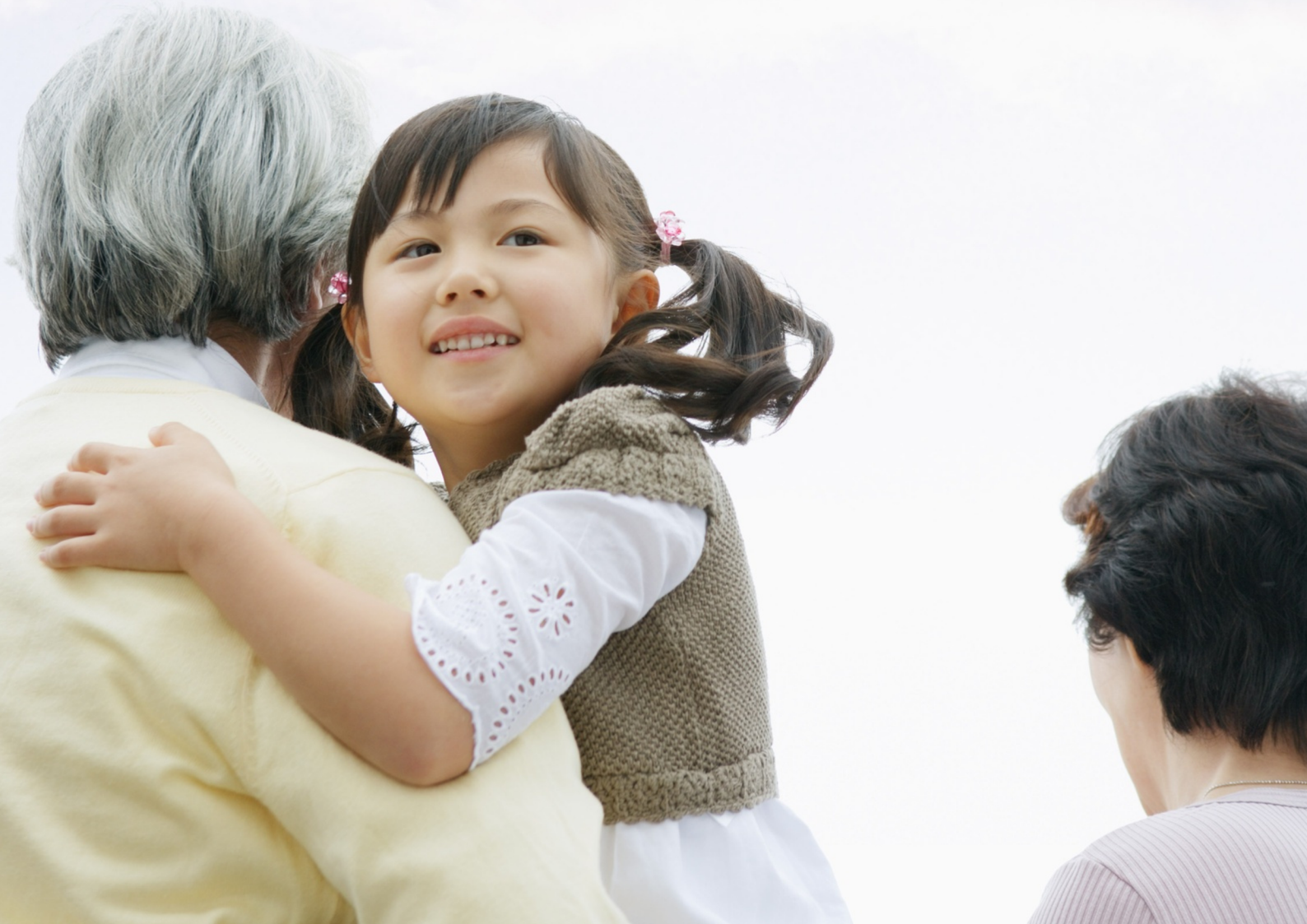
UNITED TO MAKE NEUROLOGY A GLOBAL HEALTH PRIORITY

Ensuring Neurological Conditions are a Distinct Pillar in the NCD Response

OneNeurology Partnership Position Paper for the 2025 UN High-Level Meeting on NCDs and Mental Health



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Neurological conditions are the leading cause of disability and the second leading cause of death worldwide. Yet they remain overlooked in global NCD responses. The 2025 UN High-Level Meeting is a chance to change that.

