Shaping a United Nations High-Level Meeting on Non-communicable Diseases that Delivers

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Executive Summary

In a world now crowded with intergovernmental summits, there is growing skepticism that the high-profile promises made at them by political leaders will actually be delivered and produce the desired results. However, the recent United Nations summit to review the Millennium Development Goals (MDGs) offers some offsetting optimism about the value of such summits. It provides the basis of a "Muskoka-to-MDG Summit" model to make the UN's forthcoming High Level Meeting (HLM) on Non-communicable Diseases (NCDs) in September 2011 more effective. Those involved in the preparations and execution of the UN NCD HLM can usefully learn from older and more established leaders-level meetings, especially in three key ways: crafting commitments that improve and enhance implementation; ensuring that an accountability architecture is added to monitor and encourage implementation; and securing support from surrounding summits and meetings for the central event.

In crafting commitments for the NCD HLM that will actually be implemented, a surgical approach should be used. The key commitments should be given priority placement at the start of the outcome document, backed by the full personal and political weight of the national leaders who attend. The World Health Organization (WHO) as the core international organization in this area has a relevant role, but other multilateral organizations, such as the World Bank, International Monetary Fund and Food and Agriculture Organization, should be specifically invoked to assist with implementation as well. Similarly, civil society should be included. References to specific countries, regions and past UN meetings should be avoided. The use of multi-year timetables could increase the compliance of some key countries, such as the United States, France, Japan, Italy and Canada. A one-year timetable and target will likely help increase compliance by the United States. It is not helpful to mobilize new money in the commitments themselves. To help secure these results, the HLM itself should be long enough so that the leaders and other actors involved, such as non-government organizations, multilateral organizations and academia, can engage seriously. It should include as many leaders as possible from the G8, G20 and all regions of the globe. A wide range of civil society actors and multilateral organizations should be included as well.

In adding an effective accountability architecture, standard UN monitoring mechanisms are inadequate on their own. Instead, a special, new mechanism, such as the UN's recently-created Commission on Information and Accountability for Women's and Children's Health should be considered. It should be accompanied by ongoing, independent, analytically oriented implementation assessment processes in order to

provide timely, publicly accessible, credible information for rapid assessment and course corrections where necessary.

In securing support from surrounding summits, the starting point should be a revised repetition of the successful synergy between the United Nations and the G8 in 2010, when both international summits worked together to advanced maternal, newborn and child health (MNCH) and accountability. The G8 summit hosted by France on May 26-27, 2011, should be used to set up September's UN summit on NCDs, by getting the leaders to pre-commit to the issue and event. There should also be an effort to engage further support from the broader and more balanced G20 summit, which has recently recognized the relevance of addressing NCDs for economic and social development. Also relevant are other regional and global groups, such as the summit of Brazil, Russia, India, China and now South Africa, the Summit of the Americas, the Asia Pacific Economic Cooperation forum, the Commonwealth, la Francophonie, the Organization of the Islamic Conference, the Association of South East Asian Nations, the East Asian Summit and the North American Leaders' Summit.

Introduction

The Challenge of Controlling Non-communicable Diseases

Non-communicable diseases (NCDs) are one of the biggest global health burdens. In 2008, 60 percent of all deaths in the world (38 million) were the result of four NCDs: cardiovascular disease, diabetes, cancer and chronic respiratory disease. NCDs are also one of the biggest economic burdens in the world.

NCDs pose major health threats to developing and emerging countries as well as developed ones. They are increasingly causing burdens on human health and healthcare systems and costs. While aggregate deaths from NCDs in developed countries are dropping, they are rising in developing countries. A full 80 percent of global deaths from NCDs now occur in low- and middle-income countries (World Health Organization [WHO] 2009). In the next two decades, low-income countries will be overwhelmed by strokes and heart attacks in middle-aged adults. What makes this even more tragic is that these diseases are largely preventable. NCDs are thus premiere development challenges of the twenty-first century.

The epidemic of NCDs is in part the product of failed development: of unhealthy urbanization, poor trade choices and inadequate health systems. Yet in 2006 only a miniscule $0.1 billion in official development assistance (ODA) went to basic nutrition and there was no specific investment in the prevention and control of NCDs (WHO 2009).

From a mainstream economic perspective, the NCD burden is equally acute. Almost all G20 members suffer more from NCDs than from infectious diseases. Given their rising healthcare costs and aging populations, developed countries will struggle to meet the commitment they made at the 2010 G20 Toronto Summit to cut their budget deficits in

half by 2013 unless they control their NCDs as part of their publicly funded healthcare costs.

The Challenge: Making the UN NCD Summit Work

In view of the soaring scale and spread of NCDs, it is good that the international community is increasingly coming together at the highest level to confront the challenge. In doing so they should take full advantage of the summits, commitments, approaches, meetings, studies and networks already in place. These include those focused on NCDs, health systems, food- and agri-systems and development at the national, regional and global levels (Beaglehole and Horton 2010).

The surge in summit-level attention to NCDs started at the Summit of the Heads of Government of the Caribbean Community (CARICOM) on Chronic Non-communicable Diseases on September 15, 2007. Here, eleven Caribbean leaders agreed, "immediate collective actions were necessary to manage and control NCDs" (Heads of Government of the Caribbean Community 2007).

At the fifth Summit of the Americas (SOA) in Trinidad and Tobago on April 19, 2009, the leaders devoted two of the 97 paragraphs in their concluding document to NCDs. They promised to supported the regional strategy of the Pan American Health Organization (PAHO) and WHO's tobacco control initiatives, incorporate NCD surveillance into national reporting by 2015, and encourage national planning and the establishment of national commissions on NCDs.

