NCD Alliance

Reimagining the Global Health Architecture for Current and Future Health Needs

Document Purpose

NCD Alliance has produced this document to inform the Joint Task Force on Global Health Architecture Reform's considerations towards their interim report. It contains three papers which aim to inform and contribute to the ongoing reform processes of the global health architecture, setting out recommendations for how it can better respond to current and future health needs. Together they examine three interconnected dimensions of reform: the functions, mandates and capacities needed to deliver better health outcomes; the governance, coordination and accountability required to align action across sectors and institutions; and the financing reforms needed to support integrated, equitable, resilient health systems and sustain essential global and regional health functions. The Annexes for each paper provide supporting examples and evidence.

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Introduction: Reimagining the Global Health Architecture for Current and Future Health Needs

The reform of the global health architecture (GHA), convened through the Joint Task Force on Global Health Architecture Reform (JTF) and its three workstreams, presents an important opportunity to reshape international health cooperation to better meet current and future population health needs. The process comes at a time of significant change and uncertainty. Recent cuts to official development assistance (ODA) and wider threats to multilateral engagement have exposed the vulnerabilities of a global health system heavily dependent on a limited number of donors and shared political priorities. This crisis in global health has reinforced the need for a more sustainable, equitable and resilient architecture, grounded in country ownership and collective responsibility.

The current architecture was constructed over two decades, with many of its institutions, financing arrangements and collective capabilities organised around specific disease priorities linked to the Millennium Development Goals. While these arrangements have delivered important gains, they have not evolved sufficiently to respond to changing demographic and epidemiological realities or to meet the full spectrum of population health needs. Noncommunicable diseases (NCDs) and mental health conditions illustrate this mismatch: despite their substantial contribution to death and disability worldwide, they have received an average of just 2% of ODA over the past three decades. They have also benefited far less from the collective capabilities developed around other health priorities, including product access mechanisms, market shaping, financing and accountability. The challenge is not simply institutional duplication, but also functional under-provision: essential functions are missing, insufficiently developed or fragmented across institutions, with no clear responsibility for ensuring they collectively meet country needs.

A reformed GHA must therefore start with the functions and capabilities that countries need, which do not always align with those that institutions currently provide. It should identify where essential functions are absent or weak, clarify which are best delivered nationally, regionally or globally, and strengthen cooperation across these levels. The starting point must be population health as a whole, supporting integrated, people-centred health systems that can respond coherently to infectious diseases, NCDs, mental health and emerging health threats. This includes strengthening primary healthcare (PHC), ensuring continuity of essential services and access to health products, and building resilient systems able to respond to changing needs over time.

Achieving this shift requires country ownership, alignment with national priorities and progress towards universal health coverage (UHC). The principles of the "one plan, one budget, one report" approach provide an important foundation for aligning institutional responsibilities, development cooperation and financing behind country-led health plans. Global and regional institutions should complement and strengthen national capacities, providing collective functions where cooperation adds clear value, rather than creating parallel structures or reinforcing fragmented, disease-specific approaches.

It also requires a whole-of-government and whole-of-society approach. Health outcomes are shaped by decisions across economic, social, commercial and environmental policy, including those relating to finance, trade, agriculture, food systems, education and the environment. Multisectoral governance must therefore be embedded across relevant GHA functions, with clear institutional responsibilities, coordination and accountability. Governments, civil society, communities and people with lived experience must also be able to meaningfully influence decisions, with appropriate safeguards to protect public-interest policymaking.

Finally, these changes depend on financing arrangements that reflect population health needs and support sustainable, integrated systems. This means moving beyond fragmented, donor-driven funding towards stronger domestic resource mobilisation, better alignment of domestic and external financing with national priorities, more predictable international financing, and appropriate collective financing for essential global and regional public health goods and functions.

The three papers that follow examine these interconnected dimensions of GHA reform. Workstream 1 considers the functions, mandates and capacities needed to address current and future population health needs, and how these should be strengthened across national, regional and global levels. Workstream 2 examines the multisectoral governance, coordination and accountability needed to align action across institutions, sectors and levels of decision-making. Workstream 3 addresses the financing reforms within GHA required to support integrated, resilient and equitable health systems and ensure that global and regional public goods and essential functions are sustainably funded.

Together, the papers argue for a GHA that is not simply more efficient or better coordinated, but better equipped to respond to the health needs of populations, strengthen country-led action and deliver equitable and sustainable health outcomes.

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Paper 1: A global health architecture fit for current and future health needs: Integrating NCDs and mental health into functions, mandates and capacities

1. Key messages for Workstream 1

This paper provides the following recommendations to integrate NCDs and mental health into the global health architecture, ensuring the necessary functions are available at the appropriate level in order to meet current and future health needs:

- **Identify functional gaps and overlap across the full spectrum of population health needs.**
- **Extend the scope and reach of global and regional functions to address NCDs and mental health and improve access care.**
- **Make integrated NCD and mental health prevention and care a core health system function.**
- **Reorient global health initiatives towards integrated health systems.**
- **Ensure global and regional functions support country-led action on NCDs and mental health.**

These recommendations and the reasoning behind them are presented in further detail in the sections below.

2. Context

The global health architecture (GHA) must evolve to respond to the health needs and risks countries face today and in the future. Noncommunicable diseases and mental health conditions now account for around 75% of global deaths, while demographic and epidemiological transitions, including population ageing and increasing multimorbidity, are driving greater demand for prevention, early detection, long-term treatment and continuous, integrated care.

At the same time, infectious disease threats and emergencies remain central to global health and should not be treated as separate agendas. The starting point should be population health as a whole, with the architecture supporting the delivery of integrated, person-centred care through strong primary health care (PHC) and resilient health systems that can respond coherently across infectious diseases, NCDs and mental health, while ensuring continuity of essential NCD and mental health services and access to medicines and diagnostics during emergencies and in humanitarian settings.

Meeting these needs requires action and investment at multiple levels. Countries need the health system capacity and resources to deliver integrated services while regional and global institutions must provide the collective functions and capabilities that national efforts and benefit from cooperation across countries.

A central challenge for GHA reform is that, while many essential functions already exist for some disease groups and conditions, they are not equally available or developed across the full spectrum of population health needs. NCDs and mental health conditions remain particularly underserved. **GHA reform must therefore consider not only whether essential functions**

exist and where they overlap, but also whether their scope and capacity will cover the health needs countries face today and in the future.

For Workstream 1, the Task Force should identify the essential functions required to meet these needs, assess where they are missing, weak or limited to specific diseases, and consider how they can best support country-led action at national, regional and global levels.

3. Where the global health architecture falls short of current and future health needs

GHA should aim to be 'future-proof', meaning that the functions and mandates reflect ''current and future patterns of illness and disability''. The implication for WS1 is that the gap analysis should assess not only duplication between organisations, but also functional under-provision, i.e. where essential functions are absent, weak, or available only for selected disease areas. The future architecture should be judged not only by institutional efficiency, but by whether its functions improve health, financial protection, productivity and social resilience.

The following subsections examine where the current GHA falls short of population health needs, the gaps that need to be addressed, and the wider implications for health and development.

The architecture has not kept pace with changing population health needs

The current GHA has developed a range of collective capabilities around particular disease priorities, but these have not been equally extended to NCDs and mental health. While it has delivered major gains in areas such as infectious diseases, maternal and child health, vaccines and emergency preparedness, its functions and mandates have not evolved at the same pace as epidemiological and demographic change. As a result, disease burdens are shifting towards conditions the system was not designed to address. For NCDs and mental health, the challenge is often less direct duplication than fragmentation: relevant functions are either unassigned or distributed across WHO, GHIs, development banks, regional bodies and other actors without clear responsibility for ensuring that they collectively meet country needs. Governance fragmentation has been identified as a key challenge by all six of the GHA reform initiatives, as "organisations [...] are independent of each other and do not in themselves create a shared framework across all external actors". Although individual organisations are making efforts to respond to country demand, their collective efforts remain fragmented.

Gaps in functions and capabilities needed to respond to population health needs

A central challenge for GHA is that the existing mechanisms and collective capabilities are often designed around specific disease priorities, leaving NCDs and mental health underserved. Although many of the functions needed to address these chronic conditions already exist, they are not equally available or developed across the full spectrum of population health needs.

