Other dimensions of the NCD crisis: from mental health, ageing, dementia and malnutrition to deaths on the roads, violence and disability
WHO has included several new dimensions to the crisis of noncommunicable diseases (NCDs) by drawing attention to conditions that impact the health and safety of all people. This year’s focus on depression builds awareness of mental health. Healthy ageing is a key priority, including assisting those who battle dementia. The fight against malnutrition now includes the opposite extreme of obesity. Road deaths, the biggest killer of people aged 15-29, are targeted, as is support for people with disabilities and those suffering violence, especially women and children.

Health problems caused by mental and neurological disorders, unsafe roads, violence, disability, malnutrition in its two extreme forms, and the ageing of the world’s population add considerably to the burden of noncommunicable diseases (NCDs). As highlighted on World Health Day 2017, depression is the leading cause of ill health and disability worldwide. According to the latest estimates from WHO, more than 300 million people are now living with depression, an increase of more than 18% between 2005 and 2015. Lack of support for people with mental disorders, coupled with a fear of stigma, prevent many from accessing the treatment they need to live healthy and productive lives. In addition, more than one billion people worldwide experience significant disability, and up to one billion children are exposed to violence each year.

Demographic ageing is now a universal trend, with populations ageing fastest in low- and middle-income countries. By the middle of this century, the population of people aged 65 and older will outnumber children for the first time in history. “Ageism” – based on outmoded stereotypes of the ageing process – is another barrier that blocks access to the many interventions that contribute to healthy ageing. Changes in the world’s dietary patterns now mean that severe undernutrition, which stunts and wastes young children, often exists side-by-side with overnutrition, leading to overweight, obesity, and a host of chronic health problems. In a positive trend, the number of deaths and injuries caused by road traffic crashes – though still much too high – has not increased as expected given the continuing rise of more and more vehicles on the world’s roads.

The world did not have a comprehensive and affordable plan for coping with the tidal wave of dementia that is engulfing rich and poor countries alike.
Mental health: from the shadows into the spotlight

Mental health received unprecedented attention over the past decade, moving truly “out of the shadows”. This work culminated in the World Health Day 2017 campaign on depression, which is a one-year campaign aimed at ensuring that more people with depression, in all countries, seek and get help.

The decade began with a ground-breaking series on Global Mental Health published in the *Lancet* in 2007, with WHO staff as contributing authors. Noting that mental health disorders remain both neglected and deeply stigmatized across societies, papers highlighted the scale of the problem and the treatment gap, and set out some eye-opening statistics: in some parts of the developing world, nearly 80% of people with mental health disorders receive no treatment whatsoever.

In 2008, WHO developed the mental health Global Action Programme (mhGAP) aimed at scaling up care for mental, neurological, and substance use disorders. That work culminated in 2010, when WHO published its *mhGAP Intervention Guide*. The guide covered the most prevalent mental, neurological, and substance use disorders and set out an inventory of effective interventions, often simple and inexpensive, for each. Most importantly, it showed how these disorders could be managed by health personnel with no specialized training in primary health care settings.

In preparing the guide, WHO used some of the world’s best experts to demystify and simplify their specialized knowledge, transferring vast competence into non-specialist hands. The result was a world of expertise translated into less than 100 pages of clinical wisdom and succinct practical advice. The emphasis was firmly placed on interventions that can be undertaken by busy doctors, nurses, and medical assistants working, with limited resources, at first- and second-level facilities. With publication of the guide, no country in the world could be excused for not taking action.

To address the long neglect of mental health at the policy level, WHO launched its landmark *Mental health and development report* in 2010. The report argued that people with mental health conditions were a vulnerable group that continued to be marginalized in terms of development aid and government attention. It made a strong case for addressing the needs of this vulnerable group through the integration of mental health interventions into broader strategies for poverty reduction and development.