At the Commonwealth Heads of Government Meeting (CHOGM) in Trinidad and Tobago on November 27-29, 2009, leaders called for "the consideration of a Summit on NCDs to be held in September 2011, under the auspices of the United Nations General Assembly, in order to develop strategic responses to these diseases and their repercussions. They also supported initiatives to include the monitoring of NCDs in existing national health information systems and emphasized the need for NCD indicators to be included in the monitoring of the MDGs [Millennium Development Goals]" (CHOGM 2009a). They also issued a separate statement solely devoted to non-communicable diseases (CHOGM 2009b).

The G20's Seoul Summit on November 11-12, 2010, noted the relevance of NCDs for the first time. It did so at the initiative of Indonesia, as part of the G20's new development plan (G20 2010). At the Asia Pacific Economic Co-operation (APEC) leaders' meeting in Yokohama, Japan, on November 13-14, 2010, leaders made two references, taking the form of commitments to NCDs. They agreed that NCD control "should be enhanced" (APEC 2010).

This cadence will culminate in New York on September 19-20, 2011, when the UN will hold a High Level Meeting (HLM) on NCDs. It will be the 28th special summit held by the UN, the second one on health and the first one on NCDs. The UN General Assembly voted in favour of a resolution tabled on behalf of the Caribbean Community member states to hold this special summit. Over 100 countries, including the U.S., Brazil, Canada,

Russia, China, India and the United Kingdom, co-sponsored the resolution. This shows that NCDs have become a global priority and a core development issue. The NCD HLM will address the threats posed by NCDs to low- and middle-income countries (LMICs). Bringing together public health experts and government representatives from LMICs as well as representatives from donor countries, the summit will discuss solutions to the growing danger posed by NCDs and agree on what action needs to be taken (NCD Alliance 2010).

However, the commitments made at such summits are often, at times correctly, dismissed as empty promises, made by politicians at high-profile events that are neither subsequently implemented at home or abroad. In practice there is a wide range of variation in these regards. Some summits produce commitments that are largely implemented and lead to the intended results, while others languish, unfulfilled or forgotten for a very long time. Some causes of implementation are contextual, lying beyond the control of those who design such summits and create the commitments they produce. However, others can be controlled by summit planners and producers, who can carefully craft their commitments with catalysts that increase implementation, add an accountability architecture to assist and use surrounding summits in a supportive way.

In designing the NCD HLM in 2011, it is thus important to ensure that the commitments made have the appropriate compliance catalysts, an accompanying accountability architecture and supportive surrounding summits.

Purpose

To do so, this study addresses three central questions:

1. How can the NCD HLM in 2011 best craft commitments that will enhance members' implementation and help achieve the intended results in the following years?

2. What can be done to add the best accountability mechanism(s) available to improve members' implementation and the results tied to that implementation?

3. What are the most important summits to target in the lead-up and follow-up to the NCD HLM to enhance implementation and what is the best way to engage those summits to provide support?

The Argument

A strategy for shaping a NCD HLM that delivers should be based on an adjusted "Muskoka-to-MDG summit" model, following the productive G8-UN partnership on MDGs 4 and 5 on maternal, newborn and child health (MNCH) and accountability in 2010. The strategy should take into full account the many differences between the health MDGs and NCDs, and between the G8 and UN as international institutions governing global health. This appropriately adjusted model should embrace three key dimensions: crafting implementation-enhancing commitments at the UN HLM, adding an accountability architecture to monitor NCD implementation, and securing support from

surrounding summits for the NCD cause.

In crafting implementation-enhancing commitments for the NCD HLM, a surgical approach to commitment design should be used. The most important commitments should be given priority placement in the outcome document. WHO, the core international organization on health, should be called on to play a key role. It is important that other multilateral organizations, such as the World Bank, be invoked to assist with implementation as well. Civil society should have an integral role. References to specific countries or regions or to past UN meetings should be avoided. The use of a multi-year timetable could increase implementation for certain countries, including the U.S., France, Japan, Italy and Canada, while a one-year timetable and target could help with the United States. Mobilizing new money in the commitments should be avoided.

The standard UN accountability mechanisms are inadequate on their own. A new architecture should draw on the promising model of the UN's Commission on Information and Accountability for Women's and Children's Health. Participants should commit to including such a mechanism at the HLM. It should be accompanied by ongoing independent, analytically oriented compliance assessment processes to add timely, reliable, credible information for rapid assessment and course-corrections where necessary.

In securing support from surrounding summits, the starting point should be a revised repetition of the substantially successful G8-UN synergy in 2010, when the two summits cooperated to advance MNCH and accountability. The French-hosted G8 summit in Deauville on May 26-27, 2011, could serve as a similar set-up to the UN HLM on NCDs in September by getting G8 leaders to pre-commit to the issues and event. Similar efforts should be made to engage other summits, such as the G20, SOA, APEC, ASEAN, the Commonwealth and la Francophonie.

Crafting Implementation-Enhancing Commitments

What is the best way to craft commitments for the NCD HLM to maximize members' implementation with them and enhance their success in achieving the intended results? The most important commitments should have priority placement in the outcome document. Commitments should invoke WHO, other multilateral organizations and civil society. References to the private sector and to specific countries or regions should be avoided. Multi-year timetables could be included to enhance compliance for the U.S., France, Japan, Italy and Canada. One-year timetables and targets could be added to improve U.S. compliance. Mobilizing new money in the commitments should be avoided, as it reduces compliance.

The G8's Compliance-Catalyzing Record

The above recommendations flow in the first instance from the accumulating evidence that G8 summit leaders can improve members' implementation with their collective commitments on health, development, finance and climate change by crafting them in ways that embed particular catalysts within them (see Appendix A) (Kirton and Guebert

2009a). However, only a few of the many possible and plausible catalysts affect implementation, and even fewer improve implementation. Moreover, different combinations or "cocktails" of catalysts improve individual country's implementation.