This is reflected in several areas:

- NCDs and mental health account for around 75% of global deaths, yet for decades have only received around 2% of development assistance for health.
- NCDs and mental health have benefited far less from the global collective capabilities built around other priorities, including procurement and purchasing capabilities, market shaping, dedicated product-access mechanisms, coordinated product financing and strong global accountability frameworks.

The result is a widening gap between vertical, disease-specific programmes and the growing need for strong PHC and resilient health systems that are capable of addressing "the health challenges of the future (NCDs and aging)" (see also Lusaka and EC INTPA).

- Vertical silos affect the delivery of integrated health services and health system strengthening (HSS) objectives that NCDs and mental health depend on. Despite country demand for primary health care and system strengthening, there has been a decrease in funding for HSS, and where it exists, funding remains focused on specific diseases, limiting country ownership of how it is used.
- Population ageing and multimorbidity are increasing demand for continuous, integrated care rather than episodic or disease-specific services. By 2030, more than one in five people living with HIV globally will be over 50, with higher rates of hypertension, diabetes, cardiovascular disease, cancers and mental health conditions. People living with tuberculosis also face higher rates of NCDs and mental health conditions and higher rates of multimorbidity than the general population. Vertical programming can act as a barrier to countries meeting these needs.

Global and regional collective action needs to support stronger, integrated health systems

Collective action and cooperation are needed to extend the scope of existing global and regional capabilities, while strengthening the capacity and resources of national health systems to deliver integrated services. To date, support for integrated care and resilient health systems has been insufficient.

- Important gaps remain across the full pathway for people-centred care: prevention; screening and early detection; diagnosis; treatment and long-term management; rehabilitation and palliative care.
- Major gaps exist in national capacity to deliver integrated, people-centred care, including PHC, health workforce and access to essential health products, as well as in the regional and global functions needed to support delivery. These include regional regulatory cooperation, procurement and market shaping, and global norms, research, data and accountability mechanisms. Many of these capabilities already exist but need to be strengthened and extended to address NCDs and mental health alongside other priorities.
- Emergency preparedness and response must also protect continuity of essential services and access to medicines and diagnostics for people living with NCDs and mental health conditions.

Why these gaps matter in global development

NCDs and mental health are both shaped by and have significant consequences for social and economic development. Social and economic conditions influence NCD and mental health risks and access to care, while NCDs and mental health in turn affect poverty, inequality, productivity and economic development.

- NCDs and mental health impose substantial costs through healthcare expenditure, disability and lost productivity. NCDA's earlier GHA paper cites estimates of more than US$2 trillion annually in healthcare costs and lost productivity.
- Their chronic nature can expose households to repeated expenditure on consultations, medicines and diagnostics, increasing the risk of financial hardship and impoverishment.
- NCDs and mental health therefore reinforce existing social and economic inequalities and can undermine progress on UHC, poverty reduction and sustainable development.

- The economic case for action is strong: WHO estimates that implementation of the NCD "Best Buys" would generate a return of approximately 4:1 by 2030 and 7:1 by 2035, while saving 12 million lives.

Processes to develop the new global health architecture should therefore consider how its functions can contribute to these wider health and development outcomes, alongside improving institutional efficiency.

4. Which functions are best delivered nationally, regionally or globally?

The JTF synthesis identifies strong convergence across GHA reform initiatives (the Lusaka Agenda, Accra Reset, Wellcome, EC INTPA process and HEAR CSO) that reform should strengthen national health systems and institutions, as well as building greater regional cooperation. There is also strong support among the GHA analyses for global institutions and donors to be guided be country priorities, with functions concentrated on what no country or region can provide alone and where collective action adds clear benefit.

The principle of subsidiarity provides a useful framework for considering how functions can be delivered: at the lowest level capable of performing them effectively, with regional and global action where collective approaches add scale, expertise, bargaining power or equity.

For Workstream 1, the key consideration is that national, regional and global functions and capabilities must work together to support country-led action across the full spectrum of population health needs. This includes recognising that addressing NCDs and mental health requires not only national investment and capacity, but also regional and global cooperation and collective action.

The concept of Global Public Goods for Health (GPGHs) is also relevant in this discussion, particularly where functions require collective global or regional action and investment. The financing implications of GPGHs are explored further in the Workstream 3 paper.

5. Recommendations for Workstream 1

The following recommendations aim to help ensure that global health functions meet current and future population health needs.

5.1 Identify functional gaps and overlap across the full spectrum of population health needs.

Map where essential functions are missing, weak or limited to selected diseases, as well as where responsibilities overlap or fragment these functions. Explicitly assess whether existing functions and capabilities adequately cover NCD and mental health prevention, integrated care, access to health products, surveillance, workforce and long-term management.

5.2 Extend the scope and reach of global and regional functions to address NCDs and mental health and improve access to care

Ensure that existing global and regional capabilities in research, norms and guidance, market shaping, procurement, regulatory cooperation, surveillance and other areas are available for NCDs and mental health as well as traditionally prioritised disease areas. This should include extending mechanisms that support access to health products — including NCD and mental health medicines, diagnostics and medical devices — to improve their affordability, availability, quality and security of supply. Countries and regions should also be supported to strengthen the systems and capacities needed for sustainable access, including selection, forecasting,

regulation, procurement, pricing, continuity of supply and the sustainable financing of essential health products.

5.3 Make integrated NCD and mental health prevention and care a core health system function.

Ensure that NCD and mental health prevention, screening, diagnosis, treatment, long-term management, rehabilitation and palliative care are incorporated into PHC, UHC benefit packages, workforce planning, referral systems and emergency preparedness.

5.4 Reorient global health initiatives towards integrated health systems.

Ensure that GHI mandates, financing and existing capabilities support integrated national health systems and broader population health needs, including NCDs and mental health. A diagonal approach can retain disease-specific expertise and assets while using them to advance integrated care and common system capacity.

5.5 Ensure global and regional functions support country-led action on NCDs and mental health.

Global and regional institutions should provide the functions and capabilities needed to support countries in addressing NCDs and mental health, including those which contribute to global public goods for health. This should complement and strengthen national efforts to integrate NCD and mental health prevention and care into health plans, budgets and health systems, recognising that effective responses require action at all levels.

Cross-workstream considerations

Workstream 2 Multisectoral coordination and decision-making: Priority-setting and accountability mechanisms should reflect the full spectrum of population health needs, with meaningful participation of civil society, affected communities and people living with NCDs and mental health.

Workstream 3 Financing: Financing should support the same functional transition: sustainable domestic financing for integrated services; external financing aligned behind national plans and used strategically to build durable capacity; and collective financing for regional and global functions that countries cannot efficiently provide alone. Financing arrangements should explicitly address the mismatch between disease burden and resource allocation, including by supporting NCD and mental health medicines and services within UHC benefit packages.

6. Ensuring global and regional collective functions respond to the full spectrum of population health needs

The six global health architecture functions identified by WHO provide a useful framework for assessing whether existing global and regional arrangements adequately respond to current and future population health needs. While many of these functions are already established, their scope and application remain uneven across disease areas. The following table highlights how these functions could be strengthened or extended to better address NCDs and mental health.

WHO GHA function	How it needs to respond to NCDs and mental health
Setting norms, technical guidance and standards	Ensure global guidance, norms, standards and essential product lists cover NCD and mental health prevention, diagnosis, treatment and long-term management. Establishing shared frameworks to address cross-border health determinants and risks.
Data, monitoring and knowledge	Strengthen data and evidence on NCDs and mental health, and develop common indicators across implementation, service coverage and health outcomes, supporting more effective accountability.
Surveillance and health security	Ensure surveillance and health security systems account for NCDs and mental health, including through monitoring health risk factors, disease trends, and continuity of essential services during emergencies, as well as infectious disease threats.
Product innovation and access	Extend research and innovation, regulatory cooperation, market shaping, pooled procurement and purchasing approaches, demand aggregation, and equitable access mechanisms to NCD and mental health medicines, diagnostics, and medical devices.
Development cooperation for health, including health system strengthening to advance resilience and UHC	Align external support and GHI capabilities with national priorities to advance integrated PHC, resilient health systems, and UHC, rather than reinforcing disease-specific approaches. Strengthen cooperation across countries and sectors to address the underlying determinants of health.
Humanitarian emergency response	Ensure emergency preparedness and response protects access to and continuity of essential NCD and mental health services, medicines and diagnostics, including in humanitarian settings.