In 2013, the World Health Assembly adopted its first mental health plan, the Comprehensive Mental Health Action Plan 2013–2020. The action plan and accompanying resolution – a first in the history of WHO – formally made mental health a priority in the agendas of WHO and its Member States. They further expressed the commitment of countries to work towards the achievement of several ambitious targets. The negotiations leading up to adoption of the action plan were lengthy, not because of contentious issues but because Member States were so determined to craft a resolution with enough substance to end the long neglect of mental health needs worldwide. That action definitively moved mental health out of the shadows and into the spotlight. Work done by the mhGAP programme continues as a driving force.
The action plan gave particular attention to the stigma, discrimination, and gross human rights violations that people with mental health conditions continue to face. In the view of WHO, the mental health of people cannot improve if their rights are violated in the very places that are expected to provide treatment and care. In 2012, WHO issued its Quality-Rights Tool Kit, which provides countries with practical guidance and tools for assessing and improving compliance with human rights standards in mental health and social care facilities. The tool kit aims to put an end to past neglect and abuses while also ensuring high-quality services.

In 2013, WHO used another entry point to strengthen mental health services: humanitarian emergencies and the severe mental health and psychosocial needs they create. Building back better: sustainable mental health care after emergencies used experiences from ten crisis-affected countries to show how concern about immediate mental health needs during an emergency can be channelled to build high-quality and sustainable mental health services for the future. The report provided detailed accounts of how mental health reform was accomplished under challenging circumstances, emphasizing common barriers and how they were overcome. The report provided convincing evidence that building back better is possible, no matter how weak the existing mental health system or how challenging the emergency situation.

Substance abuse: strengthening the health system response

In April 2016, the WHO Director-General addressed the UN General Assembly Special Session on the World Drug Problem, arguing that the response to the drug problem needed a strong public health focus. Her messages were straightforward and uplifting. Drug use can be prevented. Drug use disorders can be treated. Drug dependence that contributes to crime can be effectively addressed by public health interventions. People with drug dependence can be helped and returned to productive roles in society.

She asked participants to remember the people: the people wishing to be free from drugs who get no help from the health or social services, the people forced into crime or prostitution to pay for their addiction, and the millions whose injecting drug use adds HIV or hepatitis to their misery. WHO promotes a comprehensive package of interventions, including harm reduction measures, to help these people.

During the decade, collaboration between WHO and the UN Office on Drugs and Crime on health-related issues of the world drug problem has been strengthened significantly, culminating in the signing a Memorandum of Understanding for expanded collaboration in 2017. WHO brings to this collaboration its focus on normative guidance, research, and health system and technical tools on identification and management of opioid dependence, alcohol, and drug-use and substance-use disorders during pregnancy, the prevention and treatment of HIV and hepatitis among injecting drug users, brief interventions for substance use in health care settings, and community management of opioid overdose.
In March 2017, the WHO Director-General addressed the 60th anniversary session of the Commission on Narcotic Drugs. As she noted, the ultimate objective of drug control policies is to save lives: **WHO urges that public health policies be based on the medical and scientific evidence, and not on emotions or ideology.**

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**Dementia: the world gears up to tackle a devastating disease**

Of all mental disorders, dementia is among the most devastating, costly, deeply dreaded, and poorly understood by both populations and the medical profession. An estimated 47.5 million people are currently living with dementia. On current trends, WHO estimates that the number of dementia cases will nearly double every 20 years. About 60% of the disease burden falls on low- and middle-income countries, which are experiencing the most rapid acceleration of demographic ageing and have the least capacity to cope, medically, socially, and economically. In many developing countries, modernization and high population mobility have unraveled the extended family networks that traditionally cared for the elderly.

Worldwide, most care for dementia takes place in family homes. This care is immensely challenging, physically, psychologically, and financially. People with dementia need services and support, as do their carers. At the personal level, the costs of care can be catastrophic, especially as they are often paid for out-of-pocket. The wages of informal carers are sacrificed when they give up their jobs to provide the full-time care that people with advanced dementia nearly always need. In such situations, the lifetime savings of people with dementia and their carers can be lost.

The alarming trends, in numbers affected and the soaring costs of associated care, will only get worse in the absence of effective preventive strategies and better technical tools, especially for treatment. The R&D incentives to develop new medicines are potent given the burden of dementia in high-income countries. However, after a series of repeated and costly failures, pharmaceutical companies began to retreat from the search for a dementia cure. Many research projects were postponed or shelved because of the high technical and financial risks of failure.

