World Health Organization

**Executive Board**
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Agenda item 9

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# Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation and health-system readiness

## Draft resolution proposed by Chile, Egypt, Georgia, Palestine, Paraguay and Tunisia

The Executive Board,

Having considered the report by the Director-General,[1]

RECOMMENDS to the Seventy-ninth World Health Assembly the adoption of the following resolution:

The Seventy-ninth World Health Assembly,

(PP1) Having considered the report by the Director-General ;

(PP2) Recalling the commitment made by Heads of State and Government to reduce premature mortality from noncommunicable diseases (NCDs) by one third by 2030, and the need to accelerate progress toward these goals, as appropriate, as set out in Sustainable Development Goal (SDG) 3.4, and the extension of the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 to 2030,[2] the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders 2022–2031 (WHA75.11),[3] the Global Strategy on Digital Health 2020–2025;[4]

(PP3) Having considered the reports by the Director-General on noncommunicable diseases, health systems resilience and universal health coverage;

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[1] Document EB158/11.

[2] Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013 (accessed 2 February 2026)..

[3] Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031. Geneva: World Health Organization; 2022 (accessed 2 February 2026).

[4] Global strategy on digital health 2020–2025. Geneva: World Health Organization; 2021 (accessed 2 February 2026).

(PP4) Recognizing that cardiovascular diseases (CVDs), primarily and leading to stroke, are the leading cause of NCD mortality, accounting for approximately 19 million deaths annually,[5] and that stroke is the second-leading cause of death globally and the third-leading cause of disability,[6] are a principal contributor to disability worldwide;

(PP5) Noting with deep concern that the burden of stroke has grown rapidly in low- and middle-income countries (LMICs), which account for approximately 87% of stroke deaths, and that the number of new cases and deaths from stroke increased by 70% and 44%, respectively, between 1990 and 2021;[7]

(PP6) Noting with deep concern that stroke remains a leading cause of death and a major cause of disability, with differences in distribution of causes and risk factors across the life course, including for women during pregnancy, the post-partum period, and oral contraception and migraine, and further noting that women experience poorer functional recovery and higher mortality than men due to factors including age, more severe stroke, pre-stroke dependency and depression, while men experience a substantial burden of stroke at younger ages, including premature mortality and long-term disability therefore underscoring an approach that identifies and addresses gender inequalities across the life course, among other factors, in stroke research, prevention and treatment;

(PP7) Acknowledging that the high burden in developing countries is exacerbated by a lack of stroke-ready care, limited access to affordable essential medicines, inadequate rehabilitation services, and a high prevalence of uncontrolled risk factors and medical conditions such as but not limited to hypertension, diabetes, obesity, dyslipidaemia, physical inactivity, tobacco use, harmful use of alcohol and illicit drug use, air pollution, as well as undiagnosed or poorly managed atrial fibrillation and other cardiovascular diseases;

(PP8) Acknowledging that stroke imposes substantial social and economic costs, including direct healthcare expenditures and indirect costs due to loss of productivity and long-term care needs, often relying on informal caregiving, which undermine development and household financial security by increasing out-of-pocket expenditures and long-term dependency;[8]

(PP9) Concerning that the health systems of several Member States, particularly in developing countries and in resource constrained regions, lack comprehensive, coordinated stroke services ranging from primary prevention, and stroke-ready emergency systems to timely access to imaging, reperfusion therapies, and essential medicines, through to rehabilitation, community support, and long-term follow-up care;

(PP10) Noting evidence of critical gaps in certain countries across the stroke continuum: low detection and treatment rates for hypertension and other risk factors; low public awareness of stroke signs and insufficient pre-hospital emergency care; limited access

[5] Global Burden of Disease 2023. Seattle, WA: Institute for Health Metrics and Evaluation; 2025. (accessed 25 September 2025).

[6] Global stroke fact sheet 2025. International Journal of Stroke. 2025;20(2):132–144. doi:10.1177/17474930241308142.

[7] Global, regional, and national burden of stroke and its risk factors, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. Lancet Neurology. 2024;23:973–1003. doi:10.1016/S1474-4422(24)00369-7.

