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. 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. 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.

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.

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 requires an effective policy response, but often the state has limited capacity to do this. For example, Afghanistan has no national tobacco or alcohol control policies, and the donor partners have prioritized preventive or curative services for noncommunicable diseases.

With the exception of the European Commission, none of Afghanistan’s donor partners have prioritized preventive legislation and policies, and to provide comprehensive services to treat them. 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

3. Full reference list available at: http://www.who.int/bulletin/volumes/90/1/11-098863

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

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


