

NCD Alliance Advocacy Briefing
179th Session of the World Health Assembly (WHA79)
18 May – 23 May 2026






This briefing note provides background and key advocacy messages on the priorities of the noncommunicable diseases (NCDs) community for the 79th session of the World Health Assembly (WHA79), covering NCD-relevant items on the [provisional annotated agenda](#). The brief is based on the information available at the time of preparation. Where access to specific resolutions or decisions was not possible, we have explicitly noted this.

The human toll of NCDs is unacceptable, inequitable, and increasing. NCDs lie at the heart of any discussion on health equity — equity cannot be achieved without addressing NCDs, and progress on preventing and mitigating their impact is inextricably linked to closing inequities and tackling the determinants of health. Only 19 countries and territories are on track to meet the United Nations (UN) Sustainable Development Goals (SDGs) target 3.4: to reduce premature NCD mortality by one-third by 2030.

WHA79 will take place following [the fourth UN High-Level Meeting of the General Assembly on the Prevention and Control of NCDs and the Promotion of Mental Health and Well-being \(HLM4\) in September 2025](#). The UN General Assembly's adoption of the Political Declaration on NCDs and Mental Health represents a significant milestone for the global NCD agenda, particularly with the introduction of new, action-oriented targets designed to accelerate progress on prevention, care, and investment. We now need champions across the system to continue driving implementation, upholding UN commitments, and sustaining the momentum needed to deliver real improvements for people living with NCDs and mental health conditions worldwide.

Throughout this briefing, recommendation documents are classified as:

 We applaud	The NCD community welcomes and aligns with the current text and associated action.
 We recommend	The NCD community sees an opportunity for the current text and associated action to be strengthened (including alterations and additions).
 We express concern	The NCD community is concerned with the current text and would recommend caution and alteration of the text and associated action.

Logistics: WHA79 will take place in person in Geneva, Switzerland, 18 May – 23 May 2026. A full list of documents, together with updated timetables for each day, can be found in the [WHA79 Journal](#).

Summary of WHA79 NCD-related agenda items covered in this briefing document
Provide health
12.1 Follow-up to the Political Declaration of the HLM4 Resolutions on bleeding disorders and Steatotic liver disease
12.2 Mental health
12.4 Universal Health Coverage (UHC) <ul style="list-style-type: none"> • Draft global strategy for integrated emergency, critical, and operative care, 2026 -2035 • 2026–2035 Increasing availability, ethical access, and oversight of transplantation of human cells, tissues, and organs • Rare diseases: a global health priority for equity and inclusionStroke resolution
12.5 Primary healthcare (PHC)
12.6 Health in the 2030 Agenda for Sustainable Development
12.7 Substandard and falsified medical products
12.8 Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel
Protect health
13.3 Open-ended Intergovernmental Working Group on the WHO Pandemic Agreement
14.1 WHO’s work in health emergencies

Promote health
15.1 Strengthening rehabilitation in health systems
15.2 Well-being and health promotion
15.4 Maternal, infant, and young child nutrition
15.5 Draft strategy on the economics of health for all
Power and performance
Removed from the agenda
20.1 Reform of the global health architecture and the UN80 Initiative

To engage further with NCD Alliance or for more information on our advocacy asks, please contact [Mina Pécot-Demiaux mpecot-demiaux@ncdalliance.org](mailto:mpecot-demiaux@ncdalliance.org)

NCD community calls to action ¹

Pillar 1: One billion more people benefiting from Universal Health Coverage

12.1. Follow-up to the Political Declaration of the high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases ([EB158/6](#), [A79/INF./6](#))

The adoption of the HLM4 Political Declaration marks the beginning of a critical implementation phase. It is now time to translate the commitments made into concrete national policies, financing, and measurable results. The report presents follow-up to the outcomes of the HLM4 on NCDs and associated actions, including responses to resolution WHA74.5 (2021) on oral health and updates on the implementation of resolution WHA71.6 (2018) on the [Global Action Plan on Physical Activity 2018–2030](#).

The report comes at a time of growing concern over the plateauing and, in some cases, reversal of progress in reducing NCD mortality and morbidity, as highlighted in the status report. In this regard, the upcoming 3rd financing dialogue on NCDs and mental health, to be hosted by the WHO and the Philippines in September, represents a critical first opportunity to translate the commitments of the Political Declaration into action. Particular attention will be paid to mobilising investment for NCDs, building country capacity for health financing, advancing fiscal measures, and improving access to medicines and medical devices.

¹ Agenda items are listed in the order of the provisional agenda of the 158th session of the WHO Executive Board (EB158)

On this note we want to flag the report from the Framework Convention on Tobacco Control Secretariat ([A79/INF./6](#)), which highlights last year's decision [FCTC/COP11\(12\)](#). It reaffirms that domestic resource mobilization remains the central strategy for securing long-term, sustainable, and predictable funding for national tobacco control programmes, and, by extension, broader NCD action. It also underscores the important contribution of tobacco price and tax measures, while encouraging the consideration of voluntarily scaling up international financial support for tobacco control and health. To accelerate progress towards global tobacco control targets, particularly for tobacco cessation, multisectoral approaches that engage the full health workforce, including dentists and dental teams, are crucial.



We welcome:

- The commitment by UN Member States to establish targets within the HLM4 Political Declaration as well as their recommitment to many of the principles and actions set forth at the three previous High-Level Meetings (HLMs) on NCDs. New commitments include three outcome targets by 2030: 150 million fewer tobacco users; 150 million more people with controlled hypertension; and 150 million more people with access to mental health care. We also applaud the five system-level targets that cover governance, financing, primary care strengthening, multisectoral action, and data and accountability.
- The partial recognition of a more inclusive NCD agenda beyond the 5x5 framework, further acknowledging NCDs characterised by high prevalence, morbidity, or mortality, and how they interlink and share common risk factors, especially for oral health, renal and hepatic conditions, sickle-cell, and rare diseases. This helps to integrate considerations for these conditions when addressing shared risk factors, and scale up access to their care as part of UHC and health system strengthening efforts.²
- The report's emphasis on the urgent need to scale up cost-effective Best-Buy interventions, to strengthen PHC delivery, and to renew political and financial commitment — in light of evidence that most countries remain off track to achieve SDG target 3.4, and that progress has slowed markedly over the past decade despite earlier gains in cardiovascular disease and cancer.
- The report's emphasis on the urgent need to strengthen PHC delivery and to renew political commitment and sustainable financing.
- The recent technical guidance developed by the WHO on environmentally friendly, less-invasive oral healthcare.
- Progress in implementing the Global Action Plan on Physical Activity 2018–2030, including the expansion of national guidelines to 96 countries, practical toolkits across healthcare and community settings, and regional action plans — while noting that 31% of adults remain physically inactive and the world is still off track to meet the 2030 target.

² The report covers the progress in implementing the action plan on oral health 2023–2030, with additional recommendations presented later in the document.

 **We express concern:**

- Over the significant industry influence reflected in the outcomes of negotiations of the HLM4 Political Declaration. We are particularly concerned by weakened commitments on commercial determinants of health, conflicts of interest management, health taxes, and other prevention measures, which no longer reflect best practices. We are also concerned that fossil fuels were not recognised as a primary driver of air pollution. Those missed opportunities hindered efforts to advance more ambitious and progressive commitments to address NCDs and their risk factors.
- That progress in reducing NCD mortality is slow, and that most countries remain off track to achieve SDGs target 3.4, which aims to reduce premature NCD mortality by one-third by 2030.
- That persistent inequalities and regional disparities remain. Although NCD mortality declined globally between 2010 and 2019 for more than 70% of the world's population, progress slowed compared to 2001–2010 in 60% of countries, and in some cases previous gains were reversed.
- That where people live continues to determine their risk of dying prematurely from an NCD. The probability of dying from an NCD before the age of 80 is below 20% in some high-income countries in East Asia and Western Europe, but exceeds 60–70% in several Pacific Island countries and in parts of sub-Saharan Africa.
- That only 24 Member States are on track for a 15% relative reduction in physical inactivity by 2030, with progress being slow and uneven across regions, and with widening gender disparities. Addressing this calls for stronger political will, coordinated multisectoral policies, and a bigger focus on addressing inequities.
- The absence of reporting on the implementation of WHO's Global Alcohol Action Plan 2022–2030 under this agenda item, with reporting instead limited to the mental health agenda item. Alcohol policy is a critical prevention strategy across a wide range of NCDs and relies on policy approaches similar to those used for other major NCD risk factors. Going forward, progress on implementation of the WHO Global Alcohol Action Plan 2022–2030 should also be systematically reported under the NCD agenda item.