In the second decade of this century, the world had plans for dealing with a nuclear accident, cleaning up chemical spills, mitigating natural disasters, and responding to an influenza pandemic. But it did not have a comprehensive and affordable plan for coping with the tidal wave of dementia that is engulfing rich and poor countries alike.

That situation began to change in a series of watershed events. In 2012, WHO and Alzheimer’s Disease International jointly issued a report that explained why dementia must be treated as a global public health priority. The report also set out the many things that can be done to improve the lives of people with dementia and support their carers. With dementia now established as a public health priority, the UK convened a G8 Dementia Summit in London in 2013. The summit was a ground-breaking event. The deliberations expressed a strong sense of urgency to catch up with a runaway human tragedy and set out powerful proposals for doing so. Acting together.
G8 countries aimed to transform the approach to dementia, which was often summarized in four words: "Nothing can be done."

The summit – and its proposals – took a dramatically different approach. High-level leadership and commitment can defeat dementia through a three-pronged approach that steps up research for new interventions, finds ways to improve the quality of life and care, and does more to support carers and families. Participants gave particular attention to the policies and incentives needed to accelerate research and discovery by creating a more attractive environment for innovation. A better bridge between research conducted in publicly-funded academic institutes and research undertaken by industry was considered essential. In one of its most significant achievements, the summit articulated the bold ambition of doubling funding for dementia research and finding a cure or disease-modifying therapy by 2025.

To take the agenda forward, WHO convened the first Ministerial Conference on Global Action against Dementia in 2015. That event showed how a sense of urgency can inspire invention. Presentations explored ways to break through some long-standing barriers to rapid product development. Proposals looked at ways to streamline, simplify, and harmonize regulatory approval and formally coordinate research undertaken by industry with research conducted in publicly-funded academic institutions. The conference also reviewed an inventory of existing options for jump-starting innovation when market forces fail. In addition, strategies were proposed to improve the delivery of care as a way of immediately cushioning dementia’s impact on health systems and families. Above all, the conference continued the spirit of collective social responsibility that emerged during the London summit: political leadership must step in to take up the slack when market forces fail to deliver new tools for a burden of this magnitude.

A WHO Global action plan on the public health response to dementia is on the agenda for the World Health Assembly in 2017. The action plan draws on cross-cutting principles, such as the human rights of people with dementia and the empowerment and engagement of people with dementia and their carers. One area for strategic action is specifically focused on dementia awareness and “friendliness” based on an important new premise: increasing public awareness, acceptance, and understanding of the diseases can enable people with dementia to maintain their participation in social life and maximize their autonomy.

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Healthy ageing: creating age-friendly societies

Demographic ageing is a universal trend, affecting countries at all levels of development in every region of the world. By the middle of this century, the population of people aged 65 and older will outnumber children for the first time in history. Populations are ageing fastest in low- and middle-income countries. A transition towards an older society that took more than a century in Europe is now taking place in less than 25 years in countries like Brazil, China, and Thailand. In an unprecedented trend, most people can now expect to live into their 60s and beyond, and health systems everywhere are unprepared to meet the needs of the growing number of people living longer lives.
The implications for governments are huge. These older populations are a significant human and social resource, but they will also present challenges, especially when the demands of a disease like dementia are factored in. The most crucial determinant of where the balance lies between the opportunities and risks of demographic aging is the health of these older populations.

To truly liberate the potential of these older populations, health professionals need to think of health in older age as more than just the absence of disease. Most people over the age of 65 experience multiple coexisting chronic health conditions. However, when these conditions are managed effectively, older people can still enjoy good health. With this goal in mind, WHO has developed a new narrative for healthy ageing that is framed around the functioning of the older person.

This approach is articulated in the first *World report on ageing and health* released by WHO in 2015. That report moved the health needs of the elderly from the back burner at WHO to the full heat of attention and recommended actions. Apart from charting global trends, the report reached a number of conclusions that promise to reshape thinking about the ageing process and its implications for health. As the foundation for its recommendations, the report looks at what the latest evidence has to say about the ageing process, noting that many common perceptions about older people are based on outdated stereotypes. As these misperceptions are among the most pervasive barriers to maintaining the health and independence of older people, the report soundly refutes them with the facts.

