2 Annex 4 where Member States asked that WHO strengthen the design and implementation of policies to treat people living with NCDs and to prevent and control their risk factors in emergencies before the upcoming Fourth UN High-level Meeting on NCDs. (16,17)
14. Similarly, the Seventy-seventh World Health Assembly will be asked to adopted a resolution on advancing mental health and psychosocial support in emergencies. (18) Delegates at the recent 2024 Global high-level technical meeting on NCDs in humanitarian settings in Copenhagen agreed that NCDs must be systematically integrated into humanitarian preparedness and response.² This paper discusses financial allocations towards NCDs in humanitarian settings and forms part of the background resources for the International dialogue on sustainable financing for NCDs and mental health in the run up to the Fourth UN High-level Meeting on NCDs in 2025.

Sources of funding of health services in humanitarian crises

15. Following a humanitarian crisis, government or domestic support for health service delivery varies depending on the political context and nature of the crisis with access for affected populations influenced by local conflict dynamics. Breakdown in domestic funding and health systems can lead to increased reliance on out-of-pocket (OOP) payments, despite recommendations that all humanitarian health services are free at the point of use. (19) Seventy-eight per cent of health expenditure in Afghanistan and 81% in Yemen came from OOP payments, one of the most inequitable forms of health spending, creating a barrier to accessing services resulting in delays in health seeking behaviour. (20–22) Limited fiscal capacity, resource constraints and political concerns have led to restrictions in coverage of refugees seeking care including for NCDs in Jordan and Lebanon with increased requirements for OOP payments. (20) In 2018, 70% of health expenditure in Sudan came from OOP spending with around half going towards NCDs, 20% of which was on medicines. (23)
16. External financing forms an important source of support for the delivery of health services in humanitarian settings. This may be in the form of acute or shorter term humanitarian funding, or longer term sources of development funding, although in some cases the later may be suspended depending on the context and nature of the crisis. External financing mechanisms include bilateral support from public providers and the private sector direct to preselected humanitarian partners, mainly international NGOs, Red Cross and Red Crescent Societies and/or multilateral agencies or support for pooled funds managed either by multilateral agencies such as the UN Office for the Coordination of Humanitarian Affairs (OCHA) managed Central Emergency Response Fund (CERF),³ the Red Cross and Red Crescent Societies Disaster Relief Emergency Fund (DERF) or other multidonor pooled funds.
17. Short- to medium-term needs including health needs are defined at country or regional level by the Humanitarian Response Plan (HRPs). Funds are then mobilized in support of the HRP including from

² Draft report, Global high-level technical meeting on NCDs in humanitarian settings.

³ The Central Emergency Response Fund (CERF) was set up in 2006 to bring together resource (US\$4450m) from funding partners through voluntary contributions to provide lifesaving assistance under the management of OCHA. Funding includes a Rapid Response window that allows rapid deployment of resource to UN agencies who can subcontracted providers. Given the six-fold increase in needs, there are calls to increase the annual target to US\$ 1 billion.

the CERF and DERF in the immediate aftermath of a crisis, through Country Based Pooled Funds (CBPFs) and through bilateral donations from the public and private sectors.

