Explaining Compliance with Regional and Global Summit Commitments: CARICOM, UN, G8 and G20 Action on Non-communicable Disease

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Abstract

Why do members of international institutions comply with the commitments their leaders make at regional and global summits on key issues such as the prevention and control of non-communicable disease (NCDs)? To answer this question about how and why international institutions constrain the behaviour of their autonomous state members in a structurally anarchic system and to assess the effectiveness of summit governance of the most costly health challenge in the world, this study examines in turn how much and why members complied with their NCD-related commitments made at: 1. the regional CARICOM's pioneering Port of Spain (POS) summit in September 2007; 2. the multilateral United Nations High Level Meeting (UN HLM) in September 2011; 3. the plurilateral G8's annual summits since 1980; and 4. the plurilateral G20's nine summits since 2008. On this basis it identifies and assesses six compliance-enhancing accountability mechanisms that might work, as a foundation for considering how some can be strengthened and shared to better obtain the intended health, economic and environmental results.

Introduction

Why do members of international institutions comply with the commitments their leaders make at regional and global summits on key issues such as the prevention and control of non-communicable disease (NCD)? This is a key question for international relations scholars and global health policymakers alike. Scholars have long argued about how much, how and why international institutions constrain the behaviour of their autonomous state members in a structurally anarchic system, with realists, liberal-institutionalists and constructivists offering competing claims. Policymakers have come to recognize that NCD's are a shared, soaring global problem that is quickly becoming a leading killer of human life and balanced budgets in countries everywhere (PAHO-WHO 2015). The United Nations (UN) itself recognized and responded to this threat, by holding a dedicated summit on the subject in 2011 and a follow up review summit in 2014. The first United Nations High Level Meeting (UN HLM) made 205 commitments and the second 104 commitments to prevent and control NCD's. But these will make little difference unless member governments comply with these commitments and do so in ways that work, without causing collateral damage to other global goals.

Thus far, the limited evidence available suggests that compliance with such summit commitments has often been low and slow and that the accountability mechanisms alleged or added to enhance compliance have been limited in their number, capacity and effectiveness (Kirton, Roudev and Sunderland 2007, Kirton 2010, Kirton and Guebert 2011a, b, Kirton and Fitzgibbons 2014, Samuels, Kirton and Guebert 2014). From a policy standpoint, there is a need to discover reliable ways to improve compliance, especially with the rapid approach of the next UN summit in September 2015 where a set of Sustainable Development Goals (SDGs) will be authorized, with NCDs probably included for the first time.

This study thus assesses the health and NCD commitments and compliance from the major summits at several, interrelated levels: 1. the regional CARICOM's pioneering Port of Spain (POS) summit in September 2007; 2. the multilateral UN's HLM in September 2011; 3. the plurilateral G8's annual summits since 1980; and 4. the plurilateral G20's nine summits since 2008. In each case it identifies the level (and where possible the speed) of compliance with the relevant commitments, by overall average, by member, and by component issue, and, on a preliminary basis, what causes at various levels of analysis seem to be consistent with the pattern of compliance observed. It thus relies on the method of input-output matching, leaving a detailed process tracing of the pathways of compliance for a later stage of research (Alagh et al. 2012, Studer, I. & T. Contreras. 2012). On this basis it suggests in conclusion which compliance-enhancing accountability mechanisms appear to work, as an evidence-based platform for identifying how some can be strengthened and shared to more effectively obtain the intended and desired health, economic and environmental results.

This study finds that the 27 commitments made at CARICOM's POS Summit on NCDs in 2007, when converted into the 26 health indicators used by regional experts and authorities for implementation monitoring, were complied with seven years later at an average level of only 43%. While several factors appear to have caused this compliance, the most powerful seem to be the key catalysts embedded by the leaders in the commitments themselves, above all the invocation of a core international organization and a specified agent. For the 2011 UN HLM, compliance with the 205 commitments three years later was mixed at best, with the causes of compliance unclear, based on the poor quality of the available, self-reported data. In the plurilateral G8, its 254 health commitments made from 1980 to 2013 (of which 58 have been assessed for compliance) have been complied with a year later at a strong 76% rate. Compliance was raised by the commitment-embedded catalysts of a core international organization and a one-year timetable, but lowered by those of other international organizations, a multi-year timetable and the summit's finance ministers' forum. In the G20, the 58 commitments made from 2009 to 2013 in the NCD related area of food and agriculture had average compliance of 75% within the four to fourteen months after the summit was held.

