What Threats Do Non-Communicable Diseases Pose to IDP Populations, and How Can Policy Interventions Help?

Non-Communicable Diseases (NCDs) are a major global health threat, responsible for 41 million deaths every year. However, there is a scarcity of research on how NCDs particularly affect Internally Displaced Persons (IDPs), which this piece sought to address. This piece shows several ways that displacement-related experiences increase IDPs' vulnerability to a range of NCD issues, in comparison to non-displaced populations. In addition, this piece highlights the absence of adequate measures from international donors to address key NCD issues in IDP populations and offers recommendations to meet the health needs of IDPs.

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Non-Communicable Diseases (NCDs), i.e. non-transmissible diseases such as strokes, cancers, mental health disorders and heart disease, constitute a major health burden, responsible for 74% of global deaths. Nevertheless, an estimated 80% of deaths from NCDs are preventable, as NCDs mostly result from modifiable behaviours such as tobacco use, harmful alcohol consumption and physical inactivity. However, the impact of NCDs on Internally Displaced Persons (IDPs) is not well understood. IDPs are individuals and groups who are forced to flee their homes as a consequence of (or to avoid the effects of) conflict and violence, as well as other situations, such as disasters, where their lives are at risk. Unlike refugees, however, IDPs do not cross an internationally recognised border. Currently, there are roughly 71 million IDPs, with the majority (44.5 million) located in the Middle East, North Africa and sub-Saharan Africa regions. As shown by recent data,

internal displacement has largely resulted from conflict and violence, which has displaced 62.5 million, whereas disasters have displaced 8.7 million.

Existing scholarship points to a lack of research examining the extent to which IDPs are affected by NCDs. This poses further questions as to what key NCD issues face IDPs and how effective current policy responses have been to meet their health needs. The present short piece aims to improve understanding of, and responses to, this particularly overlooked issue in academic and donor circles. It also makes recommendations on policy interventions to ensure better responses and management of NCDs across IDP populations, in both conflict and non-conflict settings.

Mental health issues and substance abuse

There are several considerable NCD challenges facing IDPs. As a result of displacement, IDPs are of greater vulnerability to multiple traumatic events than non-displaced populations, which puts them at higher risk of two interrelated outcomes: mental health disorders and substance abuse. As demonstrated by studies in Sri Lanka, Kurdistan Region of Iraq, and Somalia, as the number of traumatic events faced by IDPs increased, so did the risks of developing depression and PTSD. These findings may provide one explanation as to why, in some settings (such as Ukraine), the prevalence and severity of certain mental health disorders is higher in IDP populations than in the general non-displaced population.

Consequently, greater exposure to multiple traumatic events can also increase vulnerability to substance use disorders, such as Alcohol Use Disorder (AUD), amongst IDP populations. In a recent study in Ukraine, IDPs' exposure to a greater number of traumatic events and resulting anxiety, especially amongst younger male IDPs, was associated with increased use of alcohol as a coping mechanism. The finding, that exposure to a higher number of traumatic events is associated with greater alcohol use, reflects similar findings from studies in Georgia and

Uganda, suggesting that displacement (and the numerous traumatic events that can come with it) increases IDPs' susceptibility to adopting harmful coping mechanisms.

The Ukraine study also reveals a further issue: that IDPs with AUD have been reluctant to seek treatment, owing to factors such as social stigma and limited availability of services. Furthermore, for IDPs who have not utilised existing services, they have been associated with further negative behaviours, such as social isolation and self-blame. What this shows is that AUD not only arises from poor mental health but can, by prompting individuals to adopt negative coping strategies, exacerbate the effects of diminished mental health.

It is also necessary to consider further ramifications that can potentially arise from alcohol abuse, particularly in the form of intimate partner violence. As shown by a study in northern Uganda, male IDPs' alcohol abuse is a key predictor of sexual and gender-based violence against their intimate partners. Moreover, a study in Colombia suggests that alcohol abuse is one factor behind increased intimate partner violence. A further study in Timor-Leste linked alcohol abuse to cases of rape and sexual assault in IDP camps, although the focus was not confined to intimate partners. As well as posing threats to women's sexual and reproductive health, sexual and gender-based violence also presents certain mental health risks. For example, as a study of refugees and IDPs in the Democratic Republic of Congo found, survivors of sexual and gender-based violence were consequently suffering PTSD, depression, and anxiety. Alcohol abuse, as a key instigator of sexual and gender-based violence, can contribute to further exacerbating the already diminished mental health of other IDPs. This strengthens the case for better management of AUD in IDP populations: it is not solely about protecting the health of users but ensuring the safety of those who may come to harm as a result of their alcohol abuse.