Our key asks to the WHO, Member States, and the UN system:

- **Name neurological conditions as a priority NCD in the Political Declaration** and make concrete commitments to address their burden.
- **Invest political and financial capital** in aligning the implementation of the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders with efforts on NCDs.
- **Collaborate with the neurology community**—including people with lived experience—to design integrated and cost-effective care pathways and policies.

Proposed Language for the 2025 Political Declaration:

The OneNeurology Partnership recommends the inclusion of specific language in the HLM Political Declaration. Below are key elements that Member States could incorporate (in line with agreed wording from prior documents or new commitments):

- *"We **recognize** that neurological conditions are among the leading causes of disability and death worldwide and reaffirm that mental health and neurological conditions must be integral parts of national NCD responses. We therefore commit to integrate the prevention, early diagnosis, treatment and care of neurological conditions throughout the life course, alongside mental health conditions, into our NCD strategies and Universal Health Coverage benefit packages, moving towards a comprehensive 5x5 NCD framework."*
- *"We **welcome** the adoption of the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders (2022–2031) by the World Health Assembly and **resolve** to implement it, in synergy, with national efforts on NCDs. We call upon the WHO and partners to support countries in executing the IGAP and its accompanying technical tools. We **urge** Member States to allocate resources to achieve IGAP's global targets by 2031."*
- *"We **commit** to mobilize adequate and sustainable financing for NCDs, including dedicated attention to neurological conditions and mental health. This includes strengthening health budgets, exploring innovative financing (domestic and international), and ensuring that official development assistance and philanthropic funding for health address the full breadth of NCDs, including neurology."*

- *"We **resolve** to improve equitable access to essential diagnostics, medicines, vaccines, and technologies for all NCDs – including those needed for neurological conditions. By 2030, we aim for all countries to include essential neurological medicines on national lists and for at least 80% of primary health care facilities to have them available, as per WHO's roadmap[1]. We will strengthen the health workforce and infrastructure to deliver quality neurological care in all age groups, from prevention and acute care to rehabilitation and palliative services."*

- *"We **emphasize** the importance of respecting and promoting the rights and dignity of people living with NCDs, including mental and neurological conditions. We will enhance social and legal protections, eliminate stigma and discrimination, and ensure the **meaningful participation** of those affected in decision-making at all levels. We recognize the role of civil society, patient organizations, and community groups in advancing these goals and will partner with them to implement this agenda."*

Such text would anchor neurology in the political declaration. We note that including specific references (like IGAP) would mirror how previous declarations referenced other global strategies (e.g., the inclusion of Appendix 3 of the WHO Global NCD Action Plan in prior text). It is important that, at a minimum, **'neurological conditions' appears wherever NCDs and 'mental health' are mentioned** in the document to solidify the linked but distinct nature.

I. INTRODUCTION AND HIGH-LEVEL MEETING CONTEXT

In September 2025, world leaders will convene in New York for the 4th UN High-Level Meeting on NCDs – now expanded to include Mental Health. This meeting arrives at a critical inflection point for global health. Progress on NCDs has been **uneven and insufficient**: as of 2023, only 19 countries are on track to meet Sustainable Development Goal target 3.4 on NCD mortality reduction. Meanwhile, new challenges and insights have emerged since the last HLM in 2018. Notably, **neurological conditions** – long under-recognized in global NCD discussions – have been spotlighted by recent data as a leading cause of global morbidity and mortality[2]. The World Health Organization's adoption of the Intersectoral Global Action Plan (IGAP) on Epilepsy and Other Neurological Disorders in 2022 signalled a turning point, affirming that neurological health is integral to the NCD agenda.