In the health-related area of development and finance, on the G8 priority commitments that were assessed from 1996 to 2004, three embedded catalysts improved implementation: including a timetable, placing the commitment in a priority document or section of the document (see Appendix A, "priority placement") and having G8 finance ministers repeat the commitment in their communiqué the year before and after the summit (Kirton 2006a).

On the priority climate change commitments assessed from 1987 to 2006, priority placement helped raise collective implementation, while references to international law hindered it. For the U.S., references to the core international organization (the United Nations Framework Convention on Climate Change) hindered implementation. For Canada, priority placement and references to the core international organization improved implementation, while a target, reference to a specified agent and reference to international law hindered it (Kirton and Guebert 2009b).

On priority health commitments assessed from 1996 to 2005, a one-year timetable and a reference to a core international institution (WHO) correlated with better implementation, while a multi-year timetable, reference to other international organizations (that is, other than WHO) and reference to the G8 finance ministers hindered implementation (Kirton, Roudev and Sunderland 2007; Kirton, Roudev, Sunderland and Kunz 2008; Kirton, Roudev, Sunderland, Kunz and Guebert 2010).

The G8 Health Compliance Catalysts that Count

These early findings are now adjusted by an updated, more detailed examination of 50 G8 health commitments from 1980 to 2009, over an expanded list of 20 catalysts (see Appendix C).

This examination shows that the total number of catalysts in a commitment does not improve the chances of implementation. Collective (i.e., average) summit implementation is enhanced by health commitments that contain, in order of salience, references to international organizations other than the core international one, references to the core international organization (i.e., WHO), commitments that are put in priority placement and ones that reference civil society. Implementation is hindered in health commitments that contain, in order, references to a specific country or region, a past summit, the private sector, a specified target and ones that mobilize new money in the specific commitments. Together, these nine catalysts (the four "enhancers" that improve implementation and the five "inhibitors" that lower it) account for 56 percent of the variation in the implementation that results.

A more detailed, if slightly less refined, examination of the catalysts that affect the implementation of individual G8 members reveals that priority placement raises compliance for most members, especially Russia and Italy, but not for Canada or the

European Union. References to international organizations other than WHO raise compliance for all members, particularly for France, Japan, Italy and Russia, but not for the EU. Only two catalysts — priority placement and references to other international organizations — improves implementation for virtually all G8 members. The inclusion of civil society improves implementation, often very strongly, for all members except the U.S., Canada and Russia.

Beyond these three common catalysts, implementation by the United States, the most powerful member of both the G8 and the UN, is enhanced by the inclusion of one-year and multi-year timetables and a target, but lowered by references to the WHO, civil society and all other catalysts (see Appendix A). For France, which hosts both the G8 and the G20 summits in 2011 and is thus potentially a supportive leader in setting up and following up on the NCD HLM, implementation is enhanced by one-year and multi-year timetables and G8 institutional body assistance.

For Japan, the G8's second most powerful member and the sole Asian one, implementation is enhanced by referring to a specified agent, by including a remit mandate and a multi-year timetable. Germany's implementation is higher in commitments that include one-year and multi-year timetables and that reference a G8 institutional body. The United Kingdom's implementation is enhanced, very distinctively, in commitments that include remit mandates, targets, where money is mobilized, and references to G8 ministers and international law are made. For Italy, implementation is enhanced by remit mandates, multi-year timetables and references to a G8 institutional body, core international organization and international law.

For Canada, the host and chair of the G8 and G20 summits in June 2010, implementation is enhanced by one-year and multi-year timetables and references to a specified agent, G8 ministers and the private sector. Russia's implementation tends to be higher in health commitments that include remit mandates, mobilize money and make references to the private sector, G8 ministers, G8 institutional bodies, the WHO and international law. The European Union's implementation is enhanced by commitments that include remit mandates, mobilize money, incorporate one-year and multi-year timetables, and reference international law, the WHO and G8 institutional bodies focused on health.

This analysis clearly indicates that implementation is improved by the use of priority placement and references to international organizations and civil society. Implementation is hindered by references to a regional organization (for all countries), a past summit (for all but the UK), the private sector (for all but Canada and Russia), and a particular country or region (for all but Japan, Germany and Russia). Other catalysts have offsetting effects on individual G8 members, with the U.S. motivated positively by timetables and targets, and the U.S., France, Japan, Italy and Canada motivated by multi-year timetables.

Lessons for the 2011 UN NCD HLM

There are considerable differences between, on the one hand, an annual, informal, plurilateral G8 summit of advanced countries with a comprehensive agenda and, on the other hand, a one-time only, formal, multilateral, UN HLM dominated by developing

countries and with a single theme. There are also relevant differences between the dominant infectious diseases referred to in MDGs 4, 5 and 6, which were the subject of the UN summit in September 2010 and the NCDs that will be dealt with at the September HLM in 2011. Nonetheless, several useful inferences can be made, especially given the importance of getting the very powerful and influential countries that belong to both the G8 and UN credibly committed to the NCD meeting. The transferable inferences from the central findings reported above show that the sheer number of plausible catalysts stuffed into a single commitment does not raise overall implementation with it. Thus, a selective, surgical approach to commitment design needs to be employed.

First, because priority placement is correlated with higher implementation, one key strategic component for the NCD HLM should be to include the most important commitments in the opening passages of the outcome document. This document must have the full weight of as many global leaders as possible, particularly the most important ones, who should be visibly present when it is released. One possible technique is to have the attending leaders personally sign the documents publicly, as the G8 leaders and their invited colleagues from emerging and developing countries did at the G8 Gleneagles Summit in 2005.

