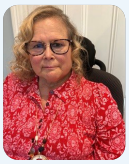
# Navigating uncertainty: NCDs in a new era of global health

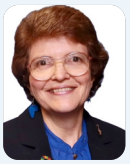
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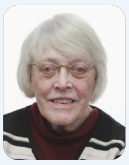

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This article updates "The 2025 UN High-level Meeting on NCDs and mental health: The art of negotiation", published in Cancer Control 2025. It explains the challenges facing implementation of the Political Declaration that accompanied the High-level Meeting, within the context of a rapidly changing world as reflected in the ongoing discussions on reform of the structures and financing of global health. Positioning NCDs at the heart of this reform is a core challenge for all advocates of better cancer prevention and treatment.

## Setting the scene

Cancer is one of the five main conditions that the World Health Organization (WHO) includes within its NCDs agenda, alongside cardiovascular disease, diabetes, chronic lung disease and mental health conditions. These commonly share five major risk factors: unhealthy diet, tobacco use, physical inactivity, alcohol use and air pollution.

The fourth UN High-level Meeting (HLM4) on Non-communicable Diseases (NCDs) and Mental Health, held in 2025, brought together governments to secure commitments, build political will, and attract increased funding *(1)*.

The article last year set out the process leading up to HLM4. The accompanying Political Declaration on NCDs and Mental Health (PD) *(2)* was negotiated amid fiscal pressures, geopolitical tensions and sustained commercial lobbying, which led to the weakening of commitments on prevention, risk-factor regulation, accountability and equity. Securing its approval was a significant achievement in an increasingly contested global health environment, and civil society played a vital role in ensuring that the final PD retained a meaningful baseline of ambition.

This article brings things up to date, discussing the challenges in making the PD a reality and the changes in wider global health that will have repercussions for NCDs including cancer.

## Progressing the Political Declaration: Slow steps forward

The months immediately following HLM4 were critical. The PD was expected to be adopted by consensus in September 2025, but last-minute objections from the United States and Argentina meant it was referred to the UN General Assembly for a formal vote. In December, it was adopted with overwhelming Member State support, showing that objections were isolated and that broad global commitment to action on NCDs and mental health remains strong.

The PD is the first to address NCDs and mental health together and includes new global targets to be achieved by 2030: reducing tobacco use, improving hypertension control and expanding access to mental health care. However, it has also been criticised for leaving several areas of comprehensive NCD care weakly addressed or largely neglected. These gaps matter because effective prevention, treatment, care and long-term support require a broader health-system response than the PD fully reflects (see Box 1). The PD is not the ceiling for ambition. Instead, it is a foundation for integrated, equitable action throughout life.

Advocacy since HLM4 has continued to underline the importance of ensuring governments translate global commitments into equitable, inclusive national policy and financing. Momentum carried into the 79th World Health

Assembly (WHA) in May 2026. Obesity and mental health featured more prominently on Member State agendas, and prevention was discussed more frequently, though often at a conceptual rather than operational level. Health should be considered an investment and not a cost: that "health is wealth" was reflected in WHA's adoption of the Economics of Health for All strategy *(3)*.

Lessons can be drawn from this year's HIV High-level Meeting, where community leadership, rights-based approaches and accountability took centre stage *(4)*. Meaningful engagement of people living with and affected by HIV is central, as it has been for many decades. The NCD agenda should draw from this model: communities and civil society must be resourced not only as advocates, but as essential partners in service delivery and accountability.

Moving from commitments to investment to implementation to impact is now the question civil society must keep pressing – within health, and increasingly, beyond it.

## Taking NCDs forward

### *Global NCD processes*

A forthcoming crucial step is the Third International Dialogue on Sustainable Financing for NCDs and Mental Health, due to be held in Manila in February 2027 (postponed from September 2026 to allow the Philippine Government more time to prepare) *(17)*. For governments, this Dialogue is the "how" to the Political Declaration's "what": it has been described by the Philippine Government as the "structure" to deliver on the HLM, and the aim is for it to deliver a series of practical steps to ensure robust financing for addressing countries' NCD burdens. A "Manila Declaration" is proposed, which will be a recommitment to UHC, financial protection and equitable access to services. It also hopes to expand on the PD by including opportunities presented by the loss of patent-protection for multiple high-impact medicines (including GLP-1s). A regional compact on improving countries' access to health products and services is planned, along with a Sustainable Financing Toolkit, and a range of country commitments on implementation and reform.