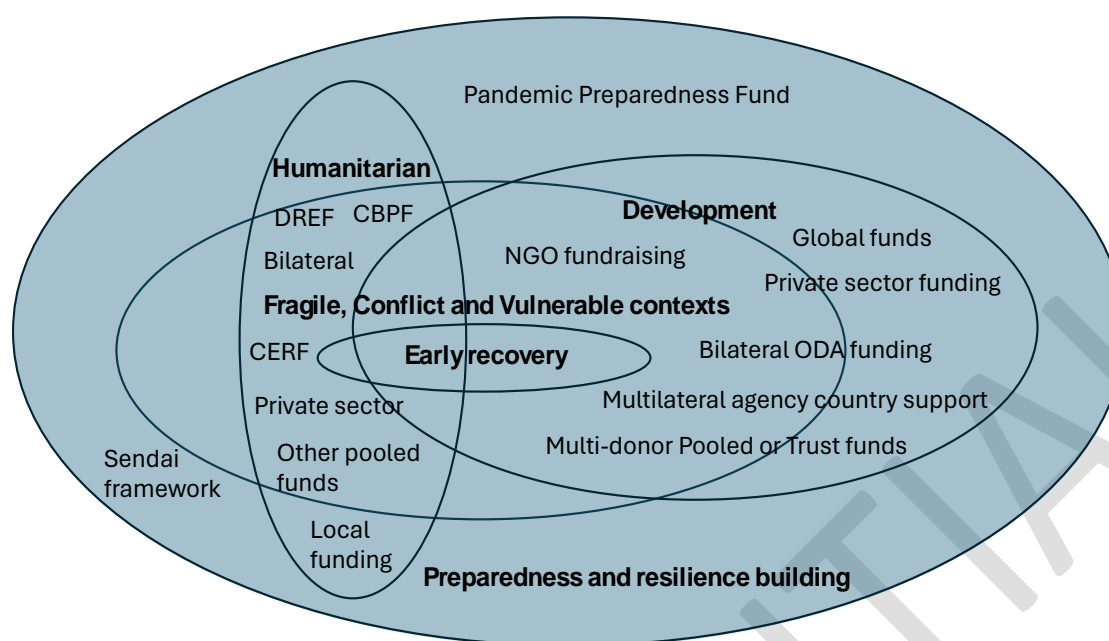


Figure 1: Summary of the potential external funding mechanisms available at different stages of a crisis ((adapted from The nexus crossroads.) (24))

18. The humanitarian development peace building nexus asks partners to ensure external humanitarian and development funds are complementary and ideally pooled, to minimize fragmentation, duplication and the undermining of government systems, where possible channelling through or at a minimum mirroring public systems and functions with the long term intention of transitioning to domestic ownership. The aim of this approach being to maintain capacity to respond to immediate needs, whilst rebuilding or strengthening the health system and preventing future emergencies and crises. (24)
19. In addition, a number of global frameworks and funding mechanisms are working to improve preparedness and prevent crises becoming humanitarian disasters include the Sendai Framework for disaster risk reduction, the Pandemic Preparedness Fund and Climate Fund, however at present very few note the impacts and vulnerabilities from and to those living with NCDs.

Trends in the humanitarian funding landscape and implications for the health sector

- 20. Needs continued to outstrip pledges despite marked increases in humanitarian assistance from donor partners.** International humanitarian assistance grew by over a quarter to around US\$ 46.9 billion in 2022 with an overall shortfall of US\$ 22.1 billion. This trend has continued through to 2023 and looks set to remain in 2024. (8–10,25)
- 21. Public donors provide the majority of humanitarian funding (US\$ 38.1 billion).** (8) Almost two thirds of international assistance came from three donors, the United States (39%), Germany (11.3%) and the European Union (6.8%). The majority of funding from the United States, European Union and the United Kingdom targeted specific country contexts. Japan and Germany gave substantial global or regional contributions (55% and 17% respectively). This is despite ongoing requests for unearmarked finance for humanitarian emergencies. (24) Almost two thirds of humanitarian support

in 2022 went to 10 countries, with Ukraine receiving the largest volume in one year (US\$ 4.4 billion). Afghanistan, Yemen, Syria, and Ethiopia all received over US\$ 2 billion each. **Donations from private donors (including academics, foundations, corporations) also increased (US\$ 8.8 billion in 2022 compared with US\$ 6.8 billion in 2021)** driven in part due to allocations towards Ukraine. (8) However, these figures do not capture fully other private donations channelled to specific crises.