Second, because a reference to, and thus reliance on, other international organizations improves implementation both collectively and individually, multilateral organizations such as PAHO, the World Bank, Organisation for Economic Co-operation and Development (OECD) and the International Monetary Fund (IMF) should be given key and ongoing roles in implementation of the appropriate commitments. The invocation of the core international organization – WHO – strongly raises compliance collectively, but not for those three G8 countries located farthest from Geneva, namely the U.S., Japan and Canada. Reliance on WHO, as the UN is doing for accountability monitoring for the 2010 MDG Summit, should be based on a consideration of the centrality of these three country's implementation with the NCD commitments. Here there could be a large role for PAHO and outside, independent organizations to play in accomplishing the accountability task.

Third, because references to civil society raise compliance collectively and for the majority of members (all but the U.S., Canada and Russia), they should be included in the commitments themselves, but in a specific way. If properly designed, this should do little harm to compliance by the U.S., Canada and Russia, and indeed could help it, given the particular civil society stakeholders centrally concerned with NCDs and the UN's well-established precedents and processes for involving civil society in UN summits and subject-specific meetings. The involvement of the business community will require careful consideration for, in a G8 context, it lowers the collective compliance of members, and for all but the two least powerful countries — Canada and Russia. One possible path is to reflect on how the business community could be involved more productively than it has been by the G8 in its commitments to date.

Fourth, among the several superficially attractive catalysts, one to avoid is designating particular countries or regions as a focus for commitments. This does not preclude

special, specified attention to particular categories of countries, such as least developed countries or low- or middle-income countries (LMICs). Similarly, also to be avoided is delegating or downloading to stand-alone, continentally confined regional organizations such as the African Union (as opposed to pan-hemispheric or trans-oceanic organizations). Here the UN's global governance — backed by principles of universality — must be maintained rather than handed over to regional governance. This does not preclude mobilizing the UN's regional commissions as a component of the global institution in the NCD HLM's implementation tasks.

Fifth, a strategy should avoid references to and reliance on past summits or HLMs of the UN. In the G8 context, members' implementation has been hindered when the commitments have been backward looking in this way. Instead, a forward-looking approach, with a fresh start at every summit, should be followed. The leaders attending the NCD HLM will not likely be much different in this respect. Reminders of past promises, especially unfulfilled ones, harm rather than help in the mobilization of new, highest-level political will, which is the unique contribution that leaders can make.

The other catalysts have offsetting effects across the members. The U.S. is motivated positively by timetables and targets. A multi-year timetable works for the U.S., France, Japan, Italy and Canada. For most members, attaching new money or funding or invoking international law in an individual commitment does not help compliance.

Adding an Accountability Architecture to Assist

What can be done to ensure that the best accountability architecture is added to the NCD HLM to assist in the implementation of commitments and impact on improved outcomes? The standard UN mechanisms for monitoring and accountability are not adequate on their own. It is also not a good idea, based on the experience of the G20 summits, to ask another international organization(s) to take full responsibility for the compliance assessment task (Kirton 2011). Instead, a new accountability mechanism is required. The UN's Commission on Information and Accountability for Women's and Children's Health provides a promising model to be considered. It is headed by well-positioned leaders from the developed and developing worlds and has a role for civil society to play. This new mechanism should be committed to at the NCD HLM and established immediately following it. It should also be accompanied by ongoing, independent, analytically oriented processes that assess implementation, and thus provide timely, reliable information, additional analysis and added credibility.

UN Accountability Approaches

Over the years, the UN and other multilateral "hard law" bodies have relied on a wide variety of approaches to assess, encourage and improve the direct monitoring of and broader accountability for the many commitments it makes (Kirton 2011; Abbott, Keohane, Moravcsik et al.; Raustiala and Slaughter 2002). They have largely relied on the use of self-reporting by member states to new or existing units in the UN permanent secretariat. This standard approach has been used, along with several enhancements, for monitoring and accountability in regard to the UN's summits and high-level meetings.

This use has increased, starting with the UN World Summit for Children in September 1990, followed soon after by the UN Conference on the Environment and Development (UNCED) in Rio de Janeiro in 1992, and reaching a new peak with the Millennium Summit in 2000. These ad hoc, special-subject meetings have relied, as their major accountability enhancement, on regular follow-on meetings, starting with the World Summit on Sustainable Development in Johannesburg in 2002 (Johnson 2002). These meetings often continued in five-year increments, with the World Summit in 2005 and the MDG Summit in September 2010, where the MDG goals were reviewed. This latter summit used three standard accountability mechanisms and one exceptional one, including plans to hold a special event in 2013 to follow up on implementation (UNGA 2010).

Very little systematic data exists in the public domain, either from these captive internal or independent outside analysts, about members' implementation with such special summit and HLM commitments, or the effectiveness of the standard accountability mechanisms in influencing, positively or negatively, this implementation and the intended results (Cockayne, Mikulaschek and Perry 2010). Most close observers of the UN system, starting with the Security Council and moving outward, suggest that members' implementation and that the standard accountability mechanisms could be greatly improved (Stewart 2011). They also point to considerable variability in the accountability mechanisms, and in members' implementation with their "regime" commitments, suggesting strongly that changes in the design of the former can improve compliance and effectiveness (Raustiala and Slaughter 2002). They further suggest that accountability measures beyond the standard UN ones are needed to enhance implementation and effectiveness of results.

G8 Accountability: The Muskoka Monitoring Mechanism

Within informal, plurilateral international institutions that have no secretariat, such as the G8 and G20 – distinct from those such as the Commonwealth and APEC, which have small ones – the measurement of implementation and effectiveness concentrates on the overall, ongoing commitments made by the political authorities at the highest level. One such recent innovation in monitoring such implementation comes from the G8 Muskoka Summit in 2010, with its Muskoka Accountability process and report (G8 2010). After various experiments, it developed a process through which the recently formed G8 Accountability Working Group assessed members' performance in meeting their commitments on development, and in specific areas such as health. The group's first report, delivered just prior to the Muskoka Summit in June 2010, used a standard framework applied across all issue areas, with a five- to ten-year assessment period.