However, current political commitments do not yet fully reflect this reality. The 2018 Political Declaration on NCDs did include an important clause recognizing that *"mental disorders and other mental health conditions, as well as neurological disorders, contribute to the global burden of NCDs"*[3]. This was a significant achievement – effectively broadening the NCD focus from the traditional four diseases (cardiovascular diseases, cancers, chronic respiratory diseases, diabetes) to a **"five-by-five" framework** that adds a fifth category of conditions (mental and neurological) and a fifth risk factor (air pollution). Yet, in practice, implementation has remained **4x4-dominated**: many countries' NCD strategies still omit neurological disorders, and funding and initiatives for NCDs typically prioritize the original four disease groups. Moreover, the uneven implementation of even the original 4x4 framework has consequences for brain health, as unmanaged risk factors like hypertension, diabetes, and alcohol use contribute to rising rates of stroke, dementia, and other neurological disorders. Preventive care for NCDs such as diabetes, hypertension, and hypercholesterolemia — which are major risk factors for stroke and vascular dementia — remains insufficient in many countries. Strengthening these efforts would not only improve cardiovascular outcomes but also significantly reduce the burden of neurological conditions.

Mental health has started to gain dedicated attention (e.g. the 2020 WHO Mental Health Action Plan extension and the inclusion of mental health in UHC discussions), but **neurological conditions are often conflated with or overshadowed by mental health**. The OneNeurology Partnership – a collective of global organisations from patient advocates and clinicians to researchers and professional societies – is advocating for the 2025 HLM to explicitly address this gap. We call on Member States to **make neurological conditions a clear priority in the Political Declaration and ensuing actions**, distinct from but complementing mental health efforts.

This position paper outlines the rationale, proposed language, and recommendations to achieve that goal. It draws on the language of previous UN political declarations (2018 NCDs, 2019/2023 UHC, etc.), WHO's IGAP and toolkit, the NCD Alliance's 2025 recommendations, and inputs from the global neurology and mental health advocacy communities. We aim to equip negotiators and decision-makers with concrete text and evidence to elevate neurology within the NCD narrative, ultimately improving outcomes for billions of people and advancing the 2030 Agenda.

II. BURDEN OF NEUROLOGICAL DISORDERS: A CRISIS IN SLOW MOTION

Neurological conditions are a leading – and growing – driver of death and disability worldwide.

According to the Global Burden of Disease data (2021) analyzed in *The Lancet Neurology*, more than **3.4 billion people** suffer from neurological disorders, which cause **over 10% of global DALYs** and were the cause of **9.0 million deaths in 2016**[4]. This makes neurological conditions the **#1 cause of disability-adjusted life years (DALYs)** and the **#2 cause of death** globally, second only to cardiovascular diseases[4]. For context, stroke alone – a neurological condition – is the second leading single cause of death and a leading cause of long-term disability. Other major contributors include dementias, meningitis, epilepsy, Parkinson's disease, encephalopathy in newborns, migraine and headache disorders, among others[2].

Many sleep disorders—such as narcolepsy, REM sleep behavior disorder (RBD), restless legs syndrome (RLS), circadian rhythm disorders, and insomnia, to some extent—are increasingly recognized as prevalent neurological conditions with substantial public health implications[12]. Poor sleep health not only worsens neurological diseases like epilepsy, stroke, and dementia but may also serve as an early symptom or risk factor for their onset. Nevertheless, sleep disorders remain underdiagnosed and inadequately addressed in responses to noncommunicable diseases (NCDs).

Notably, many neurological disorders are chronic and disabling rather than immediately fatal, which is why they dominate disability statistics. The overall burden (DALYs lost) due to neurological conditions has grown by 18% since 1990[2], even as age-standardized rates have modestly decreased; population growth and aging are driving absolute numbers up[2].

Many of the most prevalent and disabling neurological conditions — including stroke, epilepsy, dementia, Parkinson's disease, and migraine — are widely recognised as noncommunicable neurological diseases. The World Federation of Neurology has called for these conditions to be addressed through the global NCD response, highlighting their chronic nature, shared risk factors, and long-term health and economic impacts[13]. Recognising these conditions as part of the NCD framework is not only accurate — it is necessary to ensure they are no longer overlooked in policy, funding, and implementation.

Neurological conditions are the fastest-growing cause of NCD mortality.

