Political Declaration of the High-Level Meeting on NCDs and Mental Health
NCDA Priority Asks – Rev.3
6 August 2025

Introduction

NCD Alliance expresses its concern and regret that Member States have weakened and watered down the Political Declaration across several areas where action is needed to reach SDG 3.4.

We urgently call upon Member States to:

- Support the global targets
- Reinstate strong language and the target on fiscal measures
- Reinstate proven, cost-effective NCD prevention policies.

Comments on **four additional areas of concern (social participation, air pollution action, financing and financial protection, and access to diagnostics, medicines and other health technologies)** are also provided.

We urgently call upon Member States to:

Support NCD targets to 2030 and beyond

Ref: Paragraphs 40,49, 51-52, and the targets under each subheading

We welcome the retention of the fast-track targets but are deeply concerned about the weakening of the tracer targets and the removal of references to the 2030 targets in the text.

Global targets & accountability

NCD Alliance views the **fast-track** and **tracer targets** outlined in the draft text of the Political Declaration as important benchmarks contributing to achieving the 2030 targets, and **we strongly encourage Member States to retain them to drive progress and improve accountability**. Such clear targets would accelerate implementation toward UHC, strengthen health systems, and deliver significant economic returns.

We also encourage reference to the WHO Global Monitoring Framework on NCDs as a foundation for accountability and to support its further development.

Retaining these clear targets delivers on the High-Level Meeting's (HLM) Modalities Resolution mandate for an "action-oriented political declaration with a shared vision to mobilise political will" and its proposal of "consideration of measurable global targets and objectives" (A/RES/79/58 paragraph 5).

Tracer targets

- **Health promoting environments:** We urge reinstatement of the zero draft's active commitments to implementation of taxation on tobacco, alcohol and sugar-sweetened beverages (SSBs) - all WHO-recommended, cost-effective measures (see below). The Rev.3 proposed target of "80% of countries have policies and legislative, regulatory and fiscal measures to support health objectives" is so broad and unspecific that it would not drive the level of progress needed to meet agreed 2030 targets.
- **Primary health care**: We welcome the retention of this target on availability of WHO-recommended essential medicines in 80% of primary health care facilities, and improvements to the text: the

removal of the limitation to only “public” PHC facilities, and the reintroduction of “at affordable prices” and of the specific mention of mental health conditions.

- **Sustainable financing:** We are deeply concerned by the reduced ambition—from 80% to 60% of countries —which significantly weakens global commitments on financial protection policies.
- **Strengthen governance:** We note that the new governance target is a commitment carried over from earlier HLM outcome texts that adds little to driving progress. The previous drafts’ commitment to 80% of countries having integrated NCD and mental health into national preparedness and response frameworks would represent significant progress reflecting the experience of health emergencies and the evolving poly-crisis since the 2018 HLM.
- **Data, surveillance and accountability:** We welcome the return to an ambition of 80% of countries having an operational surveillance and monitoring system.

Reinstate strong language on fiscal measures

Ref: Paragraphs 43, 64, health-promoting environments target

The removal of a specific target on fiscal measures (above) and the weakening of the language and omission of sugar-sweetened beverage taxes in paragraph 43 undermines the commitment to proven, impactful, and widely supported health tax policies that could significantly benefit public health and national economies.

“*Consider* introducing or increasing” is passive and not only fails to follow through on the intention of delivering an ambitious yet actionable text, but also puts into question the value of proven, evidence-based, and cost-effective policies.[1] The removal of a commitment to tax sugar-sweetened beverages further exacerbates these concerns.

Taxes on tobacco, alcohol, and sugar-sweetened beverages have proven to be a highly impactful measure for public health and the economy, are popularly supported by the public,[2] and have been widely implemented at the national level. To date:

- 183 countries already have national cigarette taxes; however, only 40 countries implement these at WHO's recommended levels (≥75% of retail price);[3]
- 148 countries have implemented alcohol taxes at the national level;[4]
- 132 countries have adopted levies on sugar-sweetened beverages (SSBs).[5]

Last year, the Bloomberg Task Force on Fiscal Policies for Health found that if all countries increased their excise taxes to raise prices of tobacco, alcohol, and sugary beverages by 50%, it would generate US$3.7 trillion in additional revenue over five years. Of this, US$2.1 trillion would be raised in low- and middle-income countries (LMICs).[6]

We therefore urge Member States not to miss the opportunity to unlock the full **potential of health taxes to benefit both population health and national economies**. We call for:

- A strengthened para 43 that commits to "implement or increase" health taxes (rather than "consider"), including an explicit reference to taxes on SSBs. To ensure these taxes achieve their full health impact, we recommend specifying again that they be implemented "as recommended by the World Health Organization."
- Explicit inclusion of “health taxes” within the health-promoting environments target.