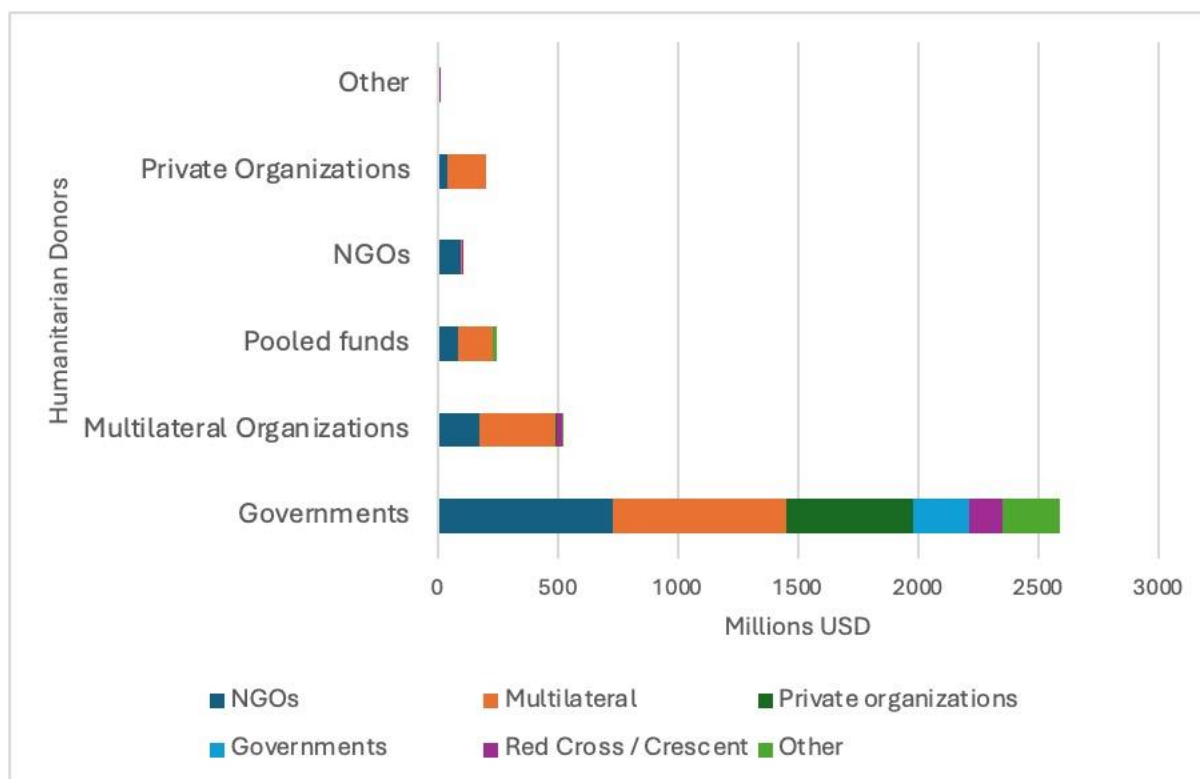
- 22. Most public funding for humanitarian emergencies is channelled to multilateral institutions and international NGOs.** In 2022 61% of funding was channelled to multilateral agencies. NGOs received around 17%, followed by the Red Cross and Red Crescent organizations (6.6%) and pooled funds (6.3%).⁴ **Only 2.1% of tracked international humanitarian assistance was channelled to local actors.**⁵ Use of cash and vouchers (particularly in response to the Ukraine conflict) rose, accounting for around 20% of total humanitarian assistance in 2022.
23. At country and regional level 58% of needs as outlined in HRPs were met in 2022 with marked variation in the proportion received by region, country (10 of 46 appeals received more than 75% of requirements) and sector. The Regional Migrant Response Plan for the Horn of Africa and the HRP for Yemen received around 97% of requirements compared with the HRP for Haiti, which received less than 25%. (8)
- 24. Variation in the proportion of funding needs met highlights the inequities that exist within the humanitarian funding system.** This can mean that countries with greater baseline resilience (with greater investment in health architecture and in preparedness activities including stockpiling of medicines and commodities) may also be those that receive the largest support through soft earmarking of funds due to their ability to attract donations from partners as has been seen with donations in support of Ukraine.
- 25. These trends are further mirrored when it comes to humanitarian spending for health.** In 2023, health accounted for around 9.4% (US\$ 5.3 billion) of the total funding request. Forty per cent was funded, with 70% of this from government donors. Private organizations contributed 5% of humanitarian health finance.
26. Multilateral organizations were the main recipient (37%) of funding for health, followed by NGOs (31%), private sector organizations (14%), governments (6%) and the Red Cross and Red Crescent Societies (5%). US\$ 1.67 billion was in support of 26 country HRPs. A further US\$ 1.55 billion was spent outside the HRPs, and US\$ 200 million went towards flash appeals, and other country and hazard specific response plans. Graph 1 shows the primary recipients of humanitarian health support and the source of funding, which very much mirrors trends in overall humanitarian spending.
27. Development assistance for health (DAH) forms an important part of resources available, particularly in FCVs. Graph 2 shows levels of development and humanitarian finance available for health in the 10 countries that have hosted half those in need over the past five years excluding Ukraine.⁶ In all instances except in the Syrian Arab Republic and Lebanon, development assistance forms a much greater proportion of external support for the health system. **It is therefore critical that humanitarian and development funds are channelled in ways that are complementary to each other and that support the ongoing building of resilient health systems as noted by the humanitarian development nexus.** This might include pooling of resources for health, and