This intergovernmental self-assessment, which was publicly reported, was a good start. However, it had several shortcomings (Guebert and Bracht 2010; Kokotsis 2010). It covered only one component – development – of the G8's commitments, leaving many others in the political security and economic fields out. Five-year assessment periods make it difficult to measure or use the results for timely course corrections where necessary and on an annual schedule that mirrors the G8 leaders'. It is also difficult to

find quantitative comparative analysis within the data to see which individual members have complied and with which commitments.

G20 Accountability: Reliance on Other Major Multilateral Organizations

In the case of the G20 summits, the dominant approach has been to ask other multilateral organizations to monitor the countries' implementation with a few specified commitments. However, the admittedly limited data currently available suggest that this approach has not had the desired implementation-improving impact. In the case of trade, where this approach was first used and where compliance data is available, the G20's repeated request to the World Trade Organization (WTO) to monitor the G20's anti-protectionist commitments was followed by declining implementation. Following the G20's London Summit in April 2009, the average G20 implementation score started off fairly high at +0.50 (higher than the summit's overall average of +0.42).[1] However, after the Pittsburgh Summit in September 2009, the score fell to +0.10 (lower than the summit's overall average of +0.33). After the Toronto Summit in June 2010, implementation improved, but only slightly, to +0.15 (again lower than the summit's overall average of +0.30).

The G20 leaders may have decided to repeat their request to designated multilateral organizations after the apparent success in London. However, the current evidence suggests that this approach has not been effective. At the same time, it is important to note that the decreasing implementation trend could have also been due to the fact that the anti-protectionist commitments became more ambitious over time, with the inclusion of a promise to redress and roll back protectionist moves. More research is required on the actual effectiveness of this accountability approach (Kirton 2011).

Hybrid Accountability: The MDG Summit, September 2010

At the UN MDG Summit in September 2010, a hybrid accountability architecture was endorsed to monitor donor commitments and recipient distribution. Leaders committed government officials, international organizations, philanthropists and civil society stakeholders to work together on monitoring implementation and the intended outcomes needed to achieve the MDGs by their 2015 deadline.

Accountability in the Summit Outcome Documents
In the outcome document released at the MDG Summit, there was a significant emphasis placed on accountability. Leaders noted the importance of enhancing transparent and accountable systems of governance at national and international levels, and in the area of international development cooperation in donor and recipient countries. They reaffirmed "the importance of accountability, transparency and improved results-based management" and agreed that "further harmonized results-based reporting on the work of the United Nations funds and programmes and the specialized agencies" was critical. They called for improving statistics and accountability monitoring and reporting by all

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[1] This is on a scale of -1 to +1. On the more common scale of 0 to 100 percent, +0.50 is equivalent to 75 percent.

members in relation to the MDGs, and that is was critical in developed, donor, developing and recipient countries (United Nations General Assembly [UNGA] 2010). At the end of the outcome document, four mechanisms were specified to perform the accountability monitoring task.

Commission on Information and Accountability for Women's and Children's Health
During the MDG Summit, the separate Global Strategy for Women's and Children's Health was launched, with no reference in the leaders' outcome document itself and thus no authority. It was, however, adopted by the UN and its members at the end of the summit. It was developed and endorsed by a wide range of actors, including government officials, international organizations, philanthropists, civil society stakeholders, the business community and academics. It was welcomed by virtually all UN members. Improving women and children's health were the ultimate goals and increased transparency and accountability were highlighted as key elements to achieving those outcomes. The first meeting of the commission noted, "accountability is essential. It ensures that all partners deliver on their commitments, demonstrates how actions and investment translate into tangible results and better long-term outcomes, and tells us what works, what needs to be improves and what requires more attention" (Ban 2010).

The Commission on Information and Accountability for Women's and Children's Health was formed to "track results and resource flows at global and country levels; identify a core set of indicators and measurement needs for women's and children's health; propose steps to improve health information and registration of vital events — births and deaths — in low-income countries; and explore opportunities for innovation in information technology to improve reliable information on resources and outcomes" (Every Woman Every Child 2010). The commission's first report is scheduled for publication in May 2011. This report and accountability approach should be given serious assessment and consideration in the lead-up to the UN NCD HLM.

Independent Accountability Assessment: The G8 and G20 Research Groups and Others

Another approach has been to rely on external accountability assessments by outside independent, professional or scientific bodies with an analytical, rather than advocacy mission. At a minimum, this could enable civil society representativeness to be engaged more effectively in multi-stakeholder monitoring. It can also help provide timely information about how fast and how well the leaders' collective political will is being implemented, and thus it provides them with the information necessary to adjust their actions and commitments as required to help them meet their goals. Further, it can provide a credible, transparent, equally and inclusively available assessment to all stakeholders that inside government-led approaches lack.

Securing Support from Surrounding Summits in 2011/12

What are the most important surrounding summits that can support the NCD HLM in its commitment and implementation tasks and how can they best be mobilized?

Several specific steps stand out. First, it is important to get leaders who are members of other influential summits, such as the G8, G20 and BRICS, to commit to attend the NCD HLM in September. This should be encouraged internally, where there is an overlap in the government officials dedicated to the issues and meetings, such those doing health and foreign policy. It should also be encouraged externally by civil society stakeholders, dealing with health, utilizing the media where possible, as reinforced by a broader coalition of development nongovernmental organizations (NGOs) with strong links to the G8 and UN. It is important for NGOs to remind leaders that citizens are suffering greatly from NCDs.