---

[1] Background about the cost-effectiveness analysis of these measures can be found here for tobacco taxes, alcohol taxes, and SSB taxes;

[2] For example a 2022 Gallup Poll found that a majority of people surveyed across several countries favored higher taxes on alcohol, tobacco, and SSBs.

[3] WHO report on the global tobacco epidemic, 2025

[4] Global Report on the use of alcohol taxes. WHO, 2023.

[5] Health Taxes: A compelling policy for the crises of today. 2024.

[6] Ibid.

We strongly welcome the reference to fiscal measures in para 64. We urge Member States to retain this reference as a concrete example of domestic resource mobilisation, in alignment with para 27(j) of the Seville Commitment on Financing for Development.

Reinstate proven cost-effective NCD prevention policies and safeguard policymaking from conflicts of interest

Ref: Paragraphs 12, 13, 15, 16, 20, 22, 27, 35, 36, 39, 41, 42, 43, 44, 45, 46, 56, 64, 81, health-promoting environments target

The health-promoting environments section has been significantly weakened, with many of the cost-effective 'best buy' prevention policies/measures entirely removed or diluted. The current draft of the declaration aligns more with the interests of health-harming industries than public health.

We welcome the inclusion of "commercial and market factors" in para 42. However, NCDA remains concerned about the significant weakening of language committing to the comprehensive legislation and regulation required to reduce the risk factors of tobacco and alcohol use, and unhealthy diets. These concerns include:

- Removing SSBs from being subject to health taxes [para 43];
- Deleting the specific reference for health warnings on tobacco packages to be graphic and accompanied by plain/standardised packaging [para 44(a)(i)];
- Weakening language on tobacco advertising, promotion, and sponsorship by mentioning restrictions rather than comprehensive bans [para 44(a)(ii)];
- Changing language on food reformulation to only address "excessive limits" and reduce as possible industrially-produced trans fats (iTFA) rather than aligning with WHO's best practices to eliminate iTFA [para 44(e)(ii)];[7]
- Referring to front-of-pack labelling as an example to deliver nutritional information rather than a necessary measure [para 44(e)(iii)]; and
- Removing specific commitment to the 'best buy' alcohol policies, such as drink-driving restrictions [para 44(f)], when other risk factor sections outline their corresponding 'best buys'. This signals a diminished prioritisation of effective alcohol policies and is suggestive of alcohol industry interference in this policymaking process, although we note and welcome the reintroduction of the mention of marketing and availability measures.

The interests of health-harming industries do not align with public health goals. In this context, we welcome the increased reference to **preventing conflicts of interest** and encourage consistency throughout the document. References to the engagement of the private sector should consistently specify "relevant" private sector (paragraph 27). Without safeguards to protect policymaking from vested interests, efforts to create health-promoting environments will remain limited and vulnerable.
The **NCD movement is not anti-business**. On the contrary, we encourage relevant private sector to continue to innovate and contribute constructively to the health and well-being of populations, in line with the whole-of-society approach. Preventing and controlling NCDs through evidence-based policies, such as fiscal measures and marketing restrictions, not only improves health outcomes but also yields significant economic dividends.[8]

[7] iTFA elimination at best-practice level is already implemented in over 60 countries. Read more on Safeguarding Global Nutrition Commitments in the Political Declaration on the 4th UN High-Level Meeting on NCDs.
[8] Read more about how the NCD response contributes to the economy and social equity despite industry arguments on Dispelling Industry Myths on NCDs.

We further recommend:

Committing to social participation and the role of civil society

Ref: Paragraphs 27, 29, 46, 57, 70(iv), 81

We express concern that prior suggestions to strengthen language on social participation have not been retained. Notably, **civil society is only referenced once** within the text (paragraph 27). We encourage Member States to recognise, support, and enhance the crucial role civil society plays to raise awareness, provide services, promote knowledge, and support implementation and accountability of the NCD response, as per paragraph 42 from the 2018 Declaration. Reinserting language that continues to recognise and advance civil society's expertise and role is important to prevent backsliding from the 2018 HLM commitments.

NCDA welcomes the retention of language recognising the important role people and communities with lived experience can play when engaged in the development of national NCD plans. We are disappointed, however, by the change in language in paragraph 70 (iv), which misses the opportunity to strengthen social participation language and recognise the importance of language such as "developed with", which emphasises the co-creation role lived experience can play throughout the development of national plans and policies. We encourage reversion to the stronger language previously proposed. NCDA also welcomes the retention of language that acknowledges the unique experiences and expertise of people living with NCDs, as well as references to families and caregivers (paragraph 29).