But the continuing marginalization of civil society is a concern – and one can but hope that the postponement of the Dialogue is taken as an opportunity for better inclusion of civil society and people living with NCDs. The global NCD community continues to have a critical role to play in holding governments accountable for their commitments – but this remains challenging if non-governmental voices are largely excluded from these important policy processes.

Another important moment for NCDs will be the Third HLM on Universal Health Coverage in 2027 *(18)*. At a time of seismic shifts within global health, this is likely to be a heavily contested Political Declaration – but with the growing burden of NCDs globally, it is crucial that gaps in NCD care are closed, preventive measures are scaled up, and NCD services are properly integrated within primary healthcare. A UHC PD that sets the tone for governments' priorities into the 2030s cannot afford to neglect NCDs.

**Box 1: What is missing? Persistent gaps in the NCD agenda**

**Several key areas remain insufficiently integrated within the Political Declaration and the NCD agenda more broadly.**

- **Mental health** continues to face chronic underfunding and limited-service capacity *(5)*.
- **Oral health** is critical to overall health and well-being, but is often neglected and health systems are not able to provide the care needed. The impacts and costs of poor oral health are felt most acutely by those living in marginalized communities, but prevention is low-cost and effective *(6)*.
- The population of people living with **advanced HIV disease (AHD)***(7)* is ageing and living with varying degrees of impaired immune functioning *(8)*. HIV has long been associated with certain cancers, and there is now increasing multi-morbidity and overlap of chronic care needs between AHD and conditions such as diabetes, heart failure, dementia and chronic lung disease.
- **Rehabilitation** is essential for maintaining function and quality of life, and **palliative care** is critical for people living with advanced or life-limiting conditions. More than three-quarters of the global need for both is in low- and middle-income countries, where fewest services are available. An estimated 2.4 billion people could benefit from rehabilitation *(9)* and over 73 million patients could benefit annually from palliative care services *(10)*, including more than 10 million children *(11,12)*.
- The management and impact of **pain** is a major problem as 80% of countries have such overly restrictive limitations on the use of pain relief that it is unavailable *(13)*.
- **Meaningful engagement of people with lived experience** remains poor across the whole of NCDs and mental health *(14)*.
- **Commercial determinants of NCDs** remained a serious and under-addressed concern. Health-promoting (and NCD-preventing) fiscal and cost-effective "Best Buy" policies (for example, on sugar-sweetened beverage taxes) were diluted or removed entirely in the final PD *(15)*, and language such as to "encourage" or "consider" some key policies was used, rather than "commit". Health-harming industries lobbied and sought meetings with governments throughout the negotiation process, and the final version of the PD seems in places to favour protection of the profits of these industries over that of public health. This is not new. The previous three HLMs on NCDs policies on alcohol, tobacco and unhealthy foods had the lowest levels of implementation, and one-third of these policies was reversed *(16)*.

### *Changes in the structures and funding of global health*

Beyond NCDs, the geopolitical shifts that have seen defence

**Box 2: An Africa-led agenda**

Two recent transformation efforts have had their genesis in Africa and are having a powerful influence on the direction of travel in global health. The Lusaka Agenda (2024) is the output of a series of consultations on ways to reshape the financing of global health *(21)*. It includes calls for the major global health institutions to strengthen their support for integrated primary care (going beyond their traditional silos) and for a transition towards domestic resourcing for health. The Accra Reset (2025) focuses on external development assistance more broadly (with health as a vital starting point), calling for a shift from the aid model to an investment model *(22)*.

spending prioritized at the expense of development assistance have led to a steep decline in donor contributions. This is forcing a complete rethink of the funding and structures of the global health architecture (GHA) – namely, the roles of different health agencies, their governance structures and how they are financed. The current GHA was developed in an era in which infectious disease and childhood and maternal health were principal health concerns. The Sustainable Development Goals recognized in 2016 that this focus was too narrow (including an SDG target on NCDs), but the surrounding GHA has not yet adapted to changing epidemiology and demographics. NCDs should be at the heart of the GHA – but have, to date, been under represented.