Second, other summits, starting with the G8, should be pressed to add NCDs directly to their agendas. A good start came when leaders referred to NCDs at the MDG Summit. There they committed to accelerate "progress in promoting global public health for all" through "strengthening the effectiveness of health systems and proven interventions to address evolving health challenges, including the increased incidence of non-communicable diseases" and accelerating progress in order to achieve MDG 6 by "undertaking concerted action and a coordinated response at the nation, regional and global levels in order to adequately address the developmental and other challenges posed by non-communicable diseases, namely cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, working towards a successful high-level meeting of the General Assembly in 2011" at the MDG Summit in September (UNGA 2010).

Efforts should be made to get leaders to make similar and more NCD-specific commitments at other international summits. Working groups, ministers and officials in relevant portfolios, such as health, development, finance, trade and food and agriculture, as well as leaders should be mobilized to adopt NCDs as an agenda item as quickly as possible, as planning for summits is a long and involved process

Third, key countries, such as those who will be hosting important meetings and thus have the important and significant roles of chairs should be utilized. Those who have experience in past summit collaborations and meetings that have focused on NCDs should also be drawn on. It is also important and beneficial to have the most powerful and influential countries attend the HLM in September. Lastly, it is important to target nations that have already shown an interest in the cause. They should be encouraged to continue to champion the initiatives in various forums, particularly summits, and draw others into the cause.

Important lessons from past summit collaborations should be drawn and built on, such as the substantially successful G8-UN alliance in 2010. The G8 Muskoka Summit's signature achievements on MNCH and accountability in June were followed by a broadened agenda, commitments and measures, including increased funding pledged at the MDG review summit in September (Global Campaign for the Health Millennium Development Goals 2010).

The 2011 G8 Deauville Summit could be used to set up the UN HLM on NCDs in a similar manner, by getting the G8 leaders to pre-commit to the issue and event. There are

also good reasons to garner support from the broader and more balanced G20 summit, which recently recognized the important connection between tackling NCDs and improving economic development. There are additional reasons to cooperate with CARICOM, the BRICS, the SOA, APEC, the Commonwealth, la Francophonie and other summits.

The G8 Summit Set-Up, Deauville, France, May 26-27, 2011

The G8 summit in Deauville, France, on May 26-27 is the only key global summit involving almost all the world's most powerful countries, to be scheduled before the NCD HLM in September. It thus presents a unique opportunity for G8 leaders to highlight their personal commitment to tackling NCDs and to attend the UN NCD HLM itself. Development, including health, will be a key theme at the Deauville Summit, with a focus on Africa and accountability. It will also likely be attended by the leaders of the African Union (AU) and the New Partnership for Africa's Development (NEPAD) and possibly several other developing and emerging country leaders. It is therefore an opportune candidate to advance the issue in a somewhat inclusive way. Since the G8 remain, by far, the largest donors of ODA in the world, and since their personal presence at the HLM can make a decisive difference in the decisions of other leaders to attend, it would be hugely beneficial to have the G8 Deauville Summit work for the NCD HLM.

Although the G8 has never directly dealt with NCDs, it is possible that Deauville, with French president Nicolas Sarkozy as host and chair, can be attracted to the opportunity of making history in taking this first step. There is a longstanding successful synergy between the annual G8 summits and UN special meetings on specific subjects. This dates back to the 1990 G7 Summit in Houston, Texas, where Canadian prime minister Brian Mulroney (2007) convinced host American president George H. Bush and the rest of the G7 to be part of the 71 leaders who attended the UN World Summit for Children in New York that September. The G7 was similarly central in shaping and supporting the 1992 UNCED Summit in Rio de Janeiro, where all of the leaders, and many others, attended. In 2002, the G8 worked in close co-operation to support the UN's International Conference on Financing for Development in Monterrey in mid-March. G8-UN cooperation reappeared in 2005, when the British-hosted Gleneagles Summit focused on debt, aid, trade and HIV/AIDS a few months before the UN World Summit to follow-up on the MDGs in September 2005.

In 2010, the G8's synergistic set-up to the UN special summit on the MDGs worked very well. In this "Muskoka-to-MDG Summit" cadence, the G8 devoted its June 2010 summit to two centrepiece achievements — MNCH and accountability. When plans for the 2010 Canadian-hosted summit were first made public in June 2008, development and health were not publicly listed among the three core themes, or even as part of the agenda at all. But due, in part, to the initiative and skill of child-focused NGOs, backed by their members and the faith community, by the summer of 2009 Canadian prime minister Stephen Harper had placed development and MNCH on the agenda (Harper 2009). Motivating factors may have included the MDG review summit scheduled to take place shortly after the Muskoka Summit, and the fact that MDGs 4 and 5, on child and maternal health, were the two millennium goals that were furthest from being realized.

The Muskoka Summit was successful in mobilizing a significant $7.3 billion (subsequently increased to an estimated $10 billion over five years) in new money for MNCH, to support existing mechanisms through simple solutions that were know to deliver fast, effective results. It was particularly noteworthy, coming from countries still suffering from the recent financial crisis. Pledges came from all G8 members, led by the Canadian hosts, from several non-G8 countries, including emerging country and G20 co-chair Korea and host of the next G20 summit, private foundations and broader civil society stakeholders, including the Bill and Melinda Gates Foundation, UN foundations and universities.

A G8-UN synergistic set-up could work just as well for the UN NCD HLM in 2011. Here the key objectives, in order of increasing ambition, should be to have the G8 leaders in Deauville, France:

1. Recognize NCDs as a G8 and broader global issue, in a health, development and economic context and ideally as an important, urgent one. At a minimum, the G8 should be encouraged to repeat and approve the G20 Seoul statement on NCDs;

2. Recognize and express support for the UN's NCD HLM;

3. Commit to attend the HLM on NCDs, and to urge all other global leaders to attend;

4. Recognize the contributions that the WHO and other key multilateral organizations, civil society stakeholders and other actors can make in addressing NCDs, and encourage their involvement as a result.