 **We urge Member States to:**

- **Accelerate implementation:** Develop (or update) and implement comprehensive, funded national NCD plans that incorporate actions on mental health, neurological conditions, and air pollution, along with cost estimates to improve financial planning. Draw on the guidance from the NCD Best Buys and other recommended interventions, as well as the [WHO menu of cost-effective interventions for mental health](#), and [recommended interventions on air pollution](#), to identify priority actions for NCD prevention and control and ensure collaboration with relevant government sectors for implementing population-wide interventions.
- **Break down siloes:** Integrate NCD prevention and control, and the provision of mental health and psychosocial support, into broader health and development agendas, such as national food system transformation pathways and national health preparedness and response frameworks, by 2030 to support health promotion and health system strengthening efforts.

- **Mobilise investment:** Encourage stronger political and financial commitment towards national NCD responses as part of governments' efforts to achieve UHC and integrated health systems through the Lusaka Agenda's "one plan, one budget" objective and supported by increased data collection, transparency, and accountability for NCD financing and spending within national health accounts, integrated health systems and cross-government multisectoral action on NCDs, and development assistance.
- **Deliver accountability:** Support the mandate for WHO to update the Global NCD Monitoring Framework in collaboration with Member States, to ensure that the extended global NCD targets are strengthened with a comprehensive set of indicators and support the development of improved accountability processes and the involvement of civil society in these processes.
- **Engage communities:** Engage and support communities, civil society organisations, and people living with NCDs to lead and scale up the implementation of the NCD response, ensuring sufficient structural, technical, and financial support. Ensure multistakeholder engagement in NCD policymaking processes and forums is safeguarded from the undue influence of health-harming industries, such as those involved in fossil fuels, unhealthy foods, breastmilk substitutes, alcohol, and tobacco products.

We note the report on physical activity. We urge Member States to:

- Implement the [WHO Best Buys](#) and other recommended interventions for physical activity, and ensure access to physical activity opportunities for people living with NCDs.
- Recognise and optimise the co-benefits of NCD interventions that promote physical activity and support reducing other NCD risk factors, such as air pollution, through the promotion of walking and cycling, green spaces, etc.

We note the report on oral health. We applaud the upcoming launch of the WHO Global Coalition on Oral Health as a platform to advance oral health commitments in the Political Declaration of the HLM4 and uphold the Bangkok Declaration on oral health.

While noting WHO's guideline on environmentally friendly, minimally invasive caries care, **we urge Member States to:**

- Prioritise oral disease prevention as the most sustainable oral healthcare strategy.
- Strengthen national capacity and build technical expertise for mercury-free alternatives and non-invasive interventions.
- Ensure continuity of oral healthcare, as well as monitoring and evaluation for conditions where dental amalgam was the gold standard, as the WHO's guidelines are implemented.³

Resolution on Global action to advance health equity for people with haemophilia and other bleeding disorders.

³ The recommendations on oral health were developed in consultation with the World Dental Federation ([FDI](#)). For further information, please contact Tolulope Osigbesan (tosigbesan@fdiworlddental.org) or Wenqin Zhang (wzhang@fdiworlddental.org)



We welcome:

- A meaningful step toward addressing historically under-recognised conditions, which strengthens global surveillance, prevention, and treatment efforts in alignment with SDGs target 3.4.
- The explicit recognition of gender inequalities. Women and girls with bleeding disorders face disproportionate barriers to diagnosis and care and their inclusion in this resolution is long overdue.
- The recognition of World Haemophilia Day on 17 April as a dedicated moment for awareness-raising and solidarity.



We express concern that:

- Inherited bleeding disorders remain significantly underdiagnosed and misdiagnosed across many regions, particularly in low- and middle-income countries — with devastating consequences: far too many children die before ever receiving a diagnosis or accessing appropriate care.
- Only 34% of the expected number of people with haemophilia have been identified globally, and disparities are even greater for von Willebrand disease — estimated to affect 1 in 1,000 individuals — and other bleeding disorders, pointing to a vast and largely invisible treatment gap.
- Access to care remains deeply uneven. More than 70% of people living with bleeding disorders worldwide have inadequate or no access to treatment, with persistent disparities across regions, resource settings, sex, and disorder type.



We urge Member States to:

- Strengthen global surveillance and data collection on bleeding disorders.
- Improve early diagnosis through newborn screening and targeted public health programmes.
- Ensure access to comprehensive lifelong care and essential therapies.
- Support equitable resource allocation and health system strengthening.
- Align national efforts with WHO commitments to UHC and health equity.⁴

NCDA takes note of **Steatotic liver disease: a missing piece in the global NCD response**. Liver disease is an important NCD and has often been overlooked within the broader NCD response, despite the comorbidities and shared risk factors with other NCDs.

12.2. Mental health

The report provides an overview of progress in the execution of decision WHA74(14) (2021), the implementation of the comprehensive mental health action plan 2013–2030, and resolution WHA77.3 (2024) on strengthening mental health and psychosocial support before, during, and after armed

⁴ These recommendations were developed in consultation with Global Action Network for Sickle Cell and other inherited Blood Disorders ([Gansid](https://www.gansid.org)). For more information, please contact Lanre Tunji-Ajayi (lanre@inheritedblooddisorders.world) for any specific questions on this resolution and related topics.

conflicts, natural and human-caused disasters, and health and other emergencies. The report also covers progress in relation to brain health and substance use, including implementation of the global alcohol action plan 2022–2030 and the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 (decision WHA75(11) (2022)).

In 2021, 3.4 billion people were affected by a neurological condition (about [one-third](#) of the global population), 1.1 billion people were living with a mental disorder, 400 million with an alcohol use disorder, and 64 million with drug use disorders. While actions have been taken by the Secretariat and Member States to scale up the public health and societal responses to the growing burden of these conditions, including increased pursuit of rights-based approaches in mental health policies, new guidance on mental health policy, training courses, and the WHO's suicide prevention initiative, (among others) countries are still off track in meeting the global targets.

The report draws attention to the new Global Status Report on Neurology, which highlights the burden of these conditions. 80% of disability-adjusted life years (DALYs) from neurological conditions occur in low- and middle-income countries (LMICs), where there is often a lack of understanding of brain health, lack of policy prioritisation and lack of resource allocation. Moreover, workforce shortages and limited access to preventive measures, essential diagnostics and medicines, and rehabilitation leads to large treatment gaps in many countries, exceeding 75% in low-income countries (LICs). Neurological conditions also place an enormous economic burden on health systems. Systemic barriers to addressing the burden of neurological conditions include insufficient policy prioritisation, treatment gaps, and underdeveloped data systems. Increased focus is crucial to address the overall burden of NCDs, as cost-effective solutions exist and can be scaled.