7. Conclusion

Recent reform proposals have explicitly called for existing global health functions, including product financing, market shaping and access mechanisms originally developed around a narrow set of diseases, to expand beyond traditionally prioritised products and include those needed for NCDs and mental health. While GHIs are unlikely to fundamentally change their mandates, working 'diagonally' within existing frameworks by combining disease-specific expertise and funding with health system strengthening efforts offers a realistic pathway towards better integration of NCDs and mental health into global health priorities.

The test for Workstream 1 is not only whether functions are better coordinated, but whether the future architecture has the right functions, at the right level, to meet the health needs countries actually face.

Achieving this shift will also require stronger multisectoral governance and accountability to align action across sectors and levels of governance, alongside financing arrangements that support integrated national systems and the collective functions needed at regional and global levels. These governance and coordination arrangements are explored further in the WS2 paper, while the financing implications are addressed in WS3.

The test for Workstream 1 is not only whether functions are better coordinated, but whether the future architecture has the right functions, at the right level, to meet the health needs countries actually face.

Paper 2: Global health extends beyond the health sector: Making multisectoral governance and accountability central to global health reform

1. Key messages for Workstream 2

A 'future-proofed' global health architecture (GHA) must enable countries to meet their health system needs as they arise from the changing disease burden, including a rising burden of NCDs and mental ill-health, and address their multisectoral drivers. This requires country-led, multisectoral plans that are implemented through coordinated action, financing and accountability across government and international partners. Multisectoral governance must be approached as a cross-cutting requirement across GHA functions, rather than a separate function requiring a new institution.

The recommendations below aim to support this and should be considered in GHA reform discussions. They are discussed in greater detail in the sections that follow, together with implications across Workstreams 1 and 3.

Recommendations:

- **Embed multisectoral health priorities in the 'one plan, one budget, one M&E' approach and align international support behind them.**
- **Establish clear institutional responsibilities for supporting multisectoral action and ensuring accountability within the GHA.**
- **Strengthen the multisectoral governance, monitoring and accountability needed to deliver many health priorities and commitments.**
- **Ensure inclusive and equitable participation in decision-making while safeguarding the public interest against conflicts of interest.**

2. Context

Health is shaped not only by health systems and services, but also by decisions across economic, social, commercial and environmental policy. The conditions in which people are born, grow, live, work and age (and their access to resources, opportunities and participation in decisions affecting their health) are fundamental determinants of health, well-being and equity. Addressing these determinants requires coherent action across government sectors and, where drivers transcend national borders, cooperation across countries and international institutions.

This is particularly evident for noncommunicable diseases and mental health conditions, whose risk factors are shaped by food systems, tobacco and alcohol markets, air pollution, climate change, urban environments and wider socioeconomic conditions. These determinants cannot be effectively addressed through health sector interventions alone. They require policy coherence across health, finance, trade, agriculture, environment, education, labour and other sectors, supported by collective action where national measures are insufficient.

Political commitments, including WHO's Fourteenth General Programme of Work (GPW14, 2025–2028)[1], the 2025 Political Declaration on NCDs and Mental Health, and WHO's Global Strategy on the Economics of Health for All, provide a foundation for such action. The challenge is to translate these principles into GHA functions, mandates, capacities and accountability arrangements that enable sustained implementation.

Multisectoral governance must be embedded across all relevant GHA functions, with clear governance, responsibilities and accountability. WHO has identified six GHA function blocks. Multisectoral governance is a cross-cutting requirement across these functions, rather than a separate function requiring a new institution. The six blocks are: (1) norms, technical guidance and standards; (2) data, monitoring and knowledge; (3) surveillance and health security; (4) product innovation and access; (5) development cooperation for health, including health systems strengthening; and (6) humanitarian emergency response.

Section 6 presents a framework based on these six GHA function blocks, illustrating how the recommendations in this paper can be embedded within them. The overall objective is to ensure that these functions address the determinants of health, connect health with other policy domains and support coherent action within and across global, regional and national levels.

3. Gaps, overlaps and unclear mandates in multisectoral action for global health

Despite strong political commitments, multisectoral action remains uneven and often dependent on individual champions or temporary coordination arrangements. Several gaps are relevant to the GHA reform process.

- **Fragmented mandates and limited policy coherence**. International institutions operate under different mandates and governance arrangements. Health institutions may identify risks and recommend action, while decisions relating to trade, investment, agriculture, food systems, environment and economic policy are taken elsewhere. There is insufficient clarity on how institutions should address conflicting policy objectives or ensure that health implications are considered across their respective mandates.
- **An incomplete connection between GHA functions and national priorities.** Global guidance, data and technical assistance do not consistently translate into coordinated national action. Health ministries may lack the authority, resources or capacity to influence other sectors, while international partners may engage countries through parallel, sector-specific processes rather than strengthening national governance arrangements.
- **Gaps in evidence and accountability.** Health outcomes are influenced by decisions beyond the health sector, yet monitoring frameworks do not consistently capture these determinants, the contribution of different sectors or the health implications of global policies. Responsibility for implementation and accountability for results can consequently remain diffuse.
- **Misaligned financing and incentives.** Sector-specific funding, reporting requirements and investment incentives can discourage joint planning and implementation. Countries may be expected to deliver multisectoral outcomes without corresponding resources, institutional authority or incentives across government.
- **Insufficient safeguards for public-interest decision-making.** Engagement with non-State actors can provide expertise and implementation capacity, but commercial and other vested interests may conflict with public health objectives. Clear arrangements are needed to manage conflicts of interest and protect public policy from undue influence.

These gaps highlight the need to clarify which existing GHA functions should support multisectoral action, which actors are responsible, where additional capacity is required, and how accountability and financing can reinforce coherent action. The recommendations below aim to address these challenges.

4. Recommendations for Workstream 2

The following considerations are intended to inform the Joint Task Force's deliberations on how multisectoral dimensions of health can be better addressed across GHA functions. A measure of success should be whether the reformed GHA enables countries and international institutions to align decisions across sectors, address shared and transboundary determinants of health, and demonstrate accountability for progress.

4.1 Embed multisectoral health priorities in the 'one plan, one budget, one M&E' approach and align international support behind them.

Health priorities should be integrated into existing governance and decision-making processes across health, finance, trade, agriculture, environment and other relevant sectors, as well as national development and economic planning. This requires a genuinely multisectoral approach to national planning – rather than health plans that simply reference other sectors.

The Political Declaration from the 4th High-Level Meeting on NCDs and Mental Health includes a commitment for 80% of countries to have operational, multisectoral integrated NCD strategies by 2030. This is supported by WHO Global Monitoring Framework indicators on multisectoral action plans. The 'one plan, one budget, one M&E' approach provides an opportunity to build on this commitment, ensuring that domestic and international support is aligned behind nationally determined priorities and that health objectives are reflected across government policies and budgets.

Evidence-based approaches can support this process. WHO's Global Strategy on the Economics of Health for All provides an important foundation, emphasising the need for whole-of-government approaches to health, stronger alignment between health and economic policy, and institutional capacity to engage and negotiate across sectors. Other useful approaches include Health in All Policies and health impact assessments, which can help governments assess the health implications of decisions across economic, fiscal, trade, food, agricultural, environmental and social policies; identify trade-offs and promote policy coherence.

This approach builds on existing WHO mandates on multisectoral action on NCDs, mental health, and social determinants, including commitments to strengthen multisectoral governance, implement cost-effective population-wide interventions, and advance Health in All Policies (WHA66.10, 67.12, 74.16) . It is also consistent with the mandate under WHA77.13 to support countries in engaging and negotiating with non-health sectors while strengthening cross-border collaboration on health.

4.2 Establish clear institutional responsibilities for supporting multisectoral action and ensuring accountability within the GHA.