[8] Stroke: WHO fact sheet, 19 December 2025 (accessed 2 February 2026).

to essential neuroimaging; limited availability of stroke units thrombolysis/thrombectomy and neurosurgery services; suboptimal secondary prevention; inadequate rehabilitation and long-term support capacity; lack of or need for strengthening national stroke registries and data to guide policy and shortages of trained health workers across primary, emergency, acute and rehabilitative care pathways as well as significant geographical disparities in access;

(PP11) Conscious of the need for dedicated global leadership and coordinated action requiring the strengthening of WHO's technical capacity for NCDs and the establishment of multisectoral national stroke units within Member States,[9] to close the existing gaps and inequalities in the stroke care pathway, thereby reducing premature mortality and disability and strengthening health system resilience in line with SDG 3.4;

(PP12) Emphasizing that effective stroke care requires action across the life course and across health system levels, including strengthened primary prevention, and that many evidence-based and cost-effective interventions exist to reduce stroke incidence and improve outcomes, including hypertension control; diabetes management; and management of dyslipidaemia; screening for atrial fibrillation; salt reduction; promotion of healthy diets and physical activity; effective tobacco cessation; alcohol strategies, interventions and policies in line with the Action plan (2022–2030)[10] to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; and responses to illicit drug use; reduction of air pollution; as well as timely and coordinated emergency medical services; access to organized stroke unit care and reperfusion therapies such as thrombolysis and mechanical thrombectomy; anticoagulation for atrial fibrillation; and long-term rehabilitation, community reintegration and social support, while noting with concern that the adoption, scale-up and equitable implementation of these interventions remain insufficient in many countries;

(PP13) Emphasizing the critical need to continue to integrate stroke prevention, control, and management into national cardiovascular disease, neurological disorders strategies and universal health coverage plans to foster equitable access to the full spectrum of care, particularly persons in vulnerable situations, and to reduce health inequalities;

(PP14) Acknowledging the central role of health system strengthening, digital health, diagnostics (including imaging), workforce training, and rehabilitation services integration in achieving measurable reductions in stroke mortality and disability;

(PP15) Noting the absence to date of a focused WHO resolution addressing stroke comprehensively, prevention, acute care, rehabilitation and system readiness, recognizing its specific time-dependent nature requiring coordinated emergency care and the opportunity to stimulate coordinated national and global action;

(PP16) Affirming the importance of standardized national stroke registries and surveillance systems to accurately monitor the incidence, prevalence, mortality, disability, quality of care and patient-reported outcomes, which is essential for evidence-based policy-making and resource allocation;

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[9] Implementation roadmap 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030. Document A75/2022/REC/1, Annex 8.

[10] Global alcohol action plan 2022–2030. Geneva: World Health Organization; 2024 (accessed 2 February 2026).

(OP)1. URGES Member States, considering national context and capacities, and where appropriate:

(1) to include stroke as one of the major public health concerns within national cardiovascular disease, neurological disorders strategies and universal health coverage planning, with dedicated objectives, across the prevention, acute care and rehabilitation continuum;

(2) to implement and strengthen population-level prevention measures as well as measures to reduce health inequalities proven to reduce stroke risk, including but not limited to large-scale detection and control programmes for hypertension, diabetes, obesity and dyslipidemia; and legislation and regulation, policies and actions, as appropriate, to reduce excessive levels of saturated fats, free sugars and sodium such as reformulation, labelling, and public awareness; and effective tobacco cessation; alcohol strategies, interventions and policies in line with the Action plan (2022-2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; promotion of healthy diets and physical activity and the implementation of health literacy and school-based education programmes to foster healthy habits among children and adolescents; and actions to reduce household and ambient air pollution, in line with national circumstances;

(3) to foster primary care readiness by developing and implementing national stroke care pathways for stroke prevention by scaling up and systematic screening for risk factors, including hypertension, hyperglycemia/diabetes, dyslipidemias and atrial fibrillation, fostering continuous supply and affordable access to essential medicines for blood-pressure, glycemic and lipid control, antiplatelet and anticoagulant therapies as appropriate, and integrating counselling for lifestyle risk modification into routine primary care contacts by using evidence based and effective methods; global coverage targets on hypertension prevention and control;

(4) to strengthen emergency care systems so that patients with suspected acute stroke receive timely triage, rapid transport and access to imaging and reperfusion therapies where clinically indicated, by:

(a) defining and designating stroke-ready levels of emergency care facilities with minimum capability standards (imaging, laboratory, trained staff, capacity for thrombolysis);

(b) establishing prehospital stroke recognition and triage protocols, public awareness campaigns for early presentation, and streamlined referral pathways between primary care, emergency services and stroke units;

(c) raising awareness of health personnel in emergency care systems about the differences in stroke symptoms among women and men to ensure equitable care for all;

(5) to expand access to timely diagnostic imaging, including CT/MRI or validated alternatives where appropriate and essential laboratory tests required for acute stroke management;