We welcome:

- The HLM4 Political Declaration and its commitment to 150 million more people with access to mental healthcare, along with two other commitments and five system-level targets. The large number of Member States that contributed to the discussions at the HLM4 and provided an outline of their current and/or intended work on mental health, including in priority areas such as service reform and suicide prevention.
- The emphasis placed by WHO on the interlinkages between NCDs and mental health;
 - The WHO Special Initiative for Mental Health, which has advanced the integration of mental health services into UHC.
- The growth in numbers of countries that have incorporated mental health and psychosocial support into disaster risk management and preparedness (48% of countries had done so in 2025, up from 28% in 2019).
- The Secretariat's new initiatives for the meaningful involvement of people living with NCDs, particularly those with lived experience of mental health conditions.
- The new Global Status Report on Neurology, which highlights the burden of these conditions on individuals and health systems.
- The focus on providing support for training non-specialist health workers on the identification and management of mental, neurological, and substance use conditions, particularly in LMICs.
- WHO's ongoing support to Member States to implement the global alcohol action plan 2022–2030 and the SAFER technical package.

 **We express concern:**

- That levels of mental health problems among young people have risen since the COVID-19 pandemic, with suicide the third leading cause of death in young people aged 15 to 29 years in 2021.
- That countries remain off track to meet global targets on mental health, and that financial and human resources made available for mental health services have not increased since 2020.
- That neurological conditions were inadequately reflected in HLM4, with a lack of consideration and specific action outlined for neurological conditions to further emphasise the need for an integrated and cross-cutting NCD response.

 **We urge Member States:**

- To ensure 150 million more people have access to mental healthcare by 2030 along with the commitments to increase investment, especially in child and youth services, to increase efforts to prevent suicide (including by decriminalising suicide), and to reform mental health services away from institutions and towards community-based care.
- To fully integrate neurological conditions into plans for implementing the HLM4 Political Declaration, and when measuring progress towards the targets set out in the WHO's action plans on mental health and related conditions, considering the burden of these diseases and the impact that addressing them may have.
- To address the risks of digital technologies on mental health, as acknowledged in other EB148 documents (see [EB158/27](#)), including harmful digital marketing practices that particularly threaten the health and well-being of children and youth.
- To implement health taxes on substances linked with mental health conditions to raise funds for mental health programmes.⁵
- To implement the WHO SAFER technical package at the country level, along with other recommended interventions outlined in Appendix 3 of the Global NCD Action Plan (the NCD Best Buys and other recommended interventions). This includes providing consumers with clear information on the content of alcoholic beverages and the health harms associated with alcohol consumption, such as through labelling and health warnings. Public awareness of the links between even moderate alcohol consumption and NCDs remains unacceptably low and must be strengthened.⁶

12.4. Universal Health Coverage

UHC has the potential to significantly improve global health and reduce poverty. However, it can only be achieved if NCDs are addressed. The Political Declaration adopted following HLM4 recognises that

⁵ For instance, Somaliland has decided to tax Khat to fund its recent mental health services (more information [here](#)).

⁶ These recommendations were developed in consultation with United for Global Mental Health. For more information, please contact Sarah Kline (sarah@unitedgmh.org) or James Sale (james@unitedgmh.org)

achieving UHC is essential for the prevention and control of NCDs, with a strong focus on a PHC approach.

The 2023 UHC Political Declaration recognises that NCDs must be addressed as a central pillar of achieving UHC, underscoring the inextricable link between NCD prevention and control and UHC progress. This is further reinforced by the latest [2025 UHC Global Monitoring Report](#), which identifies NCDs as a key driver of stalled progress toward UHC targets. With the 2027 HLM on UHC approaching, this is a critical moment to ensure that NCD commitments are fully reflected in national UHC implementation and that momentum is built ahead of the next high-level review.

Yet, progress remains off track. As highlighted in the [2025 UHC Global Monitoring Report](#), NCDs continue to test health systems' capacity to provide effective, affordable, and continuous care for chronic conditions. While service coverage has expanded in some areas, particularly for communicable diseases, these gains are increasingly challenged by the rising burden of NCDs.

 **We express concern:**

- That progress on health financing – along with reductions in out-of-pocket spending and financial hardship – remains uneven, with disparities between high- and low-income countries.
- That even as global service coverage improved significantly from 2000 to 2015, progress slowed during the SDGs era (2015–2023) and 4.6 billion people worldwide still lacked access to essential health services in 2023.
- Infectious diseases drove 52% of global service coverage index (SCI) gains, while NCDs contributed only 27% and remain in the lowest-scoring SCI sub-index.
- That financial hardship and out-of-pocket expenses declined only modestly, 34% in 2000 to 26% in 2022. Still, 2.1 billion people faced financial hardship in health in 2022.
- At the current trajectory, the world will fall short of UHC by 2030: SCI is projected to reach only 74, and nearly 1 in 4 people will continue to face financial hardship at the SDGs endpoint.

 **We urge Member States:**

- To include comprehensive NCD services across the continuum of care in national health benefit packages, from prevention and health promotion to diagnosis, treatment, care, and palliative services, while integrating NCD services and other global health priorities.
- To prioritise PHC as a cornerstone of a sustainable people-centred, community-based and integrated health system and the foundation for achieving UHC.
- To invest in preventing and controlling NCDs by ensuring adequate and sustained resources for UHC, through establishing a national financing target, which can be supported by the revenues from the effective implementation of excise taxes on tobacco, sugar-sweetened beverages, and alcohol, which provide the additional benefits of reducing consumption of these harmful products, of fewer premature deaths, and lowering health service costs;
- To ensure meaningful engagement of people living with NCDs, affected communities and civil society to keep UHC people-centred.

- To integrate NCD and UHC workstreams as they need to work in tandem through HLMs, Health Works and other initiatives. NCDs will not be adequately addressed unless they are embedded in UHC processes, and UHC will not succeed unless NCDs are prioritised within it.

The 2027 UN High-Level Meeting on Universal Health Coverage offers an important opportunity to secure stronger commitments and to ensure that NCDs and mental health are at the centre of UHC and financing agendas.

Rare diseases: a global health priority for equity and inclusion

Over 300 million people worldwide are affected by rare diseases, many of which are NCDs, and face significant barriers to timely diagnosis, effective treatment, and equitable access to care. The report summarises the key outcomes from the discussion that took place during the 158th session of the Executive Board on the Director-General’s report [EB158/13](#), which outlined the key preparatory work undertaken by the Secretariat to develop a comprehensive 10-year draft global action plan on rare diseases for consideration by the Eighty-first World Health Assembly in 2028.



We welcome:

- The reflection of the importance of moving forward with the development and implementation of a global action plan on rare diseases, among other key rare disease priorities highlighted by Member States during EB158.



We urge the WHO Secretariat:

- To move forward with the development of the Global Action Plan for Rare Diseases (GAPRD) with a clear roadmap and inclusive consultation process, as well as the establishment of a workstream to promote UHC for PLWRD, both of which were requested in WHA 78.11.
- To work with the rare disease community,⁷ WHO Regional Offices, and Member States in different regions to support the implementation of the resolution and development of GAPRD.
- To publish the technical report on rare diseases in a timely manner, to further facilitate the implementation of Resolution WHA78.11.⁸

Resolution Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation, and health system readiness (R)



We welcome:

- The Resolution on Reducing the Burden of Stroke: Strengthening Prevention, Acute Care, Rehabilitation and Health-System Readiness, which responds to the opportunity to drive

⁷ The rare disease community is mobilising through regional engagement task forces, which have already convened in the Latin America and Asia-Pacific regions, with others to form in the coming months

⁸ These recommendations were developed in consultation with [RDI](#). Please contact Alanna Miller (alanna.miller@rarediseasesint.org) for any specific questions on this item.

achievement of global health and development goals through effective stroke care across the full patient journey.

- Member States' commitment to a coordinated and strategic global response to the specific challenges of providing comprehensive, integrated, and equitable stroke care. This Resolution will support ongoing efforts of Member States to address the global burden of NCDs, as set out in the Political Declaration of the HLM4, and will build on the inclusion of evidence-based stroke treatments in Appendix 3 of the extended WHO Global NCD Action Plan 2013–2030.