The G20 Summit Follow-Up, Cannes, France, November 3-4, 2011

The central global summit of relevance for fast follow-up in implementing the UN NCD HLM results will be the G20 in Cannes, France, on November 3-4, 2011. Unlike the G8, the G20 has already recognized the importance of addressing NCDs.

The G20's primary focus at their first five summits was on economic and financial issues. Health has not appeared on their agenda in a major way. However, it has been directly and indirectly referenced at each summit. Attention has been given to development and the MDGs more specifically. At the G20's Seoul Summit in November 2010, NCDs and the health-economic link were highlighted in both the Seoul Development Consensus and the Multi-Year Action Plan for Shared Growth (Guebert and Lennox 2011).

Other Key Summits and Meetings

Other International Summits
There are other important international summits that should be utilized as well (see Appendix D). These include the East Asian Summit, the IBSA Summit (India, Brazil and

South Africa) and the CHOGM in October 2011; and the APEC Summit on November 12-13, 2011.

Regional Summits
There are also regional summits that could be used as well, such as the North American Leaders Summit and the ASEAN Summit. NCDs pose major healthcare and economic challenges in North America. ASEAN host Indonesia, which pushed for the inclusion of NCDs at the G20 Seoul Summit, is in a position to get other Asian leaders behind the cause.

Additional Important Meetings
The World Health Assembly (WHA) will meet for its 64th session on May 16-24, 2011. NCDs will be a key priority on its agenda. This and a variety of other planning meetings and ministerial meetings, such as the World Economic Forum and the ministerial meeting on NCDs in Russia in April, will also be important for helping to mobilize leaders' and officials to advance the control of NCDs.

Key Countries for Connecting Leadership

They are key countries that should be mobilized. Indonesia, which insisted on including NCDs on the Seoul G20 Summit agenda in November 2010, is scheduled to host several summits in 2011 (see Appendix D). It will thus be important to encourage Indonesia to continue to champion the NCD cause in the lead-up to and following the HLM.

The most powerful country in the world, the United States will host APEC in 2011 and the G8 in 2012. It might also be wise to draw on first lady Michelle Obama's campaign to tackle child obesity. Russia will host the first comprehensive ministerial meeting on NCDs to prepare for the HLM in 2011, as well as APEC in 2012, the G8 in 2013 and possibly the G20 in 2013 or 2014. As a global leader on many past health issues, it would be valuable to get President Medvedev to commit to attending the UN NCD HLM. France will host the G8 and G20 in 2011 and therefore could play a critical role in enhancing the NCD agenda. Mexico will take over as chair of the G20 in 2011 and suffers greatly from NCDs. They would be a critical emerging economy champion. Canada and Korea should be looked to for their collaborating experiences in 2010. China and India and others affected most by NCDs could also play an important mobilizing role.

Conclusions and Recommendations

Drawing on past successful summit experiences, above all the G8, there are three important lessons and recommendations to carry forth in order to carry out a successful UN NCD HLM in September 2011.

1. Commitments should be crafted to include catalysts that improve and enhance implementation.

2. Participants need to commit to a new accountability architecture, looking to the Commission on Information and Accountability for Women's and Children's Health for potential guidance, to ensure the commitments made at the HLM are monitored, implemented and the intended goals are achieved.

3. Actors involved in the HLM need to secure support from as many surrounding summits and meetings as possible in order to reach the best possible outcome for NCDs.

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Appendix A: List of Compliance Catalysts, N=20

Definitions of Catalysts

Total Catalysts. Refers to the total number of compliance catalysts (see list above) in the said commitment.

Priority placement. When a commitment is highlighted in the preamble or is stated in the Chair's Summary it is considered a priority placement.

Past Reference to Summit: This refers to commitments that mention past summits. They are considered iterations. For example, just like at the G8 Evian Summit, we stress… (from a more recent summit)

Past Reference to Ministerial: This refers to commitments that mention past ministerial meetings. See above catalyst.

Targets. When a commitment refers to a set goal, percentage or numerical allocation it is considered a target. For instance, we will reduce; we will cut in half; or we will increase by 75%. It does not include time targets, which are considered time tables. See below.

Time Tables. When a commitment refers to a time target, it is considered to include a time table. This can be short-term (1 year of less) or long-term (more than 1 year). Some may include both short- and long-term break downs. It includes phrases such as "within a year," "by the next summit," "by 2015" and specific dates. It also includes references to words and phrases such as the Millennium Development Goals (MDGs), which include well-known time targets.

Self-monitoring: These refer to commitments where the institution in question pledges to monitor their actions on the said commitment. They could pledge to 'monitor,' or provide a report, to follow up on said promises.

Remit mandates. These include commitments that refer to future assessment, most often at a future summit. For example, "We will review progress on our Action Plan at our next summit."

Money mobilized. When a commitment refers to funds or a set dollar value it is considered money mobilized. This includes commitments to replenish funds and provide monetary aid.

Specified Agents. When a commitment refers to a specific agent through which it will work with or through it is considered to be involving an agent. For example, with the Bill and Melinda Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis or Malaria or with the International Fund for Agriculture and Development. It does not include general references to agencies, such as the private sector or civil society.

Institutional Body: a commitment that refers to an agent that was created by the institution to deal with the particular issue area. For example, the G8-created Gleneagles dialogue on climate change or the Global Fund to Fight AIDS, Tuberculosis and Malaria. It includes bodies that are referred to in commitments that are created at the summits in question.