As the evidence shows, the loss of capacity and ability associated with ageing is only loosely related to a person’s chronological age. Some people in their eighties retain the robust health of a twenty-year-old, while others require significant care and support at much younger ages. As the report makes clear, there is no “typical” older person. This diversity in the capacities and health needs of older people is not random, but rooted in events throughout the life course that can often be modified, underscoring the importance of a life-course approach to healthy ageing. Moreover, contrary to common assumptions, ageing has far less influence on health care expenditures than other factors, including the high costs of new medical technologies.

Guided by the evidence, the report aims to move the debate about the most appropriate public health response to population ageing into new – and much broader – territory. The overarching message is optimistic: *with the right policies in place, population ageing can be viewed as a rich new opportunity for both individuals and societies*. The resulting framework for taking action offers a menu of concrete steps that can be adapted for use in countries at all levels of economic development.

Throughout the report, examples of experiences in different countries are used to illustrate how specific problems can be addressed through innovative solutions. Practical examples show how health systems can be better aligned with the needs of older people and how fair and sustainable systems for long-term care can be built in every country. The report further illustrates what is meant by age-friendly environments and explains how the many knowledge gaps that plague understanding of healthy ageing can be filled.

The report provided the foundation for the WHO Global Strategy and Action Plan on Ageing and Health, which was adopted by the World Health Assembly in 2016. The plan has two complementary goals. First, where sufficient evidence exists, it proposes action to maximize
Combating ageism is another central objective: unless ageism is tackled and fundamental misconceptions about older people are changed, the capacity to seize innovative opportunities to foster healthy ageing will be limited. The strategy was subsequently endorsed by the 2016 G7 summit meeting in Ise-Shima, Japan, in its Vision for Global Health, which specifically called for implementation of the strategy, with adaptation to suit national contexts in all countries.

These major steps forward build on other significant work undertaken by WHO over the past 10 years. This work includes the WHO Global Network for Age-Friendly Cities and Communities which, by 2017, had become a movement embracing more than 400 cities and communities and 11 affiliated programmes that together cover 146 million people. All these municipalities aspire to becoming better places in which to age, whether it be through providing better access to transportation, lifelong learning and social support or through initiatives to foster links between generations and overcome isolation.
Nutrition: ending all forms of malnutrition

The prevalence of malnutrition as a public health problem is characterized by the two extremes of undernutrition and overnutrition. Traditional determinants of undernutrition persist while newer drivers of overweight and obesity split the nutrition profile. WHO estimates that nearly 160 million young children are stunted and 50 million are wasted. Deprived of essential nutrients so early in life, many of these children will suffer life-long health consequences. The four countries in Africa and the Middle East currently on the brink of famine constitute a humanitarian crisis on a scale not seen since the end of World War II.

In addition, more than two billion people suffer from micronutrient deficiencies, leading to complications ranging from poor pregnancy outcomes, to the impaired cognitive development of infants and young children, to blindness. At the same time, nearly an equal number of people are obese or overweight. Since 1980, WHO estimates that the prevalence of obesity has nearly doubled in every region, with the fastest increases recorded in low- and middle-income countries. These countries often face a double burden of malnutrition, with undernutrition occurring side-by-side with overweight and obesity in the same communities and families across the life-course. WHO estimates that, in 2015, more than 1.9 billion adults worldwide were overweight and more than 600 million were obese. In the same year, around 42 million children under the age of five were obese or overweight.

WHO has long contributed to the technical foundations for sound nutrition policies by recommending a range of acceptable daily intakes of micronutrients, with the minimum intake needed to prevent deficiency diseases and the upper intake needed to prevent chronic diet-related diseases. WHO has also contributed to the safety of the food supply through a long-standing series of reports that have set acceptable daily intakes for several hundred food additives, contaminants, and veterinary drug and pesticide residues in food. Risk assessments on a number of foodborne pathogens have likewise been undertaken by WHO. These evaluations and assessments contribute to the work of the joint FAO/WHO Codex Alimentarius Commission, which has been setting international standards for food safety and quality and providing information for consumers since 1963.