 **We express concerns:**

- About the persistent gap in global and national policy responses and health system planning to meet the specific gaps and opportunities in relation to acute stroke treatment and rehabilitation. Stroke is a leading cause of NCD-related death and disability, responsible for 7 million deaths and 145 million disability-adjusted life years (DALYs) each year. Without prioritisation and coordinated action, the global stroke burden is projected to rise by one-third by 2050, at an estimated economic cost of US\$1.6 trillion. Almost all of this burden will be borne by people living in low-middle income countries, where healthcare systems face significant challenges in providing basic stroke care.
- Over 80% of strokes are linked to manageable risk factors, and despite significant advances and opportunities for effective prevention, have not been fully realised — particularly in LMICs. Access to cost-effective, evidence-based acute stroke treatment within organised systems of care, which can transform outcomes for patients, remains insufficient and inequitable, while provision of stroke rehabilitation and psychosocial support continues to undermine the recovery and mental health of 94 million stroke survivors and their families.

 **We urge Member States:**

- To adopt this Resolution, with a commitment to bringing forward national stroke action plans, developed with meaningful engagement of people with lived experience, strengthened by robust surveillance, data, and accountability mechanisms.⁹

We also recognise the importance of the draft global strategy for integrated emergency, critical, and operative care, and the 2026–2035 draft global strategy on increasing availability, ethical access, and oversight of transplantation of human cells, tissues, and organs. We urge Member States and the Secretariat to integrate NCDs to ensure a comprehensive and equitable response to emergency care. We also recognise the importance of the global strategy on transplantation for addressing patients' needs for lifesaving or life-enhancing transplantation and urge Member States and the Secretariat to continue to engage in the next steps of the strategy's development.

We also note the resolutions on Precision medicine: a path toward personalised and equitable care, on Strengthening equitable access to diagnostic imaging through teleradiology, and on Advancing

⁹ These recommendations have been developed in collaboration with the World Stroke Organisation (WSO). For further details, please contact Anita Wiseman (awiseman@world-stroke.org) or Mia Grupper (mgrupper@world-stroke.org)

Smart Pharmacovigilance as an essential tool for robust, sustainable, resilient, and responsive health systems, for everyone, everywhere.¹⁰

12.5. Primary healthcare (PHC)

The report, submitted in response to resolution WHA72.2 (2019) and decision WHA77(16) (2024), provides an overview of global progress towards UHC by 2030 with a focus on strengthening PHC as the foundation of resilient, equitable, and people-centred health systems. It reaffirms the central role of PHC in achieving UHC, in line with the Declaration of Astana, and highlights several important areas for action, including WHO support through the UHC Partnership, the work of the Global Coalition on PHC, efforts to strengthen PHC financing, and initiatives to improve integration and alignment with global health initiatives. Importantly, the report also helps frame priorities in the lead-up to the third UN HLM on UHC in 2027, making this a timely opportunity to strengthen political attention to PHC as a central delivery platform for UHC.

This agenda item is especially important because PHC is also recognised as a cornerstone of the HLM4 Political Declaration on NCDs and mental health, including through its commitment to integrate essential NCD medicines into PHC. PHC can deliver many essential health interventions required for UHC and is therefore a central platform for NCD prevention, early detection, diagnosis, treatment, long-term care, and palliative care. As NCDs are the leading cause of death globally and account for a large share of health needs across the life course, strengthening their place within PHC is essential both for implementation of the HLM4 Political Declaration and for achieving UHC. The road to the 2027 UHC HLM should therefore be used to elevate PHC further and secure stronger commitments to ensure that NCD prevention and care are central within PHC systems.



We welcome:

- The fact that primary health care is being discussed as a stand-alone agenda item, with clear recognition of PHC as the foundation of UHC and of resilient, equitable, and people-centred health systems.
- The report's practical focus on implementation, including WHO support to countries through the UHC Partnership and the Global Coalition on PHC, as well as related initiatives on service delivery and quality, governance and social accountability, workforce capacity, financing reform, and the integration of essential public health functions within primary care.
- The report's emphasis on integration, including efforts to align disease-specific programmes and broader health system priorities more closely with PHC.
- The attention given to the relationship between PHC and global health initiatives (GHIs), including work to reorient funding and service delivery through the PHC-GHI Toolbox, which is particularly relevant in the context of current discussions on the future of the global health architecture and in the lead-up to the 2027 UN HLM on UHC.

¹⁰ These recommendations were developed by the World Stroke Organisation (WSO).

 **We express concern:**

- That NCDs are not strategically reflected within the report’s vision for PHC, despite being the leading cause of death globally and a major share of health needs across the life course, while other areas are addressed more explicitly.
- That while the report emphasises PHC integration and alignment with global health initiatives, it does not clearly state that PHC-oriented reform should be guided by current disease burdens.
- That although the report refers to governance, social accountability, and empowered communities, it does not give sufficient attention to the meaningful engagement of people with lived experience in PHC design, delivery, and evaluation.

 **We urge Member States:**

- To ensure that NCD prevention, diagnosis, treatment, long-term care ,and palliative care are central to PHC reform, including through national PHC strategies, benefit packages, service delivery platforms, and effective referral systems linking primary care with higher levels of care.
- To implement the target set in the HLM4 Political Declaration on NCDs and mental health, so that by 2030 at least 80% of PHC facilities in all countries have affordable availability of WHO-recommended essential medicines and basic technologies for NCDs and mental health conditions.
- To ensure that PHC-oriented reform and alignment with global health initiatives are guided by current disease burdens, including NCDs, so that financing and service delivery better reflect today’s epidemiological reality.
- To strengthen community engagement and social accountability in PHC by meaningfully involving people with lived experience, including people living with NCDs, in the design, implementation, and evaluation of services.
- To adopt an “early is better” approach by strengthening PHC capacity for NCD prevention, screening, and early intervention, including through routine screening, community outreach, strong referral systems, and monitoring of coverage and effective control to strengthen accountability.
- To make PHC systems more people-centred, equitable, and financially protective, including by reducing financial barriers and out-of-pocket costs for essential NCD services.

12.6. Health in the 2030 Agenda for Sustainable Development

The report provides an overview of health-related SDGs progress to date, and describes the progress made in strengthening data and health information systems, including by harnessing frontier technologies, such as artificial intelligence (AI), to address persistent gaps in timely and disaggregated data.



We welcome:

- The report, and particularly applaud Member States for being globally on track to reduce per capita alcohol consumption by 20% by 2030, while recognising that further progress is needed across all regions. We also commend:
- The progress made in SDG indicator data coverage, with 70% of indicators now having good coverage in 2025, compared to only one-third in 2016.
- The revision of UHC indicators in 2025, aligned with the principle of leaving no one behind.



We express concern:

- That despite gains since 2015, the world remains significantly off track to achieve the health-related SDGs by 2030. As highlighted in the report, stagnation, and in some cases reversals, in maternal and child health or UHC, with 4.5 billion people still lacking access to essential services and financial protection weakening, underscoring urgent need for stronger, more timely, and more reliable health data systems to better guide global and national agendas.
- About the lack of action on NCDs, resulting in slow progress in achieving the SDGs target of a one-third reduction in premature NCD mortality by 2030 and the persistent gaps in strong, reliable, and timely data on NCDs, which continue to hinder accurate monitoring of trends and assessment of progress against NCD targets.
- On the reduction in official development assistance, leading to disruption of population surveys that collect disaggregated data.



We urge Member States to:

- **Accelerate action on NCD risk factors:** To achieve SDGs target 3.4, Member States must invest in prevention and address the major risk factors for NCDs, including unhealthy diets, tobacco and alcohol use, physical inactivity, and air pollution, many of which are addressed under other interconnected SDG 3 targets (3.5, 3.9, and 3.a). A comprehensive, multisectoral approach is also needed to reduce exposure to the NCD risk factors, given their social and commercial determinants, which extend beyond the remit of the health sector alone.
- **Advance on strong, accessible, and resilient health systems:** Strategic investments are urgently needed to strengthen system capacity for prevention, early diagnosis, treatment, rehabilitation, and palliative care for NCDs. These investments must be integrated and inclusive, contributing to broader system strengthening that benefits all health conditions and supports UHC.
- **Strengthen health information systems and accountability:** Improved health information systems are vital for evidence-based policymaking, prioritization within UHC frameworks, and greater transparency and accountability. Countries must invest in systems that enable real-time data use, disaggregated monitoring, and effective stakeholder engagement to accelerate SDGs implementation.