GHA reform should clarify the distribution of responsibilities for multisectoral action across WHO, regional institutions and other international actors, identifying where mandates overlap or gaps exist in supporting national health plans, particularly in addressing the multisectoral determinants of health. This includes defining which institutions are responsible for different aspects of multisectoral support, and how their respective mandates and capacities complement one another rather than duplicate existing efforts.

As countries transition towards integrated health systems and greater domestic resource reliance, the GHA should provide predictable financial and technical support, with the respective roles of WHO and other international and regional actors reflected in country-led plans from the outset. Clear inter-institutional accountability arrangements are also needed, defining which institutions are responsible for which functions and how they are held accountable, including through joint reporting, shared review processes or designated focal points.

Regional institutions can play an important role in coordinating progress towards shared priorities, supporting countries and participating in governance arrangements, where this offers clear added value and avoids the creation of parallel structures.

4.3 Strengthen the multisectoral governance, accountability and monitoring needed to deliver many health priorities and commitments.

The GHA should support countries to build and sustain the national mechanisms needed to make multisectoral action work in practice, in line with the Economics of Health for All approach. This includes supporting countries to integrate health objectives into national development strategies, economic planning, budgets and relevant sectoral policies, while strengthening national capacity for whole-of-government governance, including cross-sectoral planning, policy analysis, negotiation and implementation.

Support should also strengthen collaboration between health and relevant non-health institutions to identify and assess environmental, food system, climate-related and other threats to population health. Cross-sectoral coordination should be promoted in emergency preparedness, response and recovery, including on food security, nutrition, water and sanitation, environmental risks and continuity of essential health services. Emergency planning should also consider the wider determinants of vulnerability and the differentiated impacts of crises.

The GHA should support countries to establish comprehensive indicators that connect health outcomes with cross-sectoral policy actions and the contributions of different institutions, enabling countries to measure progress and hold institutions accountable against shared objectives. Appropriate sharing and integration of surveillance information across sectors and borders can further strengthen transparency and inform assessments of progress.

Two design principles should govern all of the above: 1) build on existing surveillance, health security, and review processes wherever possible rather than creating additional reporting structures; and, 2) ensure that new coordination mechanisms have clear responsibilities and do not duplicate established systems.

4.4 Ensure inclusive and equitable participation in decision-making while safeguarding the public interest against conflicts of interest.

GHA governance arrangements should ensure that LMICs, civil society and affected communities can meaningfully shape priorities, influence policies, and participate in monitoring and accountability. This includes strengthening the representation and participation of communities affected by NCDs and mental health conditions in the decisions that influence their health and access to services.

At the same time, public interest decision making must be protected from undue commercial and other vested interests. This requires strengthening safeguards and establishing clear expectations for transparency, due diligence and effective management of conflicts of interest, building on existing instruments such as the WHO Framework Convention on Tobacco Control (WHO FCTC). Particular attention should be given to the health implications of product design, composition, marketing and availability, while respecting established institutional mandates and avoiding duplication of regulatory functions.

Implications of multisectoral governance for Workstreams 1 and 3

Embedding multisectoral governance across GHA functions will have implications beyond Workstream 2. These are key considerations for Workstreams 1 and 3.

Workstream 1 (functions, mandates and capacities) should consider how multisectoral sub-functions can be embedded within the six GHA blocks, identifying where existing functions support action on the determinants of health and where functional gaps remain. This includes mapping mandates and comparative advantages across institutions and levels, identifying overlaps, unassigned functions and gaps in responsibility, particularly where health outcomes depend on policies beyond the health sector. Capacities required at national, regional, and global levels to deliver multisectoral functions should be identified, including policy analysis, health impact assessment, cross-sectoral negotiation, evidence generation, and implementation support. Finally, it should distinguish global public good (GPG) provision from operational and country-support functions, clarifying which functions are best delivered globally, regionally or nationally and informing appropriate financing arrangements.

Workstream 3 (financing) should identify financing needs for multisectoral action across the six GHA function blocks, including funding for evidence, policy analysis, cross-sectoral planning, implementation, and monitoring of shared health outcomes. This requires distinguishing financing for GPGs from that needed for national implementation and essential regional functions, and clarifying the respective resource requirements and responsibilities at each level. It should also consider how global funding and development cooperation can be better aligned with country-defined priorities, ensuring that financing, technical assistance and investment incentives support national multisectoral plans and existing governance arrangements rather than creating parallel processes. Finally, it should address fragmented funding and misaligned incentives, identifying how sector-specific funding, earmarking, reporting requirements and investment conditions can undermine policy coherence and joint implementation across government sectors, while strengthening transparency, accountability and public-interest safeguards in financing. This should ensure that resource allocation is protected from conflicts of interest and undue influence.

5. Functions to be delivered nationally, regionally or globally

Delivering these priorities requires clear allocation of responsibilities across national, regional and global levels. Applying the principle of subsidiarity, functions should be delivered at the level best placed to achieve results, strengthening national ownership and regional capacities while reserving global action for collective public goods and challenges that cannot be addressed effectively at national or regional levels.

- **National level: governance and implementation.** Governments should lead the identification of priorities and establish clear responsibilities across ministries. Functions include integrating health into economic and sectoral policies, conducting policy-impact assessments, coordinating plans and budgets, monitoring implementation, managing competing interests and ensuring accountability. International partners should support these processes in line with country-defined priorities.
- **Regional level: cooperation and shared capacities.** Regional institutions should support peer learning, cross-border policy coordination, shared evidence and approaches to transboundary determinants. They can help align regional economic and development policies with health objectives and connect national priorities to global processes.
- **Global level: public goods, coherence and collective action.** Global institutions should produce shared evidence, norms and technical guidance; support comparable monitoring and knowledge exchange; coordinate action on transboundary determinants; identify inconsistencies across international policies and incentives; and promote accountability for global commitments. WHO should provide public health leadership within its mandate, working with other institutions whose responsibilities shape the determinants of health.

6. Global health functions to support multisectoral action on NCDs/MH

Multisectoral governance should be embedded in the six GHA function blocks identified by WHO. The following table draws on the considerations above to illustrate how this can be operationalised, the levels at which action is needed, and the global public goods for health to which these functions may contribute.

Across all six blocks, a cross-cutting function is required to convene relevant actors, clarify responsibilities, address policy incoherence, support implementation, and establish accountability for shared objectives. This function should connect the blocks without creating a new silo.

WHO global health function	**How multisectoral governance should be embedded**
Norms, technical guidance and standards	Develop guidance and approaches for integrating health considerations into economic, fiscal, trade, food, agricultural, environmental and social policies, including Health in All Policies, Economics of Health for All and health impact assessments. Promote coherence across international instruments and standards, and safeguards for public interest decision-making.
Data, monitoring and knowledge	Generate and synthesise evidence on the social, commercial, economic and environmental determinants of NCDs and mental health, including the distribution of risks and impacts across populations. Develop indicators connecting health outcomes with cross-sectoral policies and actions, and strengthen the use of evidence in decision-making.
Surveillance and health security	Strengthen collaboration between health and non-health institutions to identify and assess environmental, food system, climate-related and other threats to population health. Promote appropriate sharing and integration of information across sectors and borders, building on existing surveillance and health security mandates to avoid duplication with established systems.
Product innovation and access	Ensure innovation and access approaches consider current and future population health needs, equity and affordability, and the wider determinants of health that shape access to essential health technologies and products. Strengthen coherence between health product policies and relevant regulatory, trade, industrial and financing policies, while addressing the health implications of product design, composition, marketing and availability.

Development cooperation for health, including health systems strengthening[2]	Strengthen national capacity for whole-of-government governance, including cross-sectoral planning, policy analysis, negotiation, implementation and accountability. Align international technical assistance and development cooperation with country-defined priorities and existing national coordination arrangements, and support regional cooperation and peer learning.
Humanitarian emergency response	Promote coordination between health and non-health actors in emergency preparedness, response and recovery, including food security, nutrition, water and sanitation, environmental risks and continuity of essential services. Ensure planning considers wider determinants of vulnerability and differentiated impacts on populations, and strengthens links between humanitarian action, health system resilience and longer-term recovery.