The NCD Countdown 2030 report highlighted that neurological disorders had the poorest trends among NCDs. Between 2000 and 2016, the risk of dying from a neurological disorder (before age 80) *increased* in over half of all countries, unlike the decline seen for many other NCDs[5]. This made neurology the **fastest-growing cause of death within NCDs**[6]. If these trends continue, neurological disorders will impose an even greater burden in coming decades; projections indicate a ~50% jump in neurological DALYs by 2040[7]. For example, the number of people living with Parkinson's disease has more than doubled from 1990 to 2015 and is expected to continue rising dramatically due to aging populations. Diabetic neuropathy was noted as the fastest-growing neurological condition globally (linked to rising diabetes)[2].

Neurological conditions have a disproportionate impact on LMICs and vulnerable populations.

As with other NCDs, low- and middle-income countries (LMICs) bear the heaviest burden. Over **80% of the burden of stroke** (one of the deadliest neurological conditions) is in LMICs, where stroke mortality and disability rates are nearly four times higher than in high-income nations[5]. Limited access to preventive care (e.g. hypertension control), acute treatment (thrombolysis, neurosurgery), and rehabilitation means outcomes are worse. Many neurological disabilities in LMICs strike younger people – for instance, in sub-Saharan Africa, the average age of stroke is younger than in the West, often causing loss of productivity during prime working years[5]. Additionally, conditions like epilepsy, which can often be well-controlled with medication, have treatment gaps of over 70% in low-income countries – meaning the majority of people with epilepsy are not receiving the care they need, leading to avoidable seizures, injuries, and stigma.

Certain populations require a special focus: **children** (paediatric neurological disorders such as epilepsy, cerebral palsy, neurodevelopmental disorders, neuromuscular diseases, etc., can impose lifelong challenges if not managed) and **older persons** (neurodegenerative diseases like Alzheimer's and Parkinson's are rising with longevity).

Women often face a double burden – they provide the majority of care for family members with neurological illness[5], and some neurological conditions (migraine, dementia) affect women disproportionately[2]. Beyond these biological factors, gender inequities in healthcare access, research representation, and diagnosis also persist. For example, women with neurological symptoms are more likely to be misdiagnosed or face delays in care, and caregiving responsibilities often limit their ability to seek timely treatment themselves. Addressing the burden of neurological conditions thus requires a gender-responsive approach that accounts for both the specific vulnerabilities and the caregiving roles of women.

Neurological conditions generate massive economic costs and health system burdens.

A WHO and the World Economic Forum study estimated that from 2011-2030, NCDs would cost trillions in lost output – with neurological conditions contributing significantly to these losses[14]. The cost of care for neurological patients can be catastrophic for families, especially where long-term care is needed (e.g. dementia care, lifelong care or disability support of children and young people). Health systems struggle when neurological care is not integrated – patients bounce between services or, worse, go untreated. For example, in many countries, mental health and neurological services are siloed, even though patients with coexisting conditions — such as epilepsy and depression or acquired encephalopathy and behavioural disorders — require coordinated, cross-disciplinary care. Yet such collaboration is often limited or ad hoc. This reflects a broader gap in integrated approaches to managing chronic conditions, where medical, social, and support services are rarely aligned. By highlighting neurology in national plans, health systems can better plan for training, infrastructure (like neuroimaging facilities), and referral networks to manage these conditions efficiently.

III. WHY TREAT NEUROLOGICAL HEALTH AS DISTINCT FROM MENTAL HEALTH?

While neurological and mental health conditions often intersect, there are compelling reasons to treat them as distinct pillars in policy:

- **Biomedical differences**
  Neurological disorders are diseases of the central and peripheral nervous system (which include diseases of spinal motor neurons, muscles and peripheral nerves) with often visible pathological changes (e.g. stroke – vascular occlusion in the brain; Parkinson's – loss of dopaminergic neurons, spinal muscular atrophy – loss of motor neurons). They frequently require different diagnostic tools (MRI, CT scans, EEG, EMG, spinal taps, genetic diagnostics) and specialist interventions (neurosurgery, physiotherapy for rehabilitation, gene therapy, etc.) that differ from those typically used in primary mental health care. Medication needs also differ: while there are cases of overlap — for instance, certain antiseizure medications are used in psychiatric care, or to treat migraine or Tourette syndrome — most neurological conditions require disease-specific treatments not covered in standard mental health formularies. When budgets or policies bundle "mental health and neurology" without specificity, there is a risk that neurological tools, diagnostics, and therapies are deprioritised or overlooked entirely.