Now, however, the world is being forced to do more with less. Providing assistance on only one disease at a time is not cost-effective and does not effectively benefit those most in need. Instead, integration must be at the heart of any reforms. This approach was strongly highlighted in the PD – although it fell short of its promise by setting a process target for mental health (access to care) and outcome targets for NCD risk factors, when the aim should be true integration of prevention and care across the lifecourse *(19)*.

There are several responses to the crisis running in parallel (see also Box 2). At the level of UN agencies, a WHO-coordinated Joint Task Force (comprising governments (including the UK), UN agencies and the major funders – but with no formal seat at the table for civil society) is developing a process for a new approach to global health *(20)*.

This is a crucial moment: how the cards fall will dictate how NCDs fit into funding and global structures for years to come. But many questions remain to be answered:

- Will reform be the needed root-and-branch changes, or merely tweaking of existing systems?
- Will power and decision-making be re-situated with national governments rather than with donors?
- Will health funding be rebalanced towards areas of greatest need – including, increasingly, NCDs and mental health?
- Crucially, how will the views and voices of civil society and people with lived experience be included, both within the ongoing processes and within the final, reformed architecture?
- Decisions should be made with input throughout from those whose lives depend on those decisions – among them, the millions of people living with and at risk of NCDs including cancer.

**Box 3: What can you do?**

- **Stay informed and stay connected.** There are international networks that exist to keep implementation moving when the global picture stalls. In the UK and beyond, these include the NCD Alliance, the UK Working Group on NCDs, the UK-Ireland Global Cancer Network, HearCSO, and the Global Mental Health Action Network. Whatever your role – clinical, research, policy – use it: HearCSO's regular surveys and consultations, GMHAN's Advocacy Roadmap *(23)* and evidence such as the new WHO Global Status Report on Cancer *(24)*.
- **Build on existing lived experience expertise,** in which cancer and mental health both have strong traditions. The harder task is a collective one. NCDs are a disparate group of diseases, and advocacy that speaks with one voice does not assemble itself. We now have a strong guide: the WHO Framework for Meaningful Engagement *(14)*. Press for lived-experience representation on boards, task forces and government delegations, and remember that the power for securing a seat cannot rest with people traditionally excluded from decision-making.
- **Make your voice heard.** Locally, within your community, or through international campaigns such as World Mental Health Day, Universal Health Coverage , World Hospice and Palliative Care Day and the annual Global Week for Action on NCDs *(25)*.
- **Finally, integration is not only a policy demand.** Cancer, for example, rarely arrives alone; it comes with comorbidities, including other NCDs, and takes a toll on the mental health of patients and families. To the extent possible and appropriate, protect the factors that matter – movement, good nutrition, connection, not smoking or drinking alcohol – in the systems that we run and in our own lives. Those of us in the sector should lead by example. Every family is touched by NCDs. This is not someone else's agenda. It is everyone's business – and it starts, quietly, with us.

## The future of NCD advocacy

The PD hands the NCD and cancer communities a real lever for advocacy. It also arrives in a fracturing world, with donor commitments cut, health systems at risk of backsliding and multilateralism itself being renegotiated. The Declaration is only as strong as the implementation behind it, and the political weather is against progress.

The honest response is neither despair nor toxic positivity.

Advocates should concentrate on what we have and get it implemented, including guarding against the pessimism that paralyses: aspiration and realism are not opposites here. And the real work will be in the accountability. The PD's targets are new, but the older ones are already being missed, and national targets matter as much as global ones. The next Financing Dialogue has produced commitments; the question is who returns to them in three years and asks what was delivered. That is a role that belongs to everyone in our field (see Box 3). ■

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