7. Conclusion

Reforming the global health architecture requires recognising that health outcomes cannot be delivered by the health sector alone. The policies and decisions that shape population health span multiple sectors, yet global health cooperation has not consistently provided the governance, coordination and accountability needed to support effective multisectoral action. Addressing this gap is essential to ensuring that global health commitments translate into coherent, sustained action at country level.

Multisectoral governance should therefore be embedded across the functions and institutions of the global health architecture, rather than treated as a separate or additional area of work. This requires clearer institutional responsibilities, stronger alignment behind country-led priorities and plans, more effective monitoring and accountability, and meaningful participation by civil society and affected communities, alongside safeguards to protect public interests. By making these elements central to GHA reform, the international system can better support governments to address the wider determinants of health, strengthen policy coherence and deliver more equitable and sustainable health outcomes.

Paper 3: Global health depends on sustainable financing: Aligning resources with country priorities and essential global functions

1. Key messages for Workstream 3

The reformed GHA must transition from fragmented, donor-driven vertical funding streams towards financing systems that respond to the full spectrum of population health needs, strengthen country ownership, support integrated and resilient health systems, improve access to affordable care, and protect populations from financial hardship due to health spending. This requires addressing the under-provision of essential health system functions and ensuring that financing is aligned with changing health needs, rather than disease-specific priorities.

The GHA process must clearly define institutional roles and shared responsibilities within financing to support integrated care and health system strengthening and resilience and respond to population needs now and in the future. This means ensuring that NCDs and mental health are fully integrated into health system financing arrangements, rather than treated as peripheral additions to existing priorities.

The recommendations below outline key shifts in global health financing that are needed to achieve this shift. These recommendations are described in further detail in the sections that follow.

- **Ensure health financing is equitable, inclusive and responsive to the needs of marginalised populations.**
- **Expand sustainable domestic resource mobilisation and support equitable transitions towards domestic financing.**
- **Align domestic and external financing behind country-led health plans, budgets and monitoring frameworks.**
- **Improve the predictability, transparency and effectiveness of international health financing, strengthening coordination and accountability across funding institutions**.
- **Develop the role of multilateral development banks (MDBs) in financing integrated, resilient and equitable health systems**.
- **Establish predictable, equitable collective financing for essential global and regional public health goods and functions**.
- **Use strategic access levers to improve affordability and supply.**

2. Financing context: the mismatch between health needs and resources

Global health needs are changing, driven by demographic shifts, epidemiological transitions and the growing prevalence of chronic multi-morbidities. Yet financing has not kept pace with these

changing needs. In many countries, health systems remain under-resourced and reliant on fragmented funding streams that are misaligned with current population health priorities and the need for integrated, continuous care. This mismatch undermines countries' ability to respond across the full spectrum of health needs and to deliver on the promise of universal health coverage (UHC).

The scale of this challenge is illustrated by NCDs and mental health conditions, which are the leading cause of death and disability worldwide. The five major NCD groups – cardiovascular diseases, chronic respiratory diseases, diabetes, cancer, and mental health and neurological conditions – cause nearly US$2 trillion in economic losses every year through premature deaths, lost productivity, and healthcare costs. At the same time, 100 million households are pushed into extreme poverty each year by out-of-pocket spending on health, with much of this burden driven by NCDs and mental health conditions. Low- and middle-income countries (LMICs), where health systems are least able to respond, face a disproportionately high burden.

Despite this burden, NCDs have received an average of just 2% of development assistance for health (DAH) financing over the past three decades.[1] Cost-effective medicines and medical devices for NCDs and mental health remain excluded from many national health benefit packages, while global out-of-pocket spending for NCDs and mental health is estimated to be twice that for infectious diseases. For conditions that often require long-term or lifelong treatment, seeking and sustaining care poses a significant financial burden for individuals and their households.

These challenges point to a wider financing gap. To build health systems capable of meeting population health needs, financing must be aligned with epidemiological and demographic realities and advance all three dimensions of UHC: expanding population coverage to reach marginalised groups, broadening essential service coverage, and ensuring financial protection against out-of-pocket costs. GHA reforms must support this shift and be firmly grounded in evidence and the epidemiological reality. National health plans and budget allocations must be matched to changing needs, while shifting from fragmented, disease-specific funding towards more integrated and predictable financing.

Member States formally recognised the challenges posed by out-of-pocket expenditure (OOPE) in the 2025 Political Declaration on NCDs and Mental Health, emphasising the need to accelerate primary healthcare delivery, essential medicine access, and accountability. Achieving these commitments requires moving beyond policy commitments toward concrete, system-level reforms that shift from reliance on high out-of-pocket spending to predictable, publicly financed access.

For Workstream 3, the central issue is the clear and fundamental mismatch between population health needs and the resources allocated to respond. NCDs and mental health are a clear example, historically receiving a nominal amount of DAH despite the scale of the burden they represent and remain insufficiently integrated into health systems and health financing arrangement. Recent funding cuts have exposed the fragility of a GHA that is heavily dependent on donor financing and shared political objectives. A reformed GHA must transition away from fragmented, disease-siloed funding streams toward integrated financing models aligned with the principles of "one plan, one budget, one report" to build long-term, resilient institutional capacities.

3. Recommendations

The following recommendations are intended to inform the Joint Task Force's deliberations on how GHA can better support health financing that responds to current and future population health needs.

3.1 Ensure health financing is equitable, inclusive and responsive to the needs of marginalised populations.

This requires shifting the burden of chronic care away from out-of-pocket payments towards predictable public financing, ensuring people can access and sustain treatment. Equity must be a core consideration in resource allocation, reflecting differences population health needs, income level, and countries' fiscal capacity. Civil society, communities and people with lived experience should participate in and influence financing decisions, with predictable support for community-led organisations and services.

Aligning financing with need is essential for achieving equity, and it is the test GHA reform should be held to. Member States should ensure that resource allocation aligns with national disease burdens and unmet health needs. NCDs and mental health conditions illustrate the consequences of underinvestment: despite causing 18 million premature deaths globally and driving substantial long-term care costs, they remain severely underfunded in many settings. A reformed GHA should support countries to allocate resources according to population needs and national priorities, and monitor whether essential services, medicines, diagnostics and medical devices are adequately financed, particularly for populations at risk of being left behind.

Financial protection must account for the full cost of seeking care, not only the medical bill. Member States have committed to ensuring that at least 60% have financial protection policies or measures in place that cover or limit the cost of essential NCD and mental health services, diagnostics, medicines and other health products by 2030. GHA monitoring frameworks should track progress against this commitment and capture the indirect costs of accessing care, including transport, accommodation, loss of income and caregiving expenses, which can make essential services inaccessible even when medical costs are covered.

None of this can be held to account without measurement, making transparent and disaggregated expenditure data essential. GHA reform should support the routine publication of sufficiently granular data on health budgets and spending, enabling governments and civil society to assess whether resources are being allocated efficiently and equitably, identify gaps and reduce duplication. Better expenditure data can also strengthen forecasting of medicine and medical device needs and inform supply chain planning to support continuous access. Tracking resource allocation for NCDs and mental health can form part of this broader accountability framework, alongside monitoring investment across other health priorities.

3.2 Expand sustainable domestic resource mobilisation and support equitable transitions towards domestic financing

Ensure that transitions away from external funding are adapted to country contexts and supported by a country-led plan, with safeguards to avoid financial "cliffs" disrupting health systems, essential services and access to health products. Mobilising sustainable domestic resources for health should include comprehensive, whole-of-government fiscal polices, including taxes on unhealthy products and subsidy reform. These measures can generate revenue while reducing exposure to health risks, saving lives and lowering healthcare costs.

There is broad consensus that domestic revenue should be the main source of financing for national health systems, supported by catalytic international funding where needed. Fiscal policies, including health taxes and subsidy realignment, remain under-used tools for mobilising these domestic resources. Adequate taxation of unhealthy commodities – such as tobacco,

alcohol and foods high in fat, sugar and salt – can deliver a triple win: reducing consumption and preventing disease, improving health equity and reducing costs to health systems and the wider economy, while generating revenue for government budgets. In its 2024 report, *Health Taxes: A Compelling Policy for the Crises of Today*, the Task Force on Fiscal Policy for Health found that a 50% increase in taxes on tobacco, alcohol, and sugar-sweetened beverages could avoid 50 million premature deaths in the next 50 years. This same price increase would also raise an additional US$ 3.7 trillion in the immediate 5-year window; US$ 2.1 trillion of this would be in LMICs.