Core International Organization: when a commitment refers to a separate international organization (as an organization) that has a particular focus on the issue in the commitment at hand. For example, in the area of health, this would include the World Health Organization (WHO); in development, it would include the World Bank; in trade it would refer to the World Trade Organization. It does not include references to an international organization when they are NOT institutional references. For example, a reference to WTO inconsistent measures is not a reference to an IO. It is a reference to international law. References to regional or other international organizations are not core international organizations. They are considered other international organizations or regional organizations. See below.

Other International Organization: when a commitment refers to a separate international organization (as an organization) that is NOT the core international organization for the issue in the commitment at hand. For example, in the area of health, this would include the references to the World Bank, International Monetary Fund or Financial Stability Board.

Regional Organization. When a commitment refers to a regional organization, such as the African Union, NEPAD or the European Union. It does not include regional

International Law. International Law includes both general references to international law and references to specific legal instruments (Kyoto, for example). Only codified law, not customary law, is included since it is neither specific or binding within the international setting (the content of the codified instrument has international agreements that take clear precedence over national discretion). Example of this catalyst include the following: Charters, Conventions, Treaties, Protocols, Declarations, Agreements, Frameworks, Guidelines, Internationally Recognized Principles or Standards. Also included are the calls for the implementation or development of specific international legal instruments.

Ministers. Commitment refers to a group of ministers. For example, "we ask our energy ministers to…"

International Organization Accountability Ask. Refers to commitments that ask international organizations to monitor the groups' compliance with the commitment. For example, we ask the WTO to monitor our compliance with this commitment.

Civil Society. Commitments that make general reference to working with civil society, including nongovernmental organizations and academia.

Private Sector. Commitments that make general reference to working with the private sector, public-private partnerships, business (including the pharmaceutical industry).

County or Regional Specification. Commitments that make references to working with or in a particular country or region, such as Africa. It does not include broad references to developed or developing countries.

Notes

Compliance catalysts are coded as either a 0 or a 1. They are either present or they are not. If they are in the commitment repeated times, there are still coded as 1 (i.e., present), not multiple times.
Catalysts should be coded with the broader context of the commitment in mind; therefore, the coder needs to read the commitment in its broader context, which may include the surrounding sentences, paragraphs or documents. A catalyst that applies to a particular commitment may lay outside of the specific commitment text.

Appendix B: Agreed Elements on Non-communicable Diseases from Previous Summits

Element	SOA	CHOGM	G20	APEC
Support PAHO Regional Strategy	Yes			
Support WHO's Tobacco Control	Yes			
Nation Surveillance by 2015	Yes	Yes		
National Reporting by 2015	Yes			
National Planning and Coordination	Yes			
National Commissions Created	Yes			
UN NCD Summit Endorsed		Yes		
MDG Monitoring for NCDs		Yes		
Separate NCD Statement		Yes		
Explore NCDs that prevent productivity			Yes	
Enhance NCD Control				Yes

Notes:

SOA=Summit of the Americas; CHOGM=Commonwealth Heads of Government Meeting; G20=Group of Twenty; APEC=Asia Pacific Economic Cooperation.

Appendix C: G8 Health Compliance Catalysts that Count

	Average	Common	U.S.	JAP	GER	UK	FRA	ITA	CAN	RUS	EU
Catalysts											
Core International Organization	+	4	-	-	+	-	-	+	-	+	+
Other International Organization	+	8	+	+	+	+	+	+	+	+	-
Priority Placement	+	8	+	+	+	+	+	+	-	+	-
Civil Society	+	6	-	+	+	+	+	+	-	-	+
Country/Region	-	3	-	+	+	-	-	-	-	+	-
Private Sector	-	2	-	-	-	-	-	-	+	+	-
Target	-	4	+	-	+	+	-	-	-	-	+
Money Mobilized	-	5	-	+	+	+	-	-	-	+	+
Multi-year Timetable		5	+	+	-	-	+	+	+	-	-
Ministers		6	+	+	-	+	-	+	+	+	-
One-year Timetable		5	+	-	+	-	+	-	+	-	+
Specified Agent		2	-	+	-	-	-	-	+	-	-
Institutional Body		5	-	-	+	-	+	+	-	+	+
Remit Mandate		5	-	+	-	+	-	+	-	+	+
Past Reference-Summit		1	-	-	-	+	-	-	-	-	-
International Law		5	-	-	+	+	-	+	-	+	+
Regional Organization		0	-	-	-	-	-	-	-	-	NA

Notes: + represents a compliance enhancer. — represents a compliance inhibitor. Two separate regressions were run and have been included in this chart. Average column includes regression results by Nick Roudev on G8 summit health compliance as a whole. Common column represents the number of members for which the catalyst in questions enhances compliance. Common column includes regressions results by Alexandra Irena Eremia on individual G8 members' health compliance.

N=50 health commitments with compliance assessments completed, as of February 1, 2011.

Appendix D: 2011 Timeline
for Plurilateral Summit Institutions

April 14	BRICS Summit, Sanya, China (Brazil, Russia, India and China, with South Africa invited by the Chinese host)
April (postponed)	Summit of the Organization of the Islamic Conference (OIC), Cairo, Egypt
May 7-8	ASEAN Summit, Jakarta, Indonesia
May 26-27	**G8 Summit, Deauville, France**
June 15	Shanghai Cooperation Organization Summit, Astana, Kazakhstan
September 19-20	**United Nations Summit on Noncommunicable Diseases, New York, United States**
October 17-23	ASEAN Summit, Bali, Indonesia
October	East Asian Summit, Indonesia
October	IBSA Summit, South Africa
October 28-30	Commonwealth Heads of Government Meeting, Perth, Australia
November 3-4	**G20 Summit, Cannes, France**
November 12-13	APEC Summit, Honolulu, United States
Date not announced	North American Leaders' Summit, Canada
Date not announced	East Asian Summit, Indonesia (with Russia and United States)