⁴ Includes CERF, Country Based Pooled Funds and other pooled funds such as the WHO Contingency Fund for Emergencies, DREF, Start Fund, Network for Empowered Aid Response Change to name a few.

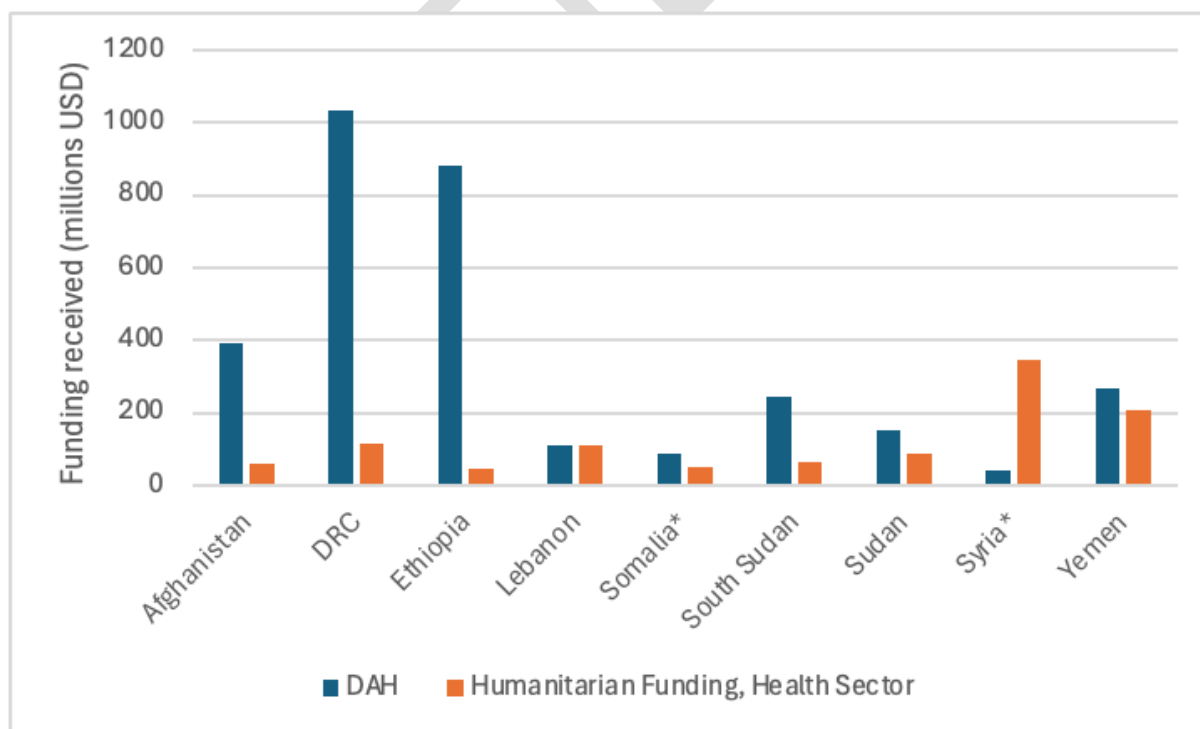
⁵ True figure likely to be higher but tracking not available

⁶ Ukraine excluded due to the timing of data available which predated the start of the current conflict in Ukraine.

subcontracting/strategic purchasing of services in line with national policies and plans. (21,26) Of concern is the gradual trend in international support to countries with long term crises being channelled as humanitarian assistance rather than as support for development or peace building. If this trend is real and continues this will have marked implications in terms of building of resilience of health systems and in turn for NCDs.