WHO’s role in leading the global response to malnutrition assumed a higher profile in 2012, when the World Health Assembly adopted a Comprehensive Implementation plan on maternal, infant and young child nutrition. The plan charted the way forward to 2025 with six global nutrition targets. The Global action plan for the prevention and control of noncommunicable diseases, adopted in 2013, included two diet-related targets to be reached by 2025: to achieve a 30% relative reduction in mean population intake of salt, and to halt the rise in overweight and obesity. The Global Monitoring Framework for NCDs also includes indicators on saturated fatty acids, trans-fatty acids, fruits and vegetables, and policies to reduce marketing to children.

Another pivotal point occurred in 2014 when FAO and WHO jointly convened the Second International Conference on Nutrition in Rome, Italy. The conference achieved consensus on the multiple challenges of malnutrition, including obesity and overweight, a vision on the way forward, and commitments to undertake specific actions. Two outcome documents were adopted: the Rome Declaration on Nutrition and a corresponding Framework for Action, which
recommends a set of policy options and strategies to promote diversified, safe, and healthy diets at all stages of life.

In 2015, the 2030 Agenda for Sustainable Goals set a bold goal of ending hunger, including targets for ending all forms of malnutrition and ensuring sustainable food production. The sense of urgency communicated in the Rome documents prompted the UN to launch a Decade of Action on Nutrition starting in July 2016. Nutrition had truly arrived on the international development agenda, with WHO and FAO given the leadership role in coordinating the response. The pressure was on as never before to implement the decade’s specific, measurable, achievable, relevant, and time-found policies – the so-called SMART policies.

The determinants of malnutrition are multiple and extremely complex. Action to end malnutrition in all its forms – from hunger and disease associated with micronutrient deficiencies, to obesity and overweight as risk factors for diabetes, cardiovascular disease, and cancer at several sites – will require a movement that engages all of society, from consumer groups to businesses, and from those who negotiate trade agreements to multinational corporations.

All of these groups must also be engaged in ensuring that food, as it moves from the farm to the plate, is kept safe. WHO estimates that unsafe food – contaminated with bacteria, viruses, parasites, or chemical substances – causes more than 200 diseases. Food safety is inextricably linked to nutrition and food security. Unsafe food creates a vicious cycle of disease and poor nutrition, especially in infants, young children, the elderly, and people with underlying conditions. WHO estimates that foodborne diseases cause 600 million illnesses and 420,000 deaths every year. In 2015, WHO devoted World Health Day to food safety, asking both producers and consumers to be aware of the many common errors that can turn a meal into the start of a foodborne disease.

Road safety: 1.25 million predictable and preventable deaths

Unsafe roads cause significant premature deaths and disabilities that place a heavy burden on health systems, both for trauma care and long-term rehabilitation. The fact that the overwhelming majority of traffic deaths and injuries are predictable and preventable provides a powerful incentive to act. As the causes of traffic crashes are so numerous, preventing them requires collaboration with other sectors, such as those responsible for municipal infrastructure, transport systems, road engineering, education, vehicle registration and safety, trauma care, and far-reaching legislation and law enforcement.

In 2009, the Russian Federation hosted the first Global Ministerial Conference on Road Safety in Moscow to give the issue a higher profile on the international agenda. That conference led the following year to the adoption of a UN General Assembly resolution which proclaimed 2011–2020 as the Decade of Action for Road Safety, with WHO appointed to serve as the decade’s secretariat. To track trends and monitor progress, WHO issued its second Global status report on road safety in 2013. In 2015, as the midpoint in the decade approached, WHO issued an
updated global status report which became the centrepiece for the Second Global High-level Conference on Road Safety held the same year in Brazil.

The WHO report showed that the toll of road traffic crashes, as measured by the number of deaths and injuries, had not increased as expected given the continuing rise in the number of vehicles on the world’s roads. However, the numbers were still far too high. The report estimated that road traffic crashes were claiming 1.25 million lives each year. Strategies put in place since the first ministerial conference were saving some lives, but the pace of progress was too slow.