Overall, there is an urgent need for responses that take into account the complex relationship between AUD and mental health disorders: one way this can be done is for IDPs to be given improved access to mental health services whose treatments also screen for and treat their alcohol abuse. Particular attention is needed for IDPs who have been exposed to a relatively high frequency of traumatic events. At the same time, policymakers should acknowledge the role alcohol can play in relation to sexual and gender-based violence in IDP populations, particularly within domestic spheres. It is necessary, however, that services prioritise survivors of intimate partner violence: as shown by studies of IDP camps in Somalia and northern Uganda, sexual and gender-based violence has primarily been committed by intimate partners.

The relationship between trauma and physical health issues

The previous points made by this piece, that indicate trauma, poorer mental health and substance abuse as consequences of displacement, prompt a further question: how might such issues impact the physical health of IDPs? There are several ways in which experiences of displacement can put IDPs at higher risk of physical health issues, particularly in the form of cardiovascular diseases (CVD). For example, high levels of trauma have been associated with hypertension (high blood pressure). One consequence of hypertension is, by blocking arteries, that it can decrease blood flow and oxygen to the brain, which can cause stroke. Hypertension can also pose other physical health threats: it can narrow the blood vessels to the heart by causing a build-up of plaque (atherosclerosis), which can result in coronary heart disease. There is evidence that it can also result in vascular dementia and kidney damage.

Research on this issue in relation to IDP populations is limited but does offer some useful insights. A study in Georgia found a strong association between PTSD and hypertension in IDPs, as well as stroke and heart attack episodes. Moreover, this study showed that IDPs, compared to

the non-displaced general population, were experiencing hypertension and cardiovascular problems at higher rates. In a study of Croatian IDPs' sustained exposure to stress, compared to the unaffected control group, the IDPs showed increased rates of hypertension and higher risk of stroke. There are also studies of IDPs in Pakistan and Iraq that have identified hypertension in IDP populations, however, the authors did not examine the potential role of PTSD as a contributing factor. It could be said that the IDPs in these studies, based on findings from previous studies, may have been experiencing hypertension as a result of displacement-related trauma.

At the same time, displacement may worsen symptoms for IDPs with *pre-existing* hypertension. As another Ukraine study showed, certain consequences of displacement, such as trauma, psychological distress, and interruptions to medication and care, meant that IDPs were perceiving worsened symptoms of pre-existing hypertension (among other NCDs) at higher rates compared to non-displaced groups. Such factors suggest that displacement-related consequences may act as a tipping point, by raising blood pressure to the point that CVD develops. It must also be noted that alcohol consumption (especially heavy alcohol consumption) is linked with increased blood pressure, which puts IDPs with AUD at greater risk of developing CVD. Overall, these findings highlight the significance of displacement as an explanatory variable for poorer cardiovascular health in IDPs, compared to non-displaced populations. This is the case for two key reasons. Firstly, displacement brings greater exposure to multiple traumatic events and increases susceptibility of alcohol abuse amongst IDPs, which both raise the risk of hypertension and related CVD. Secondly, displacement disrupts access to necessary care and treatment, which can exacerbate pre-existing hypertension.

Another factor that affects the physical health of IDPs (and refugees) are overcrowded camp conditions, which can result in physical inactivity. Although studies are limited, one study in Nigeria found one-third of

IDPs in camps to be physically inactive, which increased with age. The implications of physical inactivity are that it heightens risk of a range of NCD issues, such as coronary heart disease, type II diabetes, and stroke. Furthermore, physical inactivity can worsen pre-existing mental health disorders of IDPs, highlighting the breadth of problems that can emanate from this issue. Considering IDPs who have hypertension, overcrowded camp conditions may pose considerable challenges, as limited space reduces their opportunities to engage in physical activities that can reduce their (already heightened) risk of CVD. As a recent World Bank study of four countries found, extreme overcrowding in IDP camps was an issue in three of these countries. Further research is needed to explore what physical health issues can arise as a result of overcrowding.

Current policy interventions from international donors: how effective are they?