12.7 Substandard and falsified medical products

Substandard and falsified medical products remain a global public health challenge, accounting for over one million deaths each year. It is estimated that approximately one in ten medicines in LMICs are substandard or falsified, contributing to increased disease prevalence, adverse health outcomes, antimicrobial resistance, and economic losses.

The WHO Member State Mechanism on Substandard and Falsified Medical Products was established through Resolution WHA65.19 to improve coordination between Member States and the WHO in addressing challenges related to substandard and falsified medical products. It operates as an intergovernmental forum that:

- Convenes Member States;
- Facilitates knowledge exchange;
- Issues policy recommendations;
- Supports collaborative efforts; and
- Coordinates actions against substandard and falsified medical products.



We welcome:

- The report of the Fourteenth Meeting of the Member State Mechanism on Substandard and Falsified Medical Products and applaud Member States for the progress made on the list of prioritised activities 2024-2025. In particular, we applaud the production of new materials (e.g., Handbook on Developing a National Action Plan against Substandard and Falsified Medical Products, etc.) and recommendations issued by Working Groups.
- The responses to the recommendations issued in the latest report on the Independent Evaluation of the Member State Mechanism. We support Member States' recommendation to pursue Option 1B (i.e., to maintain the Member State Mechanism plenary and Steering Committee with streamlined Working Groups).
- The Strategic Plan's proposed goals and actions to strengthen Member State engagement, technical capacity, and access to safe, effective, affordable, and high-quality medical products.



We express concern:

- That the financial sustainability of the Member State Mechanism remains a challenge. We would also encourage Member States to further engage with and leverage civil society stakeholders, with regard to Activities B and D, to facilitate cooperation and strengthen multisectoral action.



We urge Member States:

To endorse the draft list of prioritised activities to implement the work plan of the Member State mechanism for the period 2026-2027, namely:

- Detection technologies, risk communication, and regulatory strengthening for the prevention, detection, and response to substandard and falsified medical products;

- Develop strategies to address unregulated distribution channels for substandard and falsified medical products through informal markets, including internet sales; and
- Strengthen the supply chain of high-risk excipients and related raw materials.

Finally, we call on Member States to remain vigilant with respect to emerging issues related to substandard and falsified medical products. We believe that the WHO Global Surveillance and Monitoring System will continue to play an essential role in early detection, reporting, and coordinated response.¹¹

12.8 Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel¹²

The world is facing a [health workforce shortage](#), with significant disparities between countries and within them: the latest WHO estimates project a health workforce shortage of 11.1 million by 2030. These shortages increase disparities in access to care for NCDs and exacerbate health inequities, leading to inadequate preventive care, delayed diagnosis and treatment, poor management of chronic conditions, reduced quality of care, and increased costs of managing NCDs. NCD care must begin at primary level with awareness, prevention, and early detection, but PHC workers are often not equipped with the necessary competencies. Aligning workforce policies with disease burden data, leveraging the WHO Academy and regional training centres, and integrating community health workers into national health strategies while ensuring that they are adequately trained, supported, provided with supervision and compensated are some effective and equitable strategies to optimise the existing health workforce to address the burden of NCDs.

Additionally, the WHO Global Health and Care Worker Compact — Technical Guidance Compilation emphasises the urgent need for decent and safe working conditions for health workers, to retain and motivate the workforce. It also underscores the importance of educating and training an adequate number of health professionals, aligned with national needs and resources, to address current and future health challenges.

The Report of the Expert Advisory Group (EAG) provides insight into a key global dynamic affecting the implementation of sustainable workforce policies: the international recruitment of health personnel. The Report provides a useful overview of the effectiveness and relevance of the WHO Global Code of Practice on the International Recruitment of Health Personnel and provides recommendations for consideration by the Executive Board. The EAG highlights the growing relevance of the Code in the face of increasing health emergencies and the interdependence of health systems. The EAG notes that Member State engagement with the Code is also growing to reflect these challenges.

¹¹ These recommendations were developed by the World Heart Federation (WHF).

¹² The recommendations on the Code of Practice were developed in consultation with the World Health Professionals Alliance.



We welcome:

- The EAG’s note that the Code’s effectiveness has progressed, via improved data on the global health workforce, reporting on bilateral agreements, increased awareness of the Code among stakeholders, and the adoption of some of the Code’s provisions in national and international policies.



We express concern:

- That the Code’s implementation still needs to be strengthened. There are continuing challenges related to the international recruitment of health personnel which may exacerbate inequalities, for example due to the savings that high-income countries can make on the costs of education of health professionals by encouraging international recruitment and which places LMICs at a disadvantage. Small Island Developing States (SIDS) face particular structural challenges.ⁱ
- That the lack of decent and safe working conditions for health workers, as outlined in the WHO Global Health and Care Worker Compact, continues to undermine workforce retention and motivation, particularly in under-resourced settings.
- That despite international commitments, efforts to address workforce shortages, inequities, and migration challenges remain fragmented, with limited accountability mechanisms in place to track progress. The growing burden of NCDs continues to strain health systems, yet investments in health worker training and resources for NCD prevention, treatment, and management remain inadequate, particularly in PHC settings.
- That many countries still fail to educate and train an adequate number of health professionals aligned with national needs and resources, leading to persistent gaps in service delivery.



We urge Member States:

- To consider the suggestions for improvements and additions to be made for strengthening the Code.
- To prioritise the implementation of the WHO Global Health and Care Worker Compact by ensuring decent and safe working conditions for all health workers, including fair compensation, occupational safety, and mental health support.
- To address the root causes of health workforce shortages, including investing in the education and training of health professionals in line with national needs and resources, as emphasised in the Compact.
To strengthen accountability mechanisms to monitor progress on workforce equity and address migration challenges.

Pillar 2: One billion more people better protected from health emergencies

13.3 Open-ended Intergovernmental Working Group on the WHO Pandemic Agreement

In May 2025, after more than three years of negotiations, countries secured a draft global agreement aimed at strengthening pandemic prevention, preparedness, and response (PPPR). While the

Pandemic Agreement achieved consensus on a wide range of PPPR issues across 37 articles, details of a Pathogen Access and Benefit Sharing (PABS) system were delayed to an annex to be defined in a separate Intergovernmental Working Group (IGWG). However, the IGWG on PABS ended its sixth session in April 2026 without finding a shared position on the core elements of the PABS system.



We welcome:

- The efforts of Member States and the INB Bureau to work towards consensus on PABS through multiple IGWG sessions and draft texts.
- The commitment in the Pandemic Agreement to develop, protect, and invest in a skilled, multidisciplinary healthcare workforce, with clear references to decent working conditions, mental health and wellbeing, gender equality, and the elimination of discrimination in the workplace. A skilled, supported, and resilient workforce is essential for ensuring uninterrupted care during crises, especially for people living with chronic conditions.
- The commitment in the Pandemic Agreement to UHC, whole-of-government and whole-of-society approaches, and the inclusive definition of “persons in vulnerable situations”, including “those with a disproportionate increased risk of infection, morbidity, or mortality, as well as those likely to bear a disproportionate burden owing to social determinants of health in the context of a public health emergency of international concern”.



We express concern:

- That Member States were unable to reach consensus on the core elements of the PABS system after multiple rounds of negotiations, and that the Pandemic Agreement will not be open for ratification until consensus is reached on PABS.