Together these findings suggest that compliance is influenced by the commitment-embedded catalysts easily controlled by and available to summit leaders, with the invocation of a core international organization raising compliance for the POS and G8. Iteration of the commitment or issue by leaders at their subsequent summits appears to raise compliance for the POS-CARICOM and G8. Ministerial reinforcement may lower compliance in the G8 and support from the surrounding summits of the UN lower compliance for the POS. Compliance is higher in the summit institutions with no secretariat of their own, In the G8, the advent of addition of an informal Accountability Working Group and the arrival of autonomous analytical assessment appear at first glance to have had a compliance reducing effect. Together these patterns suggest that compliance with summit health commitments can be strengthened through improved accountability mechanisms, but much more needs to be known about the many other causes of compliance before many prescriptions can be confidently advanced. At the moment, invoking the core international

organization in the commitment as a health compliance catalyst is the only advice that the relevant social science supports.

CARICOM's Port of Spain Summit 2007

The first summit focused on NCDs was held by the members of CARICOM at their summit in Port of Spain, Trinidad and Tobago in September 2007 (Kirton, Guebert and Samuels 2011, Kirton and Fitzgibbon 2014). It raised awareness of the costs on NCDS on people's and their countries' health and economy, led to action on tobacco control, physical activity, diet and wellness, and came with an accountability process to facilitate and monitor implementation (CARICOM 2007, Kirton, Guebert and Samuels 2011).

Commitments

In the concluding Port of Spain Declaration, a total of 27 commitments were identified from the final using the commitment identification methodology developed by the G8 Research Group (G8RG) at the University of Toronto. Commitments were defined as a discrete, specific, publicly expressed, collectively agreed to statements of intent; a "promise" or "undertaking" by summit members that they will undertake future action to move toward, meet or adjust to meet an identified welfare target (Kokotsis 1999). Compliance with the 27 POS commitments was measured not by the G8RG methodology but according to 26 indicators identified by Alafia Samuels at the University of the West Indies.

Compliance

Compliance with the 26 indicators was measured in 20 countries over each of the seven years from 2008-2014 (Appendix A). Indicators were organized into six categories: a general commitment to NCDs, Tobacco, Nutrition, Physical Activity, Education/Promotion, and Surveillance. Implementation of the indicators was measured on a three-point scale; the indicator was either in place, in process/partially implemented or not in place.

In the beginning compliance across all indicators was low. By 2008, one year after the POS summit, only two indicators had more than 25% of the CARICOM members in compliance. Both indicators were in the area of tobacco, to ratify the Framework Convention on Tobacco Control (FCTC) and to implement the Global Youth Tobacco Survey. Compliance then increased significantly between 2008 and 2009. In 2009, 5 indicators had at least 50% implementation. The number of indicators with 50% implementation increased incrementally year after year until it plateaued in 2013 at 12, with no increase in 2014.

Within the first year after the summit implementation across the 26 indicators was sparse with only a small number of countries implementing a handful of indicators. In 2008, 9 countries conducted a Global Youth Tobacco Survey and 6 countries ratified the FCTC. In 2009, implementation of these two tobacco indicators increased significantly to 14 and 12 countries, respectively. However implementation then stagnated. Implementation also increased significantly in five other areas in 2009. Six countries developed an NCD Plan and a multi-sectoral NCD Commission. Implementation of the NCD Commission indicator stagnated in 2012 at 8 countries, while the number of countries with an NCD Plan increased by two each year until 2012. Since 2012 the number has remained unchanged with thirteen countries having NCD Plans. Eight of these NCD Plans include an NCD Budget, another indicator under the General NCD category.