- **Health system channels**
  Mental health care often involves community-based psychosocial services and psychiatric care and is moving towards integration into primary care via task-sharing. Neurological care should also be integrated into primary care (e.g., primary care doctors managing migraine or epilepsy), but linkage to specialty services is essential for many complex neurological diseases. **Ignoring neurology might mean primary care initiatives lack training on seizures or stroke**. For instance, a primary care package for NCDs that covers depression and diabetes but not epilepsy means a continued treatment gap for epilepsy. Implementation of screening programmes in primary care services in LMIC will improve early detection of potentially treatable diseases in children.

- **Stigma and human rights**
  Both mental and neurological conditions carry stigma, but of different kinds. Epilepsy in some cultures is heavily stigmatized as being 'possessed' or cursed, requiring public education tailored to that misconception. Dementia faces stigma related to aging and cognitive decline. The facial stigma of neurocutaneous disorders is often the cause of social exclusion in adolescence and adults (for example, tuberous sclerosis, Sturge Weber syndrome). These require specific public health messaging distinct from mental illness stigma campaigns (which often focus on depression, schizophrenia, etc.). Legal and rights-based challenges affect people with both mental and neurological conditions, often rooted in stigma and exclusion — and should be addressed in line with the UN Convention on the Rights of Persons with Disabilities and WHO's biopsychosocial framework. However, specific legal legacies differ: for example, many countries have only recently repealed laws that restricted marriage or driving for people with epilepsy, while mental health and developmental advocacy often focuses on issues such as decriminalising suicide, ending forced institutionalisation, or addressing discrimination against children with autism. These differences call for coordinated but tailored legal and policy responses.

Synergies:

Brain health is emerging as an umbrella concept[8]. Many risk factors overlap (e.g. chronic stress is a risk for mental disorders and possibly some dementias; unhealthy lifestyles contribute to stroke and depression). Co-morbidities are common (people with epilepsy are at elevated risk of depression; people with brain injury are often impaired in social interaction by behavioural problems; people with severe mental illness have higher rates of certain neurological conditions). Thus, a *coordinated but differentiated* approach is best – akin to how we handle, for example, HIV and TB as distinct but often collaborative programs. In practical terms, this could mean ensuring **neurology and mental health units within Ministries of Health coordinate** their strategies and share resources for common areas such as brain health promotion, anti-stigma campaigns, or integrated training for primary care. This approach is not only efficient, but impactful: many NCD prevention strategies — such as managing hypertension, promoting physical activity, and reducing social isolation — are also key modifiable factors in reducing the risk of neurological conditions like dementia, as highlighted by the 2024 Lancet Commission on dementia prevention[15].

IV. BUILDING ON THE 2018 POLITICAL DECLARATION AND OTHER INSTRUMENTS

The **2018 UN Political Declaration on NCDs (A/RES/73/2)** was the first HLM outcome to reference neurological conditions. Paragraph 13 of that Declaration *"recognize[d] that mental disorders and other mental health conditions, as well as neurological disorders, are an important cause of morbidity and contribute to the global burden of NCDs"*[3]. It called for the integration of these conditions into the NCD response. This was reinforced by the **2022 WHO Executive Board resolution EB150.R8**, which noted with concern the growing burden of neurological disorders and the need for coordinated action.