We urge Member States:

- To continue negotiations on the PABS annex to advance ratification and implementation of the Pandemic Agreement.
- To ensure that PPPR strategies, including the adoption and implementation of the Pandemic Agreement and the amended International Health Regulations (IHRs), are supported by commitments and investments that enable the continuity of essential health services, recognising that people living with NCDs face disproportionate risk during health emergencies.
- To actively participate in the 2026 High-Level Meeting on Pandemic Prevention, Preparedness and Response and its Political Declaration negotiations, recognising that the Pandemic Agreement does not stand alone but forms one pillar of a wider architecture that includes the revised IHRs and existing access and benefit-sharing agreements such as the Nagoya Protocol and the Convention on Biological Diversity.

14.1 WHO’s work in health emergencies [\(A79/9\)](#)

People living with NCDs face greater challenges when living in a humanitarian setting. Health systems and services that were previously provided within a country may be completely destroyed or seriously

undermined, including due to the disruption in the delivery of healthcare and supplies of medicines and products, affecting continuity of care across prevention, diagnosis, treatment, rehabilitation, and palliative care. The HLM4 Political Declaration recognises this disproportionate NCD burden in humanitarian settings and commits governments to ensuring access, continuity, and integration of NCD and mental health care into humanitarian response across the full humanitarian-development continuum and within PHC systems — a critical step toward leaving no one behind, with implications for the delivery of essential health services before, during, and after emergencies.

The report provides an overview of global trends and challenges related to health emergencies in 2025, as well as the WHO's response to major acute and protracted health emergencies during the reporting period, including outbreaks, natural disasters, and conflict-related crises. It outlines key global trends, operational challenges, and funding constraints affecting emergency preparedness and response.



We welcome:

- The recognition of the impact of climate change on global health, and specifically in humanitarian settings, as a driver exacerbating NCD risks, disrupting continuity of care, and increasing pressure on fragile health systems.
- The fact that WHO has provided medical supplies valued at US\$ 38.78 million, including US\$ 4.3 million for cross-border deliveries from Chad, to support 18,800 emergency surgeries and primary healthcare and NCD services for 5.1 million people. Through its coordination of 50 partners across 1,244 health facilities, WHO has reached 3.4 million of the 8.9 million people targeted for humanitarian health assistance.



We express concern:

- That the report misses the opportunity to reference the need to integrate NCD care into health strategies and emergency planning frameworks, including within PHC, mental health, rehabilitation services, health information systems, and specialised care across preparedness, response, and recovery phases.
- Regarding donors' cuts in emergency response, which have affected 5,687 health facilities across 20 humanitarian settings, left over 2.2 million women without access to critical health services in Sudan and Afghanistan, and have deprived almost 750,000 people of mental health services across 32 countries, further constraining sustainable and flexible financing required to ensure continuity of NCD care in both acute and protracted crises.



We urge Member States:

- To recognize NCDs as a core component of health security, universal health coverage and emergency preparedness agendas, ensuring that people living with NCDs are identified as a vulnerable population in humanitarian and fragile settings.
- To integrate essential NCD services through PHC before, during, and after the emergency cycle, to deliver a coordinated emergency response, and to protect supply chains to maintain

access to essential NCD services, medicines, and supplies, ensuring continuity of care through resilient, community-linked PHC systems.

- To strengthen primary care models that are people-centred, affordable, and provide a continuum of care from diagnosis to rehabilitation and palliative care, integrating mental health and psychosocial support and enabling delivery through community-based approaches.
- To recognise people living with NCDs as a vulnerable group in national and emergency health planning, particularly in fragile, conflict-affected, and climate-vulnerable settings where disruptions to care are prolonged.
- To expand workforce capacity by training health workers to prevent, diagnose, and treat NCDs in humanitarian settings to improve care delivery, including community health workers and volunteers supporting prevention, early detection, referral, follow-up, and self-care.
- To reduce exposure to NCD risk factors in humanitarian settings by promoting access to healthy diets, clean fuels, and physical activity opportunities, and regulating the promotion and distribution of unhealthy products, through multisectoral and community-level interventions adapted to crisis contexts.
- To establish sustainable financing mechanisms to integrate NCD prevention and treatment into development assistance and humanitarian health programmes, ensuring innovative, flexible, sustainable financing that bridges humanitarian and development approaches and supports continuity of care.¹³

Pillar 3: One billion more people enjoying better health and well-being

14.2. Strengthening rehabilitation in health systems

People living with NCDs often have multiple interactions with the health system over long periods and may require disability management, such as rehabilitation, and long-term care. As stated in the Seventy-sixth World Health Assembly's report on Strengthening rehabilitation in health, "the need for rehabilitation is increasing due to the epidemiological shift from communicable to noncommunicable diseases". The report responds to the request in [WHA76.6](#) (2023) to develop feasible global health system rehabilitation targets and indicators for effective coverage of rehabilitation services for 2030.



We welcome:

- The development of global health system rehabilitation targets and indicators for effective coverage of rehabilitation services for 2030, as requested by the Seventy-sixth World Health Assembly, in resolution [WHA76.6](#) (2023).
- The integration of rehabilitation into UHC packages as an input indicator.
- The integration of rehabilitation into PHC as an output indicator.
- The recognition that people with musculoskeletal, neurological, respiratory, cardiovascular, mental, and other health conditions can all potentially benefit from rehabilitation services.

¹³ These recommendations have been developed with the International Federation of Red Cross and Red Crescent Societies (IFRC) and The International Alliance for Diabetes Action (IADA)

 **We express concern:**

- That NCDs are not mentioned more explicitly in the report given their large burden and the increased likelihood that people living with NCDs will need rehabilitation services and long-term care.

 **We urge Member States:**

- To fully recognise and address the needs and rights of people living with NCDs to access quality, affordable, and timely rehabilitation services across all levels of care. This can only be achieved through the collection of sufficient and disaggregated data to assess needs, monitor access, and guide effective planning and investment.

 **We urge the WHO's Secretariat:**

- To consider how the global rehabilitation indicators and future target-setting could be better aligned with existing NCD monitoring frameworks, including through clearer links to NCD-related conditions.

15.2. Well-being and health promotion

The two Director-General's reports under this agenda item address the implementation of the WHO's global framework for integrating well-being into public health and the findings of the WHO Commission on Social Connection.

 **We welcome:**

- The updates and commend WHO's efforts to advance the development of well-being measurement frameworks and indicators, in coordination with other UN processes. These efforts are critical to defining and implementing measures of social and economic development beyond gross domestic product (GDP) that reflect human, planetary, and social well-being. While SDG 3 explicitly refers to health and well-being, it currently lacks targets and indicators that directly measure well-being.
- The Commission's landmark report on social connection and its call to recognise social well-being as a core function of public health, including through highlighting its economic costs and the broader rationale for action. Social disconnection is associated with increased risks of premature mortality, cardiovascular disease, and other NCDs, including mental health conditions, as well as with major NCD risk factors such as alcohol use and physical inactivity, with these factors influencing one another in complex and reinforcing ways.

 **We express concern:**

- About the growing number of crises and natural disasters, and the insufficient integration of health promotion measures into emergency preparedness, response, and recovery.



We urge Member States:

- **To recognise health promotion as a core element across the entire continuum of care**, not only at the prevention stage. This includes implementing population-wide preventive measures (such as NCD Best Buys and other recommended interventions), facilitating access to health promotion measures and services for people at risk of or living with NCDs, and integrating health promotion into broader public health planning, including emergency preparedness, response, and recovery.
- **To measure and leverage the co-benefits of health promotion for other sectors**, to strengthen the multisectoral actions required to achieve health and social well-being.
- **To address the dual impact of digital technologies**, as highlighted in the Director-General's report, by harnessing opportunities to promote health and well-being while also mitigating risks, including harmful digital marketing practices that undermine physical and mental health, particularly among children and youth.
- **To advance a well-being economy**, in which the economic value of human and planetary health and equity is recognised, and in which the production and consumption of harmful products (including fossil fuels) are appropriately disincentivised.
- **To promote coherence across WHO strategies**, including by aligning these agendas with the WHO's draft strategy on the economics of health for all, and by ensuring that efforts to strengthen social connection are coordinated with actions addressing major NCD risk factors such as tobacco and alcohol use and physical inactivity, in order to better understand their interconnections and optimise the co-benefits of action.