So far, the issue of NCDs facing IDPs has largely been ignored in the literature and particularly by international donors. The first in-depth study of Official Development Assistance (ODA) on IDP health found 'negligible spending' on NCDs (0.44%). While there is spending on alcohol and drugs control, this only represents 0.40% of spending by international donors. The study even showed how areas, such as tobacco use control, have received no funding whatsoever. Considering existing evidence that highlights a link between displacement-related mental health disorders and negative coping mechanisms (such as substance abuse) use among IDP populations, it is imperative that, in order for ODA to be effective, donors reassess priorities and ensure IDPs can benefit from increased funding in areas such as alcohol, tobacco and other drugs control. Furthermore, as this blog has indicated, hypertension is an issue that must be managed effectively within IDP populations; however, given negligible spending in the area of 'prevention and treatment of NCDs', it appears that this issue has been overlooked by international donors.

Implications for policy

Based on the challenges outlined in this piece, several important implications for policy and practice in this field can be identified:

1. Donor agencies should support local health authorities to establish integrated mental health services that treat both mental health disorders and related substance abuse (such as AUD or harmful tobacco use). Donor agencies should complement this policy with increased ODA on alcohol, tobacco and other drugs control within IDP populations.

2. Local health authorities should provide targeted public health messaging to ensure that the most vulnerable IDPs in this respect are prioritised (such as those exposed to a greater number of traumatic events), as well as messaging that challenges pre-existing negative social attitudes surrounding mental health service use. Furthermore, to encourage prompt utilisation of mental health services by survivors of sexual and gender-based violence (particularly those who have faced violence from intimate partners), donor agencies should direct funding towards helping local health authorities offer appropriate treatments, such as cognitive processing therapy, that include confidential safety plans for women who fear, or have experienced, violence. This will allow women to access appropriate services with discretion.

3. Humanitarian agencies should play a part by restructuring IDP camps (to address overcrowding), run daily outdoor clubs to increase physical activities (with increased focus on older IDPs), and provide education that increases awareness of the health impacts of physical inactivity and substance abuse. For IDPs with stage 1 hypertension (140-159 mm Hg), they can benefit from frequent participation in physical activities. Through education, they can be better informed about how factors, such as physical inactivity and harmful alcohol consumption, can increase the risk of hypertension.

4. To ensure that hypertension can be managed and treated effectively, international donors should also support local authorities to establish clinics that screen for hypertension. These clinics should also work with camp authorities, to ensure that those screened for stage 1 hypertension can also manage their condition effectively, in line with recommendation. International donors, to ensure IDPs with constant readings of high blood pressure (160 and above mm Hg) can access appropriate treatments, should invest in antihypertensives (such as thiazide, Angiotensin Converting Enzyme (ACE) inhibitors, vasodilators and statins).

Nevertheless, a potential barrier to this recommendation is the cost of medications, as shown by studies in Ukraine and Iraq. One reason why these medications may be costly is that they are patented: to overcome this, states could utilise international intellectual property law provisions to acquire cheap generic drugs, through a process of compulsory licensing. This is where a government permits a third party to manufacture a patented product without the consent of the patent-holder, which allows cheap generics to be made. This could be conducive for increasing uptake of antihypertensive medicines in IDP populations where cost is an obstacle.

Conclusions

This piece has demonstrated three ways that displacement-related experiences make IDPs particularly susceptible to a range of NCD issues, in comparison to non-displaced populations. Firstly, IDPs, by being exposed to multiple traumatic episodes, are more likely to develop mental health disorders and are also vulnerable to alcohol abuse, as a means of coping with their trauma. Secondly, the effects of trauma on blood pressure (hypertension) can make IDPs vulnerable to developing cardiovascular disease and can potentially worsen pre-existing conditions. Thirdly, lacking space to exercise in camps can result in physical inactivity, which increases the risks of several NCDs, especially

among older IDPs. Furthermore, lacking investments from donors on key NCD issues shows the inadequacy of current international responses towards tackling these issues.

This piece contributes to the wider literature by highlighting the significant role of displacement as a key factor behind IDPs' development of certain NCDs, as well as its capacity to worsen pre-existing health conditions. To complement existing work, there are several areas which are in need of further research. In particular, further research is needed to examine the spending priorities and actions of international donors regarding ODA on IDP health. Further examination of how overcrowding, and camp structure in general, limits physical activities is also needed. Researchers exploring the links between alcohol abuse and sexual and gender-based violence should also expand the focus beyond IDP camps and look at host communities also. Moving forward, increased academic and international donor attention is central for better analysis and adequate responses to NCD threats facing IDPs.

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