Data in the report raised concern on several levels. The risk of dying on the roads was strongly associated with a country’s level of economic development. Low- and middle-income countries accounted for 90% of road traffic deaths, despite having just 54% of the world’s vehicles. Europe had the lowest death rates. Africa had the highest. In a particularly alarming statistic, the report showed that road traffic crashes are the number one killer of people in the age group of 15 to 29 years. The report targeted additional vulnerable groups for action. Motorcyclists accounted for 23% of all road traffic deaths, pedestrians for 22%, and cyclists for 4%. As noted, the large proportion of pedestrian deaths called for more planning on how vehicles and people can safety share roads.

All of these initiatives and reports, with the support of many partners including Bloomberg Philanthropies, helped secure a firm place for road safety on the 2030 Agenda for Sustainable Development. The importance of road safety is explicitly recognized in two targets, one each under the goals for health and for cities: first, by 2020, to halve the number of global deaths and injuries from road traffic crashes, and second, to provide access to safe, affordable, accessible, and sustainable transport systems for all, notably by expanding public transport. The two targets provide a rallying point to stimulate further commitment and action. While ambitious, both targets are feasible. The epidemic of deaths and injuries on the road is a crisis made by people. Solutions are known and backed by abundant evidence.

**The business case for improved road safety is readily made.** Changing road user behaviour through adopting and enforcing good laws cuts road deaths. Evidence shows that laws reduce risks associated with speed and drink-driving. Laws also increase the use of established preventive measures, like seatbelts, motorcycle helmets, and child restraints. Vehicle technology exists to increase safety. These safety technologies need to be included in vehicles sold in both rich countries and poorer parts of the world.

Many affordable road improvements, such as footpaths, safety barriers, bicycle lanes, and paved shoulders, save lives. Moreover, footpaths or sidewalks and bicycle lanes encourage physical activity, which is an especially important health asset in urban environments. The SDG targets ask the international community to do two things: first, to work together to create a world free of high-risk roads, vehicles and behaviours, and second, to ensure that the benefits of safe mobility are evenly shared.
Violence prevention: an opportunity and responsibility

Interpersonal violence includes child maltreatment, youth violence, intimate partner violence, sexual violence, and elder abuse. Over the past decade, violence has moved from the margins of the development agenda to the centre. Violence prevention features strongly in three of the 2030 Agenda for Sustainable Development targets: ending violence against women; ending violence against children, and significantly reducing deaths due to all forms of violence. This shift in the attention given to violence has been driven by dramatic improvements in the ability to measure its prevalence and consequences, and rapid expansion of the scientific evidence base for what works best for prevention.

WHO first marshalled the scientific evidence for what works to prevent violence in the 2002 World report on violence and health. At that time, data on the national prevalence of different types of violence were lacking in many countries. Since then, considerable work on national data collection and scores of country surveys have led to much improved documentation on most types of violence. For example, many countries have conducted surveys to assess the extent of violence against children. At the global level, recent data show that up to one billion children worldwide are exposed to violence each year. As a result, and over the course of their lifetime, these children are at greater risk of mental illness and anxiety disorders, chronic diseases such as heart disease, diabetes and cancer, infectious diseases such as HIV, and social problems such as crime and drug abuse.

Similarly for violence against women, a surge of national surveys has helped put the problem in stark relief. Globally, WHO now estimates that around one in three women worldwide have experienced physical or sexual violence by an intimate partner at some point in their lives, leading in many instances to a similarly lifelong set of health and social consequences as those faced by children. More information than ever before has emerged about violence against older people, with elder abuse affecting one in six adults over 60 years of age worldwide – some 141 million people. Homicide is now also somewhat better documented: of the estimated 470,000 homicides each year, males account for more than 80% of all cases, and nearly half involve firearms.

In order to disseminate the evidence base on violence prevention, in 2007 WHO established an interactive online resource known as the Violence Prevention Evidence Base. The resource has shown steady, year-on-year increases in the number of published scientific studies of intervention effectiveness, and as of 2016 included 653 such studies, each one a compelling confirmation that violence is preventable. Geographically, sub-Saharan Africa has emerged as one of the most prominent growth points in the evidence base, especially as it concerns interventions to address violence against children and against women. In 2016, this evidence was sufficient for WHO and nine partner agencies to launch INSPIRE: Seven strategies for ending violence against children, a first-ever global technical package of evidence-based interventions that point the way to deeper and more effective engagement in violence prevention everywhere.