Resolution: Radiation and health: strengthening global protection, preparedness, and response

15.4. Maternal, infant and young child nutrition

This report will assess progress towards the comprehensive implementation plan on maternal, infant, and young child nutrition (extended to 2030), with six revised global targets. These include childhood overweight (to reduce and maintain overweight in children under 5 to <5%) and exclusive breastfeeding (to increase to $\geq 60\%$ exclusive breastfeeding in the first 6 months). The remaining targets focus on undernutrition (anaemia in women of reproductive age, low birth weight, wasting, and stunting). It is important to highlight that exposure to undernutrition in early life (including pregnancy) has also been linked to a greater risk of NCDs later in life. For instance, [malnutrition-related diabetes mellitus](#) is a distinct form of diabetes linked to chronic undernutrition and recognised as the fifth classification of diabetes.

The Director-General's report ([EB158/30](#) & A79/5) warns that all targets are off track. Current projections estimate a 5.4% prevalence of childhood overweight by 2030¹⁴, and 53.6% exclusive breastfeeding in the first six months. The report outlines a series of WHO activities and resources

¹⁴ This would represent a slight increase compared to the 2012 baseline (5.3%), but a reduction (and not just halting the rise) of child overweight is important given childhood overweight and obesity increases the likelihood of worsening adult overweight and obesity, poor oral health and the development of other NCDs later in life.

aimed at integrating nutrition objectives across food systems and policies that influence dietary quality, which are critical for addressing childhood overweight and broader forms of malnutrition.



We welcome:

- The update and commend Member States championing the WHO Acceleration Plan to Stop Obesity and those that, in recent years, have adopted legislation aligned with the International Code of Marketing of Breast-milk Substitutes to protect mothers and children from misleading promotion of infant formula and to promote health.



We express concern:

- **That only 33 Member States have legal measures substantially aligned with the Code**, and that significant progress to protect, promote, and support optimal breastfeeding practices will not be achieved by 2030 unless Member States further strengthen and enforce their legislation and measures.
- **That in 2023, 35.9% of children aged 6–23 months consumed sweet beverages on the previous day**, contributing to the childhood overweight epidemic. Without substantial action on sugar-sweetened beverages (SSBs) and other unhealthy foods, this trend will persist.



We urge Member States:

- **To integrate these targets into existing national nutrition, health, and NCD strategies**, ensuring alignment across plans, and to implement national monitoring frameworks to track progress.
- **To ensure sufficient alignment and coherence among government sectors involved in these policies** and globally integrate health and nutrition considerations into food system and broader development policy processes, including through tools such as NCDA's [From Policy to Plate](#) guide.
- **To deliver on the financial and policy commitments made** at the 2025 Nutrition for Growth Summit to help achieve these targets.
- **To accelerate implementation of evidence-based nutrition policies at national level**, including taxation of SSBs, marketing restrictions on unhealthy foods to protect children (including across digital environments), and other healthy-diet NCD Best Buys and recommended interventions.
- **To consider the [WHO's guideline on fiscal policies to promote healthy diets](#)**, aimed at supporting countries to use taxes and other fiscal measures to reduce consumption of unhealthy foods and create healthier food environments.
- **To promote breastfeeding as a powerful and cost-effective double-duty policy action**, protecting women against breast cancer and children against overweight and obesity, and consequently reducing future NCD risk.
- **To strengthen or develop national legislation to protect, promote, and support breastfeeding** in line with the Code and WHO guidance on regulatory measures to restrict

digital marketing of breast-milk substitutes, and establish monitoring mechanisms to ensure effective implementation.

- **To engage in the development of a new Codex standard for complementary foods** to ensure public health perspectives are integrated, supporting healthier complementary feeding environments and reducing young children’s exposure to poorly formulated processed foods that contribute to childhood overweight and poor health outcomes.
- **To safeguard nutrition policymaking, public procurement, and partnerships** against conflicts of interest.

15.5. Economics of health for all (A79/5 Add.1)

The World Health Assembly is asked to consider an updated WHO draft strategy on the economics of health for all (EHfA).

The draft strategy builds on the work of the WHO Council on the Economics of Health for All, whose report rightly positioned health as a foundational investment for economic growth and social development. The Council’s report highlighted that NCDs are projected to cost the global economy US\$47 trillion between 2010 and 2030. Despite this staggering figure and the availability of proven, cost-effective solutions for the prevention and control of NCDs, health spending is still too often viewed as a cost rather than an investment and, therefore, frequently deprioritised across government sectors. Since 2015, the UN Development Programme (UNDP), UN Inter-Agency Task Force on NCDs (UNIATF), the WHO, and partners have developed national investment cases across more than 60 countries which demonstrate that prevention is consistently cheaper than the status quo. The burden of inaction costs countries 4.4% of GDP on average for NCDs alone — in most countries, the total 15-year cost of prevention measures is lower than the annual economic burden of NCDs.

The draft strategy proposes five strategic directions: economic policy for EHfA; value and invest in EHfA; financing for EHfA; capacity for implementing a EHfA approach; and evidence informing the implementation of an EHfA.



We welcome:

- The draft strategy as a timely opportunity to reframe health as a core objective of economic policy. We particularly commend the strategy for:
- **Proposing a forward-looking approach**, recognising that both immediate and long-term actions are necessary and feasible to drive systemic change.
- **Embedding strong normative foundations**, including equity, social participation, and the recognition of lived experience, gender equality, environmental sustainability, and protection of science and evidence-informed policy from undue commercial influence.
- **Promoting policy coherence and good governance across government**, including accountability, transparency, participatory co-design, health impact assessments, and the integration of health considerations into tax, trade, and industrial policies.
- **Strengthening the social and economic foundations of health**, by highlighting the roles of labour policy, social protection linked to UHC benefit packages, sustainable financing for health services, including through earmarked taxes, and equitable access to health products.

- **Advancing new models of coordination, measurement, and implementation**, including recognition of the Lusaka Agenda for aligned planning and financing, the use of multidimensional indicators beyond GDP to measure progress, and clear next steps for the WHO to support implementation through guidance and tools addressing the commercial determinants of health.



We express concern:

- That the strategy does no longer acknowledge commercial determinants of health. We insist on the importance of differentiating economic determinants (for instance, the impact of macroeconomics and austerity measures on health) from commercial determinants (impact of commercial actors / practices / products on health, which can be positive or negative). We think this differentiation is important – public and private economic interests are not the same. A strong economics of health for all model must avoid externalising the social and economic costs of health-harming products and commercial practices onto individuals and public systems. In implementing the strategy, countries must explicitly acknowledge these determinants and address the documented track record of health-harming industries in negatively influencing policy outcomes. Efforts to collaborate with the private sector in implementing this strategy must focus on “relevant private sector” actors, accompanied by clear safeguards to manage conflicts of interest and limit undue commercial influence.



We urge Member States:

- **To adopt the strategy**, and when implementing it nationally to:
- **Recognise the impact of commercial determinants on their population health and public economy** and integrate considerations for addressing negative impacts as they implement EHfA policies.
- **Support the development of a health taxonomy that goes beyond private investment**, to also support EHfA policies, investments, and system-wide actions more broadly, enabling a shared framework to align resources with national health priorities and international commitments.
- **Promote cross-sectoral budgeting**, recognising the health impacts of sectors such as transport, education, and agriculture, and ensuring health investments are reflected across government budgets, not only within the ministry of health.
- **Strengthen fiscal reform measures** by more explicitly addressing health-promoting subsidy reform, harmful tax exemptions, and tax avoidance and evasion as core elements of sustainable public financing for health.
- **Elaborate on trade policy and health**, recognising both the risks of poorly designed trade liberalisation and the role of trade rules, including TRIPS flexibilities, in protecting regulatory space and access to medicines and other health products.
- **Strengthen attention to market dynamics for health products**, emphasising fair pricing, affordability, and market-shaping tools such as pooled procurement and price transparency.
- **Link implementation with WHO NCD Best Buys and other recommended interventions** as examples of cost-effective, high-impact actions, particularly for aligning industrial policy and domestic resource mobilisations.