Member States now have a solid framework in the **WHA-endorsed IGAP 2022–2031**. IGAP's **five strategic objectives** are worth highlighting as they provide a template for national action:

1. **Prioritise and govern** – i.e. Make neurology a public health priority, develop leadership and governance structures.
2. **Provide care** – Ensure access to diagnosis, treatment, and care for neurological disorders (integrated in health systems).
3. **Promotion and prevention** – Implement strategies to promote brain health (from pregnancy onwards) and prevent neurological conditions (e.g. injury prevention, infection control for meningitis, stroke prevention via NCD risk factor control). This includes the recognition of sleep health as essential for healthy brain development, maintenance, and aging — and underscores the importance of identifying and managing sleep disorders within primary care systems[12].
4. **Research and information** – Strengthen information systems and research for evidence-based practice.
5. **Public health approach to epilepsy** – because epilepsy is common and emblematic, with well-known interventions, it gets a special focus (e.g. achieving at least a 50% treatment gap reduction for epilepsy by 2031 is one IGAP target).

There are **10 global targets** under IGAP, such as reducing preventable epilepsy, ensuring 80% of countries have a functioning surveillance system for neurological conditions, and as mentioned, 80% of countries integrating essential neuro medicines into primary care. The **IGAP Implementation Toolkit (2023)** translates these into **practical actions and 90+ resources** for policymakers[9]– an invaluable tool to leverage.

The **NCD Alliance (NCDA)**, representing a broad civil society coalition, has also integrated neurology into its asks for 2025:

- In its consultative Political Declaration text, NCDA expresses "grave concern" regarding the "***huge human and economic cost of noncommunicable diseases, including mental health and neurological conditions***" and proposes to "***finalize and deliver national multisectoral action plans and targets for the prevention and control of noncommunicable diseases, including mental health and neurological conditions***".
- NCDA emphasizes a life-course and inclusive approach: their draft mentions *"the **meaningful involvement of people living with NCDs and mental health and neurological conditions**"* in the NCD response, an important principle we wholeheartedly support.

The **United for Global Mental Health** coalition and the Global Mental Health Action Network have developed a detailed advocacy brief[10] outlining priority topics for the HLM on NCDs and Mental Health. Many of these – e.g. sustainable financing, integration into primary care, data strengthening – align with neurology needs. We stress that neurology can ride the momentum of mental health advocacy while adding our voice to ensure that brain health is addressed thoroughly. We support the Mental Health community's call that this HLM is a rare chance to have mental health at the centre of a UN summit and is perhaps the **first-ever chance** to put neurology on the agenda, too.

A concluding message from the OneNeurology Chairs:

Framing the case for neurology in the 2025 NCDs Declaration and beyond

Dear Colleagues,

The 2025 High-Level Meeting is a moment to finally bring the brain and neurological health out of the shadows and into the heart of global health policy. The opportunity is not only to correct a historical omission but also to strengthen the NCD agenda with a more complete and inclusive vision—one that recognises the role of brain health in individual well-being, economic resilience, and human development.

The Political Declaration must explicitly name neurological conditions as a core component of the NCD response. However, that recognition must be matched by concrete follow-through: investment, implementation of the WHO IGAP, and integration of neurological care and prevention into UHC and health system strengthening efforts.

Looking ahead, we also call on Member States to support a dedicated UN High-Level Meeting on Brain Health by 2030. Such a meeting would provide the political space to assess progress on IGAP, elevate emerging issues, and position brain health as a strategic driver of sustainable development. As highlighted at the 2025 World Economic Forum in Davos (forbes.com), brain capital — the cognitive, emotional, and social resources of populations — is increasingly recognised as key to economic and societal resilience. A future HLM should help embed brain health into wider policy systems, from education and employment to innovation and equity.

In a world grappling with demographic shifts, rising mental and neurological challenges, and the lingering impacts of COVID-19 (nature.com), investing in brain health is no longer optional — it's foundational.

The OneNeurology Partnership stands ready to support Member States and the WHO in taking this forward – by providing evidence, technical expertise, and a direct link to the voices of those living with neurological conditions.

What's at stake is simple: **Neurological conditions deserve dedicated mention and targets, so they don't fall through the cracks. History shows that what doesn't get named doesn't get prioritised or funded.** We urge you to use this moment to recognise neurology not just as a clinical concern but as a pillar of sustainable development, social equity, and economic resilience.

Let 2025 be remembered as the year the global community recognised brain health — neurological and mental alike — as the essential fifth pillar of the NCD agenda and began to act accordingly.

Sincerely,

Donna Walsh

Coriene Catsman-Berrevoets

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