The rapid initial implementation of the multi-sector food & nutrition plan indicator is noteworthy. In 2008 none of the CARICOM countries had implemented a plan. However, this changed quickly in 2009, when twelve countries complied. This is the only indicator under the nutrition category to be

implemented to a significant degree. Yet the number of compliant countries has not changed since 2009.

The physical activity category includes three indicators, one of which had a spike in implementation between 2008 and 2009. This was ongoing, mass physical activity or new public physical activity spaces. By 2009, eleven countries had complied, with an increase in 2011 to fifteen countries. By 2014, nine countries had complied with the indicator of having mandatory physical activity in all grades in schools.

Under the education and promotion category almost all of the countries — 19 — have taken part in multi-sector, multi-focal celebrations since 2009. This is the indicator with the fullest and fastest implementation.

Under the surveillance category, there has been slow but success in implemention. By 2012, five of the six indicators had 50% of the CARICOM members in compliance. The only indicator lacking progress was having NCD treatment protocols in more than 50% of the primary health care facilities. The Global Youth Tobacco Survey and the Global School Health Survey were implemented the fastest and fullest.

Overall, by 2014 indicators with over 70% implementation (14 of 20 countries) were: convening an NCD summit; FCTC ratification; ongoing, mass physical activity or new public physical activity spaces; multi-sectoral, multifocal celebrations; and three indicators from the surveillance category, the minimum data set reporting, the global youth tobacco survey and the global school health survey. The indicators with zero implementation by 2014 were a trans-fat free food supply, mandatory labeling of packaged foods for nutrition content, and having 50% of public and private institutions with physical activity and healthy eating programs. Moreover only one country implemented the indicator to have trade agreements used to meet national food security and health goals.

The countries with the highest compliance were the relatively big, rich ones of Barbados, Trinidad and Tobago, Jamaica and Bahamas. Bother Jamaica and Trinidad and Tobago started with a substantial number of indicators already implemented. Barbados and Bahamas had significant improvements, starting with only a few of the indicators implemented. The countries with the lowest compliance, with only one or two indicators implemented were, Haiti, Turks and Caicos, Montserrat, and Anguilla.

Causes

Thus far, analyses of compliance with the POS commitments have identified several leading candidates as causes of the compliance observed (Samuels, Kirton and Guebert 2014). These are: the diversionary shock activated vulnerability of a country (such as a Haiti devastated by an earthquake on January 12, 2010), the overall and health specific capability of a country (with the relatively rich CARICOM members such as Trinidad and Tobagomore able to comply); and the association of country leaders with the University of the West Indies which provided epistemic and entrepreneurial support for the POS and NCD cause all along.

This study explored an additional cause, lying at the individual agents' level of analysis — the summit leaders collectively and explicitly embedding in the summit commitment specific catalysts thought to improve the chance that compliance with that commitment would subsequently come (Kirton 2006). To establish their impact as causes of compliance with the POS commitments the presence or absence of a compliance catalyst in each commitment was determined. Compliance catalysts are words, phrases, or factors that are embedded in and guide a commitment. They provide instruction on how to implement, proceed or comply with the commitment (G8 Research Group 2011). An

initial fourteen and subsequent twenty two compliance catalysts had been identified by the G8 and G20 Research Groups at the University of Toronto (Appendix B).

In order to identify the number of compliance catalysts on the POS commitments, the 26 indicators were matched to one or more of the 27 commitments identified using the G8RG methodology for identifying commitments. Once the indicator was appropriately matched to a corresponding commitment, the commitment text was analyzed to identify catalysts. Eight of the eleven indicators with over 50% implementation had related commitments, six of which included at least one compliance catalyst. Eight of the fifteen indicators with less than 50% implementation had related commitments and only three of these commitments had compliance catalysts (Appendix A).

This observation leads to a preliminary conclusion that indicators/commitments with specific compliance catalysts have higher rates of implementation. In the case of the POS declaration the compliance catalysts contributing to higher implementation were those designating both an issue-specific regional and international institution to carry out the task and that incorporating a surveillance mechanism.