- **Support Small Island Developing States (SIDS)** given structural constraints and the importance of international cooperation for them in enabling an EHfA approach.

20.1 Reform of the global health architecture and the UN80 Initiative [\(A79/24\)](#)

The Director-General's report [\(A79/24\)](#) examines growing pressures on the global health architecture (GHA) arising from changing disease burdens and health risks, rapidly evolving science, AI and digital technologies, the contracting financing landscape, and increasing complexity and fragmentation in the range of health actors involved. It situates these challenges alongside ongoing reform efforts — including the Lusaka Agenda, reforms within major global health entities (Gavi, Global Fund, UNAIDS, UNICEF, UNFPA, and the WHO), and the UN80 Initiative to modernise the UN system. WHO's active engagement across these processes is highlighted, noting implications for its role in coordinating action across humanitarian and development domains. The report underscores the need for a coherent, equitable, and accountable GHA with sustainable financing, reduced duplication, and stronger country leadership. It proposes that the WHO host a joint process in 2026 to support the transformation of GHA to better respond to shifts required to meet current challenges.

Civil society organisations (CSOs), communities, and people living with health conditions are essential to effective reform of the global health architecture, as they are most affected by policy decisions, and are therefore instrumental in translating global commitments into people-centred action at the country level, while playing an active role in ensuring accountability. Meaningful CSO and impacted community engagement strengthen legitimacy, transparency, and implementation of reforms, particularly in a context of shrinking resources and competing priorities. We urge Member States to proactively support the meaningful engagement of civil society and people living with health conditions in the reform process.

NCD Alliance is part of the [HEAR-CSO](#) consortium, which is providing a coordinated platform for civil society to engage constructively in global health architecture reform, advocate for equity and rights-based approaches, and ensure that reform processes remain grounded in UHC, social justice, and the needs of communities.

NCDs account for the largest share of the global burden of disease and must be addressed in order to achieve UHC. In a context of shrinking resources and GHA reform, the integration of NCD prevention and care is essential to effectively address these main drivers of morbidity, mortality, and health system demand. For decades, the NCD community has been calling for system-wide coherence across sustainable financing, country-led prioritisation and planning, and cross-actor alignment that the report outlines and will provide important insight into the suggested reform processes.

The WHO has proposed a joint process that is organised into three function-based 'objectives' focusing on mandates, coordination, and financing. The three objectives will be taken forward by a joint task force supported by a dedicated task force secretariat. This four-phase roadmap, scheduled to run from June 2026 to May 2027, involves mapping, stakeholder consultations, and board reviews to finalise a consolidated set of recommendations for the 80th session of the World Health Assembly.



We welcome:

- The explicit recognition of NCDs and mental health among the key focus of the WHO's proposal as a "shifting priority" in global health, reflecting the growing disease burden and changing demographics.
- That the process will be guided by overarching principles of advancing equity and solidarity, the right to health, and leaving no one behind, which will help build a system that promotes health for all.
- The focus on national leadership and ownership, which will more effectively address the needs of LMICs to support health sovereignty.
- The emphasis on country health leadership and the goal to align international financing with nationally led plans, moving away from donor-driven vertical priorities.
- Under objective (iii) we welcome the review of the existing GHA financing flows with a view to improving support for national plans and budgets and national aid transitions. Provision of specific support from existing GHIs and other global health actors will be a vital contribution towards enabling this shift by national governments.
- The emphasis on PHC, placing it at the heart of resilient national health systems, which is essential for providing integrated, people-centred care. PHC needs to be seen within the broader health system context, including risk factors, determinants of health, prevention, and strong referral systems across the life course.



We express concern:

- The proposal does not explicitly name a "rights-based approach," which is essential to ensure governments remain primary duty-bearers to delivering health for all.
- The meaningful engagement of civil society and people living with health conditions has not been enacted in the planned structure of the task force. With no seat on the main body responsible for this joint process, the processes' principles of equity and impact are not met, and prevent the GHA from adequately addressing the challenges of people it pledges not to leave behind, because it fails to recognise the contributions of these groups in delivering on global commitments.
- The description of consultation with the WHO Civil Society Commission and the WHO Youth Council is unspecific – described as "engaged through regular meetings," whereas the consultations with all WHO Member States are specified as "monthly information or consultation sessions". In this structure, civil society and impacted communities will be left outside of the main process, unable to present their views directly either to Member States or the other GHA bodies on the task force, except for those task force members with provision for civil society engagement within their own governance structures.
- Under objective (i) the commitment to develop options for overlaps and gaps in the current GHA functions. We recognise the importance of finding efficiencies and improvements in the current GHA, however with its focus on disease specific verticals, there are significant gaps in providing support for health system strengthening for the delivery of integrated person-

centred care and the achievement of UHC. Solutions for addressing these gaps must be part of the outcome of this process.

- Without a dedicated institutional champion for NCDs similar to those for existing vertical initiatives represented by the GHIs on the task force, these conditions may continue to be sidelined in decision-making and accountability processes. Without specific plans to engage such groups, there is a structural disadvantage for the stated objectives of identifying and proposing solutions for gaps in responding to current and future challenges, versus attention paid to addressing efficiency in the existing structures established to address MDG-era priorities.
- The lack of detailed plans to mitigate barriers to participation for underrepresented groups and affected populations. The proposed timeline outlined by the WHO will result in a rushed process, which will prevent the work from being truly inclusive, particularly the three-month window for Phase II: Mapping & Options remains too compressed for substantive technical work and transparent decision-making. The resource implications and risk management sections outline support for groups which could not otherwise engage, and LMICs, but are not sufficient to address the capacity constraints and low levels of engagement these stakeholders have faced thus far.
- The lack of explicit safeguards to limit the influence of all health-harming industries (e.g., tobacco, alcohol, unhealthy foods) within the reform process. We recognise the reference to the Framework of Engagement with Non-State Actors (FENSA) with reference to the Civil Society Commission but note that FENSA itself does not proscribe engagement with unhealthy food or fossil fuel industries. We seek assurance that consultation inputs and wider stakeholder engagement will be safeguarded against such conflicts of interest with public health.
- The proposal lists ‘accountability’ as a principle of GHA reform, but it does not include, nor address, the establishment of accountability mechanisms to ensure that the resources and outcomes are not wasted and implemented effectively.



We urge Member States: To include at least two seats on the task force for civil society and impacted communities.

- To extend the roles of all stakeholders, including institutions with specific mandates, creating a shared responsibility in the delivery of integrated, person-centred care and UHC through resilient health systems.
- Introduce explicit safeguards and conflict-of-interest mechanisms to protect the GHA reform from undue influence by health-harming industries.
- Additionally, establish a dedicated “people living with health conditions” stakeholder group and ensure its explicit inclusion in all aspects of the engagement and consultation processes, and develop and resource detailed plans for mitigating the risk during each stage of the short timeline to ensure a truly inclusive and transparent process.
- To establish specific mechanisms to monitor and improve the implementation of the GHA process outcomes.
- To ensure that the GHA proposals not only address improving the efficiency of the current GHA but deliver meaningful proposals for filling the gaps for addressing the shifting disease burdens and risks including NCDs, a one health approach, strengthening health systems, and

achieving UHC. The role of existing GHIs and other health players in addressing these gaps must be established and enhanced as an outcome of this process

- To ensure that disease risk factors and wider determinants of health are addressed as integral to achieving Health for All, the new GHA must support health promotion and disease prevention beyond the health sector.
- To uphold the principles and shifts outlined in the Lusaka Agenda, bringing alignment between unmet health needs, resources, and the priorities of governments.

ⁱ This 'reverse foreign' aid phenomenon has been addressed in the [2023 Bridgetown Declaration on NCDs and Mental Health](#).