(6) to scale up evidence-based acute interventions, including intravenous thrombolysis where indicated and systems to enable endovascular thrombectomy in referral centers, as well as the implementation of standardized care bundles for acute intracerebral hemorrhage, including rapid blood pressure control and coagulopathy reversal, and specialized management pathways for subarachnoid hemorrhage ensuring access to neurosurgical care in referral centres with protocols for timely transfer and interfacility cooperation;

(7) to invest in multidisciplinary stroke units and rehabilitation, ensuring inpatient stroke units with multidisciplinary teams for example physiotherapy, occupational therapy, speech and language therapy, nursing and medical care, early supported discharge models, palliative and end of life care, where appropriate and community-based rehabilitation and social support for survivors to optimize functional recovery and reintegration;

(8) to facilitate the development and maintenance of national stroke registries and surveillance systems to collect standardized data, including incidence, data on key indicators of stroke, disaggregated by sex, mortality, risk factors, service availability, reperfusion therapy rates, time-to-treatment, rehabilitation access, functional outcomes, patient reported outcomes (PROMS) and long term quality of life to guide policy, monitor progress and enable quality improvement;

(9) to strengthen the health workforce by incorporating stroke prevention, acute care and rehabilitation into pre-service curricula and continuing professional development for physicians, nurses, allied health professionals and community health workers; support task-sharing where appropriate with clear competency frameworks and clinical governance; and implement retention and incentive strategies for underserved areas;

(10) to promote equitable and affordable access by targeting investments and service expansion to underserved, rural and low-income populations, ensuring financial protection mechanisms to reduce out-of-pocket costs for stroke care and rehabilitation;

(11) to adopt and implement clinical protocols and quality-assurance mechanisms, including national clinical guidelines for stroke prevention and care, audit and peer-review systems, performance indicators, and continuous quality improvement processes across the stroke care pathway;

(12) to foster regional and cross-country collaboration for shared training, referral networks, pooled procurement for essential medicines and consumables, for example telemedicine/teleradiology arrangements, and regional centers of excellence that can provide mentorship and surge capacity during emergencies;

(13) to explore and mobilize as appropriate sustainable financing for stroke prevention and care, including domestic and international resources, innovative pooled financing mechanisms, alignment with relevant donor programmes, and integration of stroke services into universal health coverage benefit packages to foster long-term affordability and scalability;

(14) to engage communities and civil society, including stroke survivor organizations and caregivers, in designing and monitoring policies and services, supporting public awareness and secondary prevention adherence and reducing stigma associated with disability;

(15) to integrate digital health solutions, for example including registries, telemedicine, teleradiology, clinical decision support and mobile health for follow-up and rehabilitation, in a manner that ensures interoperability, data protection, inclusion, and alignment with national digital health strategies; and

(16) to build workforce capacity by training health professionals across the continuum of care, from primary care providers to emergency personnel, neurologists, and rehabilitation specialists, in evidence-based stroke management;

(OP)2. REQUESTS the Director-General:

(1) to develop normative guidance and technical tools for Member States on comprehensive stroke prevention, acute care readiness, rehabilitation and long-term support, that focuses on advancing health equity, rights and gender equality;

(2) to integrate stroke into existing cardiovascular and neurological global strategies that can be adapted to each country's context;

(3) to support Member States, especially developing countries, in strengthening their capacity for stroke system models adapted to resource levels;

(4) to facilitate global stroke monitoring and reporting, harmonized with existing WHO cardiovascular disease, neurological disorders and universal health coverage monitoring systems;

(5) to promote research and evidence generation on context-appropriate, cost-effective interventions for prevention, acute management and rehabilitation in developing countries;

(6) to support equitable access to essential medicines and identify priority lists for stroke prevention and acute care, including blood-pressure medicines, medicine for management of dyslipidaemias, antiplatelets, anticoagulants, thrombolytic agents, basic imaging capability, advising on procurement strategies and supply-chain resilience, and exploring pooled procurement mechanisms where feasible;

(7) to encourage regional cooperation and technical partnerships, including, when appropriate, the establishment or designation of regional centers of excellence for stroke care that can provide training, quality assurance and surge capacity support;

(8) to report on the progress in the implementation of this resolution to the World Health Assembly through the report submitted in response to decision WHA72(11) (2019) on the follow-up to the 2018 political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which also covers the outcome of the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being on progress made in

addressing stroke as part of the global NCD agenda and of the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders 2022–2031;[11]

(OP)3. ENCOURAGES relevant stakeholders, including intergovernmental organizations, philanthropic agencies, academic institutions, professional societies, civil society, private-sector partners and donors, to support Member States and, in line with the Framework of Engagement with Non-State Actors where applicable, WHO in implementing the actions called for in this resolution, as appropriate.

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[11] See decision WHA75(11) (2022).