Graph 1: Graph showing the 2023 humanitarian health funding donors and their recipients.



Graph 2: Comparison between DAH and humanitarian assistance for health across 9 of the 10 countries with over 50% of those in need over the past 5 years. (27)

*Data for DAH for Somalia and Syria is from 2019. (28) To note Ukraine has been excluded as data available is prior to the ongoing conflict.

What does this mean for the funding of NCDs in humanitarian settings?

28. **Despite the global burden of disease caused by NCDs, external financial support for NCDs in all contexts is low** with an estimated 1.6% of DAH channelled towards NCD programmes.⁷ True estimates are likely to be slightly higher (3.25%) given the assumption that some investments in health systems strengthening and primary care also benefit NCD care. That said, efforts to set up a multi-partner trust fund for NCDs have been slow to realise financial contributions.
29. **The vast majority of funding for NCDs in all contexts are domestic** either through prepayment funding mechanisms such as through taxation or health insurance, or in many L-LMICs and FCVs through reliance on OOP payments (see Table 1). Table 1 shows funding for NCDs as a proportion of total health spend for the 10 countries where half of those in need of humanitarian assistance over the last five years live. (29) There is marked variation in the proportion of the health budget allocated to NCDs from 81.5% in Sudan, and 13.9% in Afghanistan to 3.7% in South Sudan reflecting in part epidemiological and demographic shifts but also the priority given by the health sector to NCDs. The vast majority of funding for NCDs comes from OOP payments ranging from 94.6% in Afghanistan to 32% in the Democratic Republic of the Congo.
30. Analysis of DAH for internally displaced persons (IDP) in LMICs suggests that only 0.44% of DAH for IDP health is disbursed for NCDs and mental health. (30) Yet within minimal international developmental assistance for mental health, the top recipients are predominantly conflict-affected countries and territories or nations receiving refugees. (31)
31. Rapid analysis of 25⁸ ongoing humanitarian responses and their associated humanitarian response plans (and flash appeals for Mozambique and occupied Palestinian territory (oPt) showed that 18 of the 24 countries included mention or indicators related to mental health, and that six plans (Afghanistan, Colombia, Guatemala (no indicator), oPt, Venezuela, Yemen) noted NCDs, an additional two (Somalia and South Sudan) noted needs related to disabilities. (32) There were marked regional variations with NCDs considered primarily across the Middle East and North Africa region and in Latin America and the Caribbean. This in part reflects the issue that whilst there is a NCD disease burden investment in NCD prevention and treatment is low even where there is a basic package of health services that includes NCDs such as in Afghanistan. This leads to a reluctance for humanitarian responses to incorporate NCD interventions in settings where services for NCDs are weak to begin with. In contrast NCDs are often prioritized in high income countries (HIC) and middle-income countries affected by conflict e.g. oPt, Ukraine.

Year of data	2021	2020	2021	2021	2021	2021*			2019–21	2015
Country	Afghanistan	DRC	Ethiopia	Lebanon	South Sudan	Sudan	Syria	Somalia	Ukraine	Yemen
Value of health financing by source (millions of US\$)										
Domestic	107.7	351.1	972.0	286.9	55.2	266.5			8176.0	104.1
DAH	631.0	819.4	901.0	103.8	173.3	102.6			96.7	79.5
OOP	2518.2	868.3	1178.3	345.2	95.3	560.2			7424.0	827.3

⁷ Background paper from the International dialogue commissions.

⁸ Afghanistan, Democratic Republic of the Congo, Cameroon, CAR, Colombia, Chad, DRC, El Salvador, Ethiopia, Guatemala, Haiti, Honduras, Mali, Mozambique, Myanmar, Niger, Nigeria, occupied Palestinian territory, Somalia, South Sudan, Sudan, Syrian Arab Republic, Ukraine, Venezuela, Yemen.