To take stock of how these advances work at country level, WHO published in 2014 the first Global status report on violence prevention, offering a snapshot of violence prevention initiatives in 133 countries. The report generated several headline findings: countries are beginning to
invest in prevention programmes and policies; laws related to violence prevention are critical and exist in most countries, but their enforcement remains inadequate; and the availability of services for victims of violence varies markedly, with services to protect and support victims in place in just over half of countries.

The report’s findings were widely taken up in various planning and policy processes. Importantly, these included the processes leading to the May 2014 World Health Assembly resolution on strengthening the role of the health system in addressing violence, which called for WHO to develop a global plan of action for addressing the problem. This initiative culminated in the May 2016 World Health Assembly’s adoption of a resolution endorsing the plan of action. The plan addresses interpersonal violence in all its forms, has special sections on violence against children and violence against women, and emphasizes the importance of both prevention and victim service provision.

Far from walking the violence prevention path alone, WHO is in good company with strong partners from multiple sectors. Since 2004, the Violence Prevention Alliance has continued to strengthen its network of connections with partners from criminal justice, criminology, education, and social work. Launched in 2016, the Global Partnership to End Violence Against Children is spearheading efforts to support countries in their actions to achieve the SDG target on ending violence against children, with WHO represented on its Board and Executive Committee. Moreover, as a founding partner of the Sexual Violence Research Initiative, WHO continues to commit its expertise and convening powers to this critical endeavour.

The world has an opportunity and a responsibility to prevent violence. Doing so will have a positive impact on a broad range of health, social, and economic challenges. Violence can be prevented if the global community acts now, acts wisely, and acts together.

Disability: a public health challenge

Almost a decade ago WHO embarked on an endeavour to compile the most up-to-date information on the extent of disability around the world, and the obstacles faced by people living with disabilities. The result of this effort was the 2011 World report on disability, produced in collaboration with the World Bank, which found more than one billion people in the world experience significant disability.

People with disabilities have generally poorer health, lower education achievements, fewer economic opportunities, and higher rates of poverty. These disadvantages are largely due to the lack of services available to them and the many obstacles they face in their everyday lives, difficulties that are exacerbated in less-advantaged communities. The World report on disability describes the best available evidence about what works to overcome barriers to health care, to promote rehabilitation, education, employment, and support services, and to create the environments which will enable people with disabilities to flourish. The report ends with a concrete set of recommended actions for governments and their partners which continue to be a guiding influence in setting the global agenda for disability.
WHO’s role in leading the public health disability agenda was also strengthened by the adoption of a global disability action plan 2014–2021. Through the implementation of this action plan, WHO supports Member States to take action across a number of the recommendations laid out in the *World report*. Follow-up technical tools have also been provided to guide the implementation of these recommendations. For example, WHO issued the Model Disability Survey which supports improved national data collection on disability, allowing countries to estimate the extent of disability using a standardized and internationally comparable methodology. This tool has been implemented in several countries and continues to be rolled out globally.

As the discussion regarding the post-2015 development agenda gained momentum, the international community turned to the evidence and recommendations of the *World report* to make the case for the inclusion of disability into the development agenda. In September 2013, the United Nations General Assembly convened a High-level Meeting on Disability and Development at the level of Heads of State and Government, with the overarching theme “The way forward: a disability inclusive development agenda towards 2015 and beyond.” This meeting was the first step towards the inclusion of disability into the Sustainable Development Goals.

The global disability action plan also recommends strengthening rehabilitation services and assistive technologies around the world. The Global Cooperation on Assistive Technologies was launched in 2014, and a list of priority assistive products for country implementation was launched at the World Health Assembly in 2016. In February 2017, WHO launched the initiative *Rehabilitation 2030: a call for action* to raise awareness about the need to strengthen health systems to provide rehabilitation services, with the aim of progressively achieving universal health coverage in the context of the SDG agenda.

Global efforts to address disability have been accompanied by an internal initiative to make WHO itself more disability friendly. This initiative includes ensuring equal employment opportunities for people with disabilities, making WHO offices wheelchair accessible, and issuing health information products in a variety of formats that are accessible to people living with disabilities.