Health taxes should be part of a comprehensive and cohesive fiscal policy strategy that simultaneously phases out current subsidies for health-harming industries, such as fossil fuels, to yield even greater returns. An International Monetary Fund analysis estimates that "scrapping explicit and implicit fossil fuel subsidies would prevent 1.6 million premature deaths annually, raise government revenues by US$4.4 trillion, and put emissions on track toward reaching global warming targets.

Workstream 3 should therefore champion whole-of-government fiscal policies as core instruments for domestic resource mobilisation, health promotion and sustainable economic growth, embedded within broader macroeconomic reform. This includes recognising the wider returns on investment from preventing and controlling NCDs and mental health conditions, while ensuring that fiscal policies contribute to financing health system priorities as a whole.

3.3 Align domestic and external financing behind country-led health plans, budgets and monitoring frameworks.

This should follow the 'one plan, one budget, one report' framework, aligning donor and GHI funding with national health plans and budgets that reflect the full spectrum of population health needs, including NCDs and mental health. This requires common monitoring frameworks and indicators, supported by improved and institutionalised domestic and international expenditure data, to track resource allocation and progress against national priorities.

Delivering integrated care that responds to population health needs requires deliberate shifts in national health budgeting, supported by clear domestic financing targets and indicators. These can help Ministries of Health make more accurate budget projections and advocate to Ministries of Finance and external partners for the resources needed to deliver essential health coverage. For example, NCD Alliance-commissioned research estimated that 1.1–1.7% of gross national income (GNI) is needed to deliver a package of 13 essential NCD and mental health medicines in primary care settings. However, most countries currently invest just 0.26–0.46% of GNI in this same package.

Aligning global health financing with national priorities is also essential to achieve the intergovernmental targets established in the 2025 UN Political Declaration on NCDs and Mental Health (HLM4): ensuring at least 60% of countries have financial protection policies for NCD/MH services in place by 2030 and achieving 80% availability of affordable essential NCD/MH medicines and basic technologies in primary health care facilities globally.

3.4 Improve the predictability, transparency and effectiveness of international health financing, strengthening coordination and accountability across funding institutions.

International financing needs to respond to changing population health needs, moving beyond historical disease-specific allocations. This requires greater transparency around funding

allocations and expenditure, improved coordination between funding institutions, and more predictable, multi-year financing aligned with national planning cycles. These changes can also reduce duplication and promote more efficient use of resources.

Transparency requires funding flows to be published in sufficient detail and disaggregated to enable governments and civil society to see where resources are going and what is being financed. Predictability is particularly important for countries transitioning away from external support. Multi-year commitments aligned with national planning and budget cycles allow ministries of health and finance to plan recurrent costs, including the long-term treatment costs associated with NCDs and mental health conditions. Abrupt reductions in external financing disrupt essential services and undermine efforts to build sustainable domestic financing.

3.5 Develop the role of multilateral development banks (MDBs) in financing integrated, resilient and equitable health systems.

MDBs should align their health strategies with national priorities and strengthen coordination with global health initiatives (GHIs) and national governments to support investments in PHC, health infrastructure, supply chains, manufacturing and data systems. They should make appropriate use of grants, concessional finance and guarantees, taking account of countries' fiscal capacity and debt sustainability. Joint financing packages can also support countries transitioning towards more sustainable domestic financing for health.

MDBs have a distinctive position in the financing landscape: they can lend at scale, convene finance and health ministries, and support long-term investments in nationally led health plans and priorities. Their contribution to health system resilience should focus on strengthening nationally led plans and priorities rather than through external delivery structures. This is particularly important for conditions requiring sustained, long-term investment, such as NCDs and mental health, where short-term, project-based funding is poorly suited to the continuity of care required.

Within the GHA reform, the role of regional development banks as an instrument for the collective dimensions of health financing should be further explored. As institutions that are owned by their regional members, with mandates that include regional integration, they are well placed to finance the platforms through which countries aggregate demand and improve access to essential medicines and health products, including pooled procurement mechanisms, regulatory harmonisation, and local and regional manufacturing capacity. This connects directly to the access levers described below - pooled purchasing and regional manufacturing require upfront investments and sustained institutional capacity before they deliver savings, and regional banks are uniquely poised to finance that groundwork at the scale required.

3.6 Establish predictable, equitable collective financing for essential global and regional public health goods and functions.

GHA reform should clarify which global and regional public health goods and functions require collective action and financing, and establish predictable and equitable arrangements to support them. This includes ensuring that collectively financed global and regional functions address the full spectrum of health priorities, including NCDs and mental health.

A key first step is to distinguish between global public goods (GPGs) and the global and regional functions required to produce and sustain them. As set out in the multisectoral paper, GPGs are

outputs whose benefits extend across countries and borders and cannot adequately be addressed through national action alone, whereas global functions are the activities required to produce, maintain and finance them. Not all global functions produce GPGs, and keeping these concepts distinct is important for clarifying institutional responsibilities and determining who should finance what. Few goods meet the textbook definition of a GPG perfectly - they should be viewed on a spectrum, and where a good sits on that spectrum should determine how it is financed. These classifications should not be left implicit in GHA reform because the classification is not a purely technical decision.

Financing for GPGs should be based on their shared international benefits and responsibilities, rather than relying on official development assistance (ODA) budgets or competing with domestic resources for national health priorities. Yet GPGs have increasingly relied on official development ODA, leaving their provision vulnerable to shifts in donor priorities and the current geopolitical climate. ODA is becoming increasingly transactional, with funding more explicitly linked to specific country development and donor priorities, rather than the shared responsibility of delivering global public goods. Recent contractions in global health funding have further exposed the risks of this dependence.

GHA reform should therefore establish more predictable collective financing arrangements for GPGs, drawing on the model of WHO assessed contributions, whereby financing is agreed collectively and predictably rather than renegotiated through annual voluntary pledges. Global public investment offers complementary framework, based on the principles that all benefit, all contribute, all decide, with decision-making rights decoupled from the size of contribution, as set out in the paper for Workstream 2. Financing arrangements should reflect these distinctions: sustainable collective support for GPGs, alongside appropriate domestic, international and regional financing for national implementation and essential regional functions.

3.7 Use strategic access levers to improve affordability and supply

Strategic access levers, including pooled procurement, strategic purchasing, regional manufacturing, technology transfer and appropriate pricing policies, can help overcome systemic cost barriers and establish equitable coverage. NCD Alliance-commissioned research shows that implementing the right policy levers can reduce the cost of medicines and medical devices by an average of 20-50%.

GHA reform should support national governments in using these levers to strengthen health sovereignty, affordability and supply resilience, with international partners contributing to these efforts. This could include incentivising local and regional manufacturing, diversifying supply chains, implementing appropriate pricing policies and supporting technology transfer, including through voluntary licensing. These approaches can help shape markets and develop more cost-effective and resilient local and regional systems.

Global and regional pooled and strategic purchasing should also be institutionalised as important, currently underutilised access mechanisms within international financing discussions. By aggregating purchasing power across countries, these arrangements can improve affordability and supply, although their feasibility depends on strong legal frameworks, regulatory harmonisation and careful consideration of potential effects on national manufacturing. While complex to implement, pooled purchasing alone has demonstrated potential to reduce prices of medicines and medical devices by 50-90%, which would support LMICs in access delivery.

Not all these approaches will be appropriate for every health system. Ultimately, local and regional contexts will determine which solution is most beneficial, and a careful, evidence-based evaluation recommended by the GHA reform outcomes will be key to informing strategic policy planning and development.