Other	4.4	147.3	132.9	258.4	24.0	56.0			423.0	11.0
Total	3261.3	2186.1	3184.2	994.3	347.8	985.3	0.0	0.0	16119.7	1021.9
Value of NCD financing by source (millions of US\$)										
Domestic	0.0	53.0	317.7		0.1	204.0			941.0	
DAH	21.6	22.9	21.0		9.2	0.0			683.0	
OOP and other	429.5	36.0	552.5		3.9	599.0				
Total	454.0	112.0	891.6		13.0	803.0			1624.0	
Proportion of total health budget spent on NCDs (%)										
	13.9	5.1	28.0		3.7	81.5			10.1	
Source of NCD funding as a proportion of total NCD spend										
Domestic	0.0	47.3	35.6		0.5	25.4			57.9	
DAH	4.7	20.4	2.4		70.4	0.0			42.1	
OOP and other	94.6	32.1	62.0		30.0	74.6			0.0	

* This data predates the start of the April 2023 conflict

Table 1: Source of spend on NCDs across the ten countries with over 50% of those in need over the past five years

Priority actions for the purchase and provision of NCD care in humanitarian settings

32. Given that NCDs affect all populations, and that needs will grow in the coming year this section sets out priorities to facilitate the systematic integration of NCDs into humanitarian financing mechanisms.
33. **Inclusion of NCDs as part of national essential health service packages at primary, secondary and tertiary care level** is critical to build resilience of health systems, ensuring core components of NCD care are delivered at all times, including during and after a crisis. In FCV contexts these may be financed through pooled funding mechanisms that could support delivery through agreed benefit packages, the purchasing of services using strategic purchasing or through the provision of cash or vouchers. Where possible support should mirror national structures and systems to mitigate the risk of fragmentation.
34. **Systematic integration of NCDs into all responses to humanitarian crises:** Interventions to support those living with NCDs and associated mental health conditions in humanitarian settings are often not considered “lifesaving”, and are sometimes described as “development” in nature, and as such are not routinely considered for inclusion in HRPs and appeals. This is often further accompanied by the assumptions that NCDs are covered as part of primary health care despite an absence of evidence to support this. Focus on lifesaving ignores the suffering, morbidity, disability and loss of trust in services experienced by those living with NCDs who lose access to care for their condition. Funding in humanitarian crises is limited, with HRPs receiving less than 70% of that requested. Integration of NCDs into humanitarian responses therefore requires consideration of trade-offs particularly when comparing against lower cost high impact interventions. As noted, provision of access to NCD care not only saves lives, but also alleviates suffering and reduces the risk of complications leading to morbidity, disability and mortality. Therefore a failure to provide care for NCDs in FCV settings does not remove the need for those living with chronic diseases to access care, and instead results in reliance on OOPs to meet these needs.

35. **Develop and agree a fully costed minimum service package of NCD services according to the different phases of the emergency cycle** as has been done by the Inter-Agency Standing Committee for mental health and psychosocial support. (33) This would include the following:
- a. **Defined service components across the different level of care** – – this would enable prioritization of life preserving care in the immediate aftermath of a crisis including at community or primary health care level and for more specialized (secondary/tertiary level) services depending on the baseline residual capacity available to deliver them. Service components can be defined as “Initial” or “Conditional” to enable scaling up and down according to the phase of the emergency. The “High priority health services for humanitarian settings (H3)” provides a starting point for defining these core components. (34)
 - b. **Clinical algorithms and protocols to support delivery of care based on existing guidelines.** These should be linked to a minimum set of essential drugs and supplies (e.g. the NCD kits) and linked to information system to allow quality of care and performance to be tracked, with indicators that are appropriate to emergency settings.
 - c. **Kits of medications, laboratory and medical equipment required to deliver the service components and algorithms.** The WHO NCD kit may meet the needs at primary care level, but other kits may be required for other levels of care. These kits can be used in acute and protracted emergencies to rapidly increase primary care capacity for NCD service delivery. They have also been used to promote integration of NCDs into the essential package of health services (EPHS) over the long term, as part of health systems strengthening and resilience building. In 2019, the Afghanistan Red Crescent Society and WHO used the WHO NCD kit to deliver NCD care at primary care centres, as part of pilot initiative to integrate NCDs into the EPHS.
- Such a package can then be funded as part of the HRP, or through other sources of humanitarian funding depending on the context and the crisis. In the event that out of pocket payments remain a barrier to access of care, tools such as cash and vouchers may be of use as per recommendations set out in the humanitarian development peace nexus recommendations.
36. **Agree approaches to support delivery of highly specialized life-preserving care according to the baseline capacity to delivery these services, context and needs.** Ongoing crises in Sudan, Yemen and Gaza, have highlighted the need to find ways of considering high cost life-preserving interventions such as dialysis and cancer care, which by their nature also require maintenance of infrastructure. Services such as dialysis are often considered on a case-by-case basis which heightens the risk of a cessation of funding and leads to greater impoverishment and substandard care as families try to find ways of covering the costs through OOPs. Alternatives need to be found to help manage this including potentially use of cash and vouchers to help mitigate the risks.
37. **Plan and finance the procurement of a prioritized set of medicines and supplies,** noting that this will be the main cost driver in many contexts, for example, one month supply of cancer medicines for the entire population of Ukraine came to around US\$ 5 million. Procurement of lifesaving commodities such as insulin often falls to the humanitarian provider, leading to widespread inefficiencies and fragmentation, with higher costs and variations in medicine prescribing regimens. Cost minimization/work on best buys and bankable care models has helped to bring down costs but further work is needed to find ways of bringing costs down further, for example, pooling of resource or support for more centralized procurement. This includes procurement and deployment of tools such as the NCD kits which provides access to a preauthorized set of medicines, diagnostics and tools for a catchment population of 10 000 people for three months. It has been deployed to over 27 countries affected by humanitarian crises.