We further encourage Member States to consistently reference equity and rights-based language concerning communities, people with lived experience, and civil society, notably in paragraph 70(iv), which removes reference to rights-based approaches completely.

Acting on air pollution by linking it with fossil fuels and climate change

Ref: Paragraphs 12, 13, 21, 42, 44(g), 46, 72

We welcome the acknowledgment of air pollution as a major NCD risk factor, the extent to which populations are over-exposed, and its impact on mortality in the preambular section. We also welcome the broadened scope of actions to address this public health emergency, including the promotion of active mobility and the regulation of polluting industrial sectors, vehicles, engines, fuels, and consumer and commercial products.

However, to ensure real progress on air quality and NCD prevention, we urge Member States to strengthen paragraph 44(g) by explicitly re-focusing it on air pollution, which remains an often-overlooked but critical risk factor that causes over 8 million deaths annually. Broader environmental determinants of health should be addressed in a separate sub-paragraph to avoid diluting the urgency of targeted action on air pollution. In particular, we recommend **specifying fossil fuels** (rather than the general term "fuels") as the primary source of air pollution. Targeting this major driver is essential to achieving the global goal adopted this year of a 50% reduction in mortality from human-generated air pollution by 2040. We also encourage the reintroduction of low- and zero-emission zones to reduce exposure to air pollution.

To accelerate action on this critical issue, under 44(g), we further recommend adding a commitment to adopting air quality standards in alignment with the WHO air quality guideline level, and to consider phasing out fossil fuel subsidies. We also urge Member States to reinstate climate change as a major environmental determinant of health in para 42 and under current para 44(g) by specifying that healthcare systems must be "climate-resilient". Omitting this would overlook one of the major root causes of health vulnerabilities.

Increasing financing and delivering financial protection

Ref: Paragraphs 60, 67, 69, target

We express concern at the continued weakening of ambition to take meaningful action to **reduce prices and out-of-pocket health expenditure (OOPE) and introduce financial protection measures for NCD medicines**, **products, and services** (paragraph 69). In many LMICs, OOPEs are a significant proportion of total health spending, often rivalling or surpassing public spending. With average costs per facility visit twice as high for NCDs compared to infectious diseases[9] and the long-term care and associated costs of chronic conditions, we can safely assume that out-of-pocket costs for NCDs can be attributed to the impoverishment of many of the 100 million people driven into poverty from health spending each year.

We recommend that Member States return to the language used in earlier drafts for the heading on financing, which calls for a mobilisation as well as an **increase** in financing. NCDs, including mental health, are severely underfunded, and the mobilisation of existing resources is insufficient to address the scale of the challenge. In this vein, the NCD Alliance urges the inclusion of NCDs in paragraph 67 alongside mental health, which will help to ensure that resources and technical assistance are scaled for all conditions recognised by this text.

We also express significant concern about the deletion of paragraph 67 in the previous draft. Medicines are a significant proportion of the cost to health systems, and an important topic to be included in financing discussions to ensure appropriate use of funds. We also note that "strategic purchasing agreements" has been removed and only "strengthening procurement" retained, which narrows the scope. We note that the responsibility of price transparency also sits with suppliers and producers, as noted in Rev2 paragraph 67, which should be specified in paragraph 60.

Implementing policies and technical tools to expand access to essential NCD medicines, diagnostics, and other health technologies.

Ref: Paragraphs 30, 31, 49-58, 60-63, target

NCD Alliance strongly supports efforts to **improve access to essential NCD medicines, diagnostics, and other health technologies.** We further recommend retaining strong language that (a) ensures improved health equity by highlighting the importance of using the most effective and appropriate interventions for NCDs (e.g. protecting current language for paragraphs 49-58 and reinstate Rev 1 language for specific interventions [paragraphs 49-55] and global targets for 2030 on diabetes [paragraph 50], cervical cancer [paragraph 52]) in line with WHO recommendations, and (b) supports improved access, both availability and affordability, to the most appropriate health products by protecting **the target on access to affordable essential medicines**, and language in paragraphs 60-63, especially on pricing policies, price transparency, and strengthening financial protection mechanisms through health benefit packages. We warmly welcome the new paragraph 63 on intellectual property rights, reaffirming the TRIPS Agreement and Doha Declaration.

[9] Haakenstad AM. Out-of-Pocket Payments for Noncommunicable Disease Care: A Threat and Opportunity for Universal Health Coverage [Internet]. Harvard T.H. Chan School of Public Health; 2019. https://dash.harvard.edu/entities/publication/aff66f7d-be86-497f-a4da-f71490d00175