4. Conclusion

Financing will test the credibility of GHA reform. **An architecture that is better coordinated but still continues to rely on vertical, disease-focused funding streams will fail to address current and future population health needs**. Workstream 3 should therefore recommend a series of linked shifts: aligning financing with epidemiological need; expanding sustainable domestic resource mobilisation through whole-of-government fiscal policy, including health taxes and subsidy reform, while supporting equitable transitions away from external funding; improving the predictability and effectiveness of international financing and developing the role of multilateral development banks; establishing collective financing for global and regional public health goods and essential functions; and using strategic access levers to deliver on commitments to essential NCD and mental health medicines, diagnostics and devices. Underpinning these shifts must be transparent, routinely published and disaggregated expenditure data, without which commitments cannot be tracked or held to account.

The measure of success is not only whether financing is more efficient, but whether it addresses the needs of the people and conditions that are currently left behind. NCDs and mental health provide a clear test case of whether GHA reforms genuinely achieve the paradigm shift that is needed towards integrated, country-led systems. If GHA reforms strengthen country ownership, and achieve integrated PHC, financing aligned with national needs, reduced vertical fragmentation and accountability for population outcomes, these conditions should become substantially better integrated without requiring creation of another vertical initiative.

ANNEXES

Paper 1 Annex

Integration of NCDs and mental health into global commitments (non-exhaustive)

Source	Commitment	Source
2023 Political Declaration on UHC	Recognize the importance of the prevention, treatment and control of non-communicable diseases and the promotion of mental health and well-being in contributing to a better quality of life, and the importance of addressing risk factors through promoting healthy diets and lifestyles, including regular physical activity, to prevent and reduce overweight and obesity;	2023 UHC HLM
2026 Political Declaration on HIV/AIDS	Recognize that reaching universal health coverage is central for an effective HIV response and commit to urgently integrate HIV services and HIV-related health and community systems with primary healthcare, including strengthening integrated care pathways, continuity of treatment and referral systems across different levels of care in broader health systems, programmes for sexual and reproductive health, maternal, child and newborn health, tuberculosis, pandemic preparedness, viral hepatitis, nutrition, **noncommunicable diseases**, sexually transmitted infections and **mental health**	2026 HIV/AIDS HLM
2021 Political Declaration on HIV/AIDS	90% of people living with HIV should have access to prevention, screening and treatment for noncommunicable diseases, including mental health conditions.	2021 HIV/AIDS HLM
Africa CDC	African Union Common Position | Non-Communicable Diseases, Injuries and Mental Health Launch of African Union Multisectoral Taskforce on NCDIMH	AU Common Position Press release – African Union Taskforce
Lusaka Agenda	Make a stronger contribution to primary health care (PHC) by effectively strengthening systems for health: GHIs more effectively support integrated delivery of services, aligned behind one national plan, and coherently invest in strengthening resilient health systems, including at community level, in order to meet individuals' holistic health needs and have public health impact.	Lusaka Agenda
2025 Political Declaration on NCDs and Mental Health	Target: at least 80 per cent of primary health care facilities in all countries have availability of World Health Organization-recommended essential medicines and basic technologies for noncommunicable diseases and mental health conditions, at affordable prices, by 2030.	2025 NCDs/MH HLM

2025 Political Declaration on NCDs and Mental Health	ensuring access to care for people in humanitarian settings and ensuring continuity of care for people during emergencies and prolonged movement;	2025 NCDs/MH HLM
2025 Political Declaration on NCDs and Mental Health	Promote measures to increase the number, capacity, retention and competencies, including cultural competency, of trained health care workers, to implement integrated primary health care for health promotion, prevention, screening, diagnosis, treatment, rehabilitation and palliative care for people living with or at risk of noncommunicable diseases and mental health conditions, including persons with disabilities, and to strengthen knowledge and skills related to the implementation of laws, policies, services and practices in the area of mental health;	2025 NCDs/MH HLM
2025 Political Declaration on NCDs and Mental Health	Target: at least 60 per cent of countries have financial protection policies or measures in place that cover or limit the cost of essential services, diagnostics, medicines and other health products for noncommunicable diseases and mental health conditions by 2030.	2025 NCDs/MH HLM
2025 Political Declaration on NCDs and Mental Health	Target: at least 80 per cent of countries have an operational, multisectoral, integrated policy, strategy or action plan on noncommunicable diseases and mental health and well-being by 2030.	2025 NCDs/MH HLM
2025 Political Declaration on NCDs and Mental Health	Target: at least 80 per cent of countries have an operational noncommunicable diseases and mental health surveillance and monitoring system, in line with national circumstances, by 2030.	2025 NCDs/MH HLM
2026 Political Declaration on PPPR	Express concern at the continued emergence and re-emergence of epidemic-prone diseases and recognize that pandemics have a disproportionate impact on developing countries as well as people living with co-morbidities, underlying chronic conditions, communicable and noncommunicable diseases, mental health conditions, older persons, people living in poverty, people living in rural areas, women and girls, children, Indigenous Peoples, local communities, people of African descent, migrants, refugees, internally displaced persons and persons with disabilities, as well as those in vulnerable situations, with repercussions on health and development gains;	2026 PPPR Declaration
NCDA Policy brief on access to medicines, diagnostics and devices	Summary of high-level commitments on access to NCD and mental health medicines and devices	Access brief

ASEAN Strategic Health Agenda (ASHA) 2026–2030	To reduce the burden of communicable and non-communicable diseases through prevention, health promotion, early detection, surveillance, and response through coordinated regional public health action.	ASHA Agenda
	SUPPORTING the regional aspiration to effective, integrated and resilient and people-centred health systems across AMS	ASEAN Joint statement
PAHO Strategic Plan 2026-2031	Intensify efforts to prevent diseases and premature death by taking action on risk factors and promoting healthy environments. This includes: i. Reducing modifiable risk factors for noncommunicable diseases, including all forms of malnutrition, through action on their determinants, intersectoral action, and community participation.	STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2026–2031
PAHO Strategic Plan 2026-2031	Strengthen integrated and person-centered care through the primary health care approach to boost and maintain health capacities and address communicable and noncommunicable diseases; vaccine preventable diseases; risk factors across the life course; sexual, reproductive, maternal, newborn, child, adolescent, and older persons' and migrant populations' health; and the social determinants of health.	STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2026–2031
PAHO Strategic Plan 2026-2031	Engage and empower communities in evidence-based risk reduction, preparedness, readiness, and response to health emergencies and disasters through efficient differentiated risk communication and community engagement strategies that strengthen feedback loops. Special attention will be paid to populations in situations of vulnerability that are often disproportionally affected by adverse events, such as women, children, Indigenous Peoples, people with disabilities, people living with noncommunicable diseases, older adults, people on the move, and other groups.	STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2026–2031
PAHO Strategic Plan 2026-2031	Outcome 3.1: Prevention and optimal management of noncommunicable diseases, mental health conditions, violence, and unintentional injuries accelerated and sustained Outcome 3.2: Prevention, control, and elimination of communicable diseases and related conditions accelerated and sustained	STRATEGIC PLAN OF THE PAN AMERICAN HEALTH ORGANIZATION 2026–2031
Global Fund 2023-2028 Strategy	"build the resilience and sustainability of systems for health through investments that drive impact against HTM and related conditions, including coinfections and **comorbidities**. We will seek to accelerate the shift from more siloed interventions to more **integrated, people-centered models** of prevention, treatment and care, so that individuals' holistic health needs are met.	Strategy
Unitaids/UGMH review of Global Fund	Practical recommendations to protect and scale evidence-informed and rights-based integrated systems, services and other interventions for addressing	Reveiw and mapping of

GC7 investments	comorbidities, including NCDs and mental health conditions. Guidance for shaping sustained partnership, strategic investment, and collective commitment to strengthen systems for health and enhance integrated service delivery.	GC7 investments
Global Fund GC8 Guidance	Deliver integrated HIV, TB, and malaria services through PHC outpatient departments, where appropriate—for example, acute care (including malaria) and **chronic care (including HIV, TB, and NCDs).**	GC8 Guidance
GAVI 6.0 (2026-2030)	Aims to vaccinate an additional 120 million girls between 2026-2030 (HPV)	WHO/Gavi; Gavi 6.0 guidelines
Unitaid	Proposals should also demonstrate how cervical cancer services will be integrated into primary health care, leveraging existing health platforms such as immunization, HIV/TB/NCD and maternal health	Unitaid call