38. **Develop policies for integration of refugees into national health insurance schemes** in host countries ensuring provision of services for chronic diseases not just for short term or emergency care, thus helping avoid impoverishment through OOP expenditures. Such arrangements are often in place in HIC, such as EU countries receiving refugees from Ukraine, albeit with complexities resulting in refugees only being able to benefit from a selected set of health services compared to the host population due in part to funding shortfalls. In low-income countries where the proportion of refugees to the host population is high, such provisions can be more challenging.
39. **Identify transitional financing solutions to mitigate the risk of breakdown in services during transitions** whether acute to protracted emergency or from humanitarian to development sources of funding, with a focus on reducing fragmentation and duplication. Despite the push towards humanitarian development peace nexus transition, and the focus on pooling of resource to mitigate the risks from transition from short-term to long-term finance, transition from HRP driven finance to longer term ODA is often highlighted as a challenge, with partners concerned with the breakdown of programmes funded during the acute phase of an emergency. A recent case study in Yemen noted a contribution of US\$ 300 000 to help develop a dialysis centre, humanitarian support helped with running costs, but the future of this is uncertain with the transition to longer-term forms of finance. Further work is needed to explore how best to use the nexus to facilitate health system strengthening and integration of services for NCDs to ensure better sustainability. Building back better case studies and recommendations – as exist for mental health – should also be developed for NCDs. (35)
40. **Continue to advance work to support those with mental health conditions in humanitarian settings.** While the associated area of mental health and psychosocial support (MHPSS) has benefited from relatively more attention than NCDs in humanitarian settings, much work and funding is still needed in this area, such as improving the predictability, coverage and quality of responses, for example through increased funding and systematic inclusion of the costed MHPSS minimum service package in humanitarian response plans and refugee response plans, through localization of MHPSS responses, through integrating MHPSS fully in humanitarian programme cycle from preparedness to recovery, through ensuring inclusivity of MHPSS response to also include people with severe mental disorders in institutions and through supporting population groups that tend to be neglected in emergencies, such as older adults, people with physical and sensory disabilities, and people with substance use problems.

Summary

41. There is growing interest in the best ways of financing access to NCD care for those living with and at risk of NCDs in humanitarian settings. This includes exploring ways in which resource might be pooled or channelled during the acute and more protracted phases of an emergency including for displaced or refugee populations with a focus on building and strengthening health systems. Suggestions include development of guidance on the minimum set of services for those living with NCDs, as has been done for mental health, that must be included as part of benefit packages with further dialogue needed on the best ways of supporting those with high cost lifesaving health care needs. Finally further work is needed to implement the humanitarian development peace nexus principles, to ensure care for acute and life threatening complications of NCDs no longer falls through the gap due to misconceptions of their chronic nature.

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