Paper 2 Annex

Examples of global health instruments supporting multisectoral action

Relevant global public goods (international agreements, norms and shared frameworks), non-exhaustive:

Example	Multisectoral contribution	Relevance to GHA reform
WHO Framework Convention on Tobacco Control (WHO FCTC) & its Protocol to Eliminate Illicit Trade in Tobacco Products	A legally-binding public health international treaty addressing tobacco supply and demand and requiring the protection of public policy from tobacco industry interference. Its protocol provides a framework for international cooperation on supply-chain controls, law enforcement and illicit trade.	A strong example of global rules supporting action across health, finance, trade, customs, agriculture and other sectors.
Paris Agreement on climate change	Establishes a global framework for climate action, with major implications for air pollution, heat-related illness, food security and other health determinants.	Demonstrates the importance of linking health institutions to international governance processes whose primary mandate lies outside health.
UNECE Convention on Long-range Transboundary Air Pollution	Establishes a common regional framework for countries to cooperate on monitoring, assessing and reducing transboundary air pollution. Its protocols address pollutants and emission sources affecting human health and the environment, connecting environmental regulation with transport, energy, industry, agriculture and economic policy.	Demonstrates how regional agreements, shared scientific evidence, monitoring and common commitments can enable coordinated action on a transboundary determinant of health.
Codex Alimentarius	International food standards developed by the FAO/WHO Codex Alimentarius Commission to protect consumer health and facilitate fair practices in food trade.	Connects public health, food safety, agriculture, trade and international standard-setting.
UN Sustainable Development Goals (SDGs)	Provide shared objectives linking health with poverty, food security, education, gender equality, sustainable cities, climate and other determinants.	Offer a common political framework for cross-sectoral priorities and accountability, although they do not themselves establish operational coordination.

WHO International Health Regulations (IHR)	Establishes shared international obligations and capacities for detecting, assessing and responding to public health risks, requiring coordination across multiple sectors.	Illustrates the value of common rules and national capacities for managing cross-border health threats.
WHO's Fourteenth General Programme of Work (GPW14, 2025-2028)	Sets WHO's global health agenda for 4 years and explicitly calls for action on climate change and other health determinants and the root causes of ill health across sectors.	Provides a strategic mandate for integrating health considerations into policies beyond the health sector, aligning WHO's work with Member State priorities.
WHO Strategy on Economics of Health for All	Promotes an approach to economic policy that places population health and well-being at the centre of decision-making. It connects health with fiscal policy, public investment, financing, trade, industry, innovation and social protection	Demonstrates the importance of engaging finance and economic institutions, alongside health authorities, in shaping the conditions for health. It supports GHA reform by positioning health as a cross-government and whole-of-economy objective, rather than the sole responsibility of health ministries, and by highlighting the need for coordinated financing, policy coherence and accountability.
UN HLM Political Declaration on NCDs/MH	Establishes a renewed global political commitment to accelerate action on NCDs/MH, recognising the influence of health determinants, and including a target about the need to regulate and implement policies to support health promotion, etc.	Demonstrates how high-level political commitments can mobilise action across health, finance, education, labour, agriculture, trade and other relevant sectors.

Relevant existing cross-sectoral coordination mechanisms (non-exhaustive):

Example	Multisectoral contribution	Relevance to GHA reform
UN Inter-Agency Task Force on NCDs/MH (UNIATF)	Brings together 45 UN system agencies and intergovernmental organisations to support governments in implementing multisectoral NCD/MH responses.	A model for coordinating institutions across mandates and providing integrated support to countries.
WHO Global Coordination Mechanism on	A Member State-led platform for multistakeholder engagement, cross-sectoral collaboration, knowledge	A mechanism for connecting Member States, UN organisations and non-State actors, with an

NCDs/MH (GCM/NCD)	exchange and action on NCDs/MH. Its mandate has been extended to 2030.	opportunity to strengthen links to implementation and accountability.
AU–Africa CDC Multisectoral Task Force on NCDs/MH	Provides a regional coordination mechanism to engage relevant AU departments, institutions and partners and support multisectoral implementation.	Illustrates the regional coordination function needed to connect national priorities with continental strategies and facilitate cooperation across institutional mandates.
WHO FCTC Conference of the Parties and Secretariat	Supports treaty implementation, international cooperation and coordination with relevant intergovernmental organisations.	Demonstrates how an international instrument can create a sustained institutional basis for multisectoral action and protect public-interest policymaking.
WHO Health in All Policies (HiAP) initiatives and Global Network	Provides approaches, tools and capacity-building to integrate health considerations into policy decisions across government.	A source of implementation support that can be applied across countries and policy areas.
FAO/WHO Codex Alimentarius Commission	Coordinates international food standards through a joint FAO/WHO intergovernmental process.	Illustrates an established cross-sectoral standard-setting arrangement connecting health protection and food trade.
UN Food Systems Coordination Hub	Coordinates action to improve food systems in follow-up to the UN Food Systems Summit process and countries' national pathways.	Illustrates an established hub to deal with multifactorial food system challenges that should also include health considerations.
UN-Nutrition	Coordinates UN action on nutrition globally, regionally and in-country.	Illustrates an established mechanism that could be leveraged to ensure health, nutrition and food system policy alignment.

Relevant guidance and evidence (non-exhaustive):

- WHO Publication (2025): Governance for public health across the health and allied sectors: a report to guide country-level institutional capacity for essential public health functions underpinning multisectoral approaches

- WHO Publication (2025): Advancing multisectoral and multistakeholder actions on noncommunicable diseases: thematic issue briefs
- WHO Bulletin (2024): Multisectoral interventions and health system performance: a systematic review
- WHO publication (2023): Working together for equity and healthier populations: sustainable multisectoral collaboration based on health in all policies approaches
- WHO publication (2020): Multisectoral preparedness coordination framework
- BMJ Tobacco Control (2019): Impact of the WHO FCTC over the first decade: a global evidence review prepared for the Impact Assessment Expert Group
- BMJ Global Health (2018): Governing multisectoral action for health in low-income and middle-income countries: an agenda for the way forward
- European Observatory on Health Systems and Policies – Studies Series (2012): Intersectoral governance for health in all policies: structures, actions and experiences

Paper 3 Annex

Examples of global health instruments supporting NCDA recommendations for Workstream 3

Example	Financing contribution	Relevance to GHA reform
WHO Global Strategy on the Economics of Health for All (WHA Resolution)	Establishes that health is a long-term productive investment rather than a cost, demanding public financial management (PFM) reforms and Medium-Term Expenditure Frameworks (MTEFs) that protect health budgets from austerity.	Provides the core economic rationale for Workstream 3 to urge international financial institutions (IFIs) and ministries of finance to **integrate health funding into broader macroeconomic planning**.
Multilateral Organisation Performance Assessment Network (MOPAN) Principles	Focuses on shifting international development assistance away from fragmented vertical projects toward nationally owned, country-led financing channels.	Supports GHA reform demands to **align external development assistance with national priorities** and eliminate donor duplication in country-level NCD/MH programming.
The WHO Framework Convention on Tobacco Control (WHO FCTC) & Article 6	Mandates specific tax and price measures on tobacco products as an explicit mechanism to reduce consumption while generating sustainable public revenue.	Serves as the international legal precedent proving that **health taxes can be successfully institutionalized** across global and national legal frameworks to fund public health.
The 2024 / 2026 World Health Assembly Resolutions on UHC and Financial Risk Protection	Reaffirms global commitments to reducing catastrophic out-of-pocket health spending (SDG indicator 3.8.2) through predictable, publicly financed primary health care packages.	Directs GHA Workstream 3 to **prioritize financial risk protection** mechanisms specifically designed to **shield households from chronic disease impoverishment**.
The Paris Agreement on Climate Change & Health Nexus Declarations	Connects environmental and climate financing commitments to public health resilience, highlighting how cross-sectoral funding avoids overlapping health and climate crises.	Supports arguments for **whole-of-government fiscal strategies** (such as eliminating fossil fuel subsidies) to simultaneously free up macroeconomic space for health.