UN HLM on NCDs, September 2011

The next summit dedicated to NCD's was the UN HLM on the Prevention and Control of NCDs, held in New York City in September 2011, a full four years after the POS Summit (Kirton and Guebert 2011a,b). The HLM flowed first from the hard law, multilateral path of the UN's lower level specialized work on the subject, notably the Global Strategy for the Prevention and Control of NCDs endorsed by the World Health Assembly (WHA) in 2000, the World Health Organization's (WHO) FCTC adopted by the WHA in 2003 and the Global Strategy on Diet, Physical Activity and Health in 2004. It also flowed from the path of plurilateral summit institutions (PSIs), as CARICOM members took the results of their 2007 summit to secure endorsements in 2009 from the Summit of the Americas (SOA) in April and the Commonwealth Heads of Government Meeting (CHOGM) in November. In May 2010, the UN General Assembly (UNGA) agreed to convene a HLM on NCDs. At the Millennium Development Goals (MDG) Review Summit in September 2010, the outcome document referred for the first time to the increased incidence of NCDs and the importance of cooperating in order to have a successful HLM on NCDs the following year.

Commitment

The UN HLM Outcome document contained 205 commitments, independently identified by the Global Health Diplomacy Program (GHDP) at the University of Toronto using the G8RG methodology. Three years later, the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-Communicable Disease was held at the HLM of the General Assembly on July 7, 2014. It made a further 104 GHDP-identified commitments of its own, about half the number that the first NCD HLM had.

The UN HLMs on NCDs focused on a multiyear timetable and target, based on arbitrarily chosen big numbers all divisible by five. They centered on a goal of reducing the number of premature deaths from NCDs by 25% by 2025. The HLM review in 2014 provided a general review of progress and agreed to set national targets and implement so-called "best buy" interventions starting in 2015, a full four years after the first HLM was held. It further agreed that the UNGA would hold a third HLM to assess progress in 2018. The three year interval between the first two HLMs has now lengthened to four between the second and the third, even as implementation had clearly failed within the first three years. The Global Action Plan for NCDs 2013-2020 identified nine voluntary global targets addressing the major NCD risk factors. A WHO report released on January 19, 2015 presented the baseline data for measuring progress on them.

Compliance

Compliance with these HLM commitments can be assessed in two major ways. The first is to rely on the UN's own members' self reporting and the resulting overall reports produced by the UN itself. Such self-reporting confirmed the compliance failure. The report of the Global Action Plan for NCDs 2013-2020 declared that most countries were off course to meet the 2025 targets, with slow progress on almost all indicators, especially in middle and low-income countries (LICs). As of December 2013 only 69 countries had a plan to reduce the burden of tobacco use.

The second way is through country-specific and commitment-specific monitoring by qualified independent assessors with no advocacy stake in the results. The GHDP, employing the framework and method developed to assess compliance with the commitments of the G8, G20 and BRICS summits, began such an assessment in late 2014.

It chose to assess compliance with commitment UN 2011-68 on tobacco. Here the parties committed to "Accelerate implementation by State parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures, including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the Framework Conventional on Tobacco Control, recognizing that substantially reducing tobacco consumption is an important contribution to reducing non-communicable diseases and can have considerable health benefits for individuals and countries, and that price and tax measures are an effective and important means of reducing tobacco consumption."

An assessment of the compliance with this commitment was conducted for the 36 countries of the Western Hemisphere and the Associate Members of CARICOM, including those under the jurisdiction of the United Kingdom (Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Turks and Caicos) (McGurn 2015).

It showed that one year after the 2011 HLM, covering the period September 20, 2011 to September 18, 2012, the compliance of the 36 polities assessed averaged a strong 81% (+0.62). No or negative compliance (-1.00) came only from five polities: Argentina, Cuba, the Dominican Republic, El Salvador and the USA. Partial compliance (scored at 0) came from a further four: Nicaragua, Trinidad and Tobago, Uruguay and Venezuela. While these finding are preliminary, they demonstrate the feasibility and value of such independent analytical assessment and provide a basis on which to build.

Causes

They further provide a foundation for inferring what might cause such compliance. The high compliance score with commitment UN2011-68 contrasts with the concern expressed by some at the time the 2011 HLM Political declaration was released that it came with too many multiyear targets and arbitrary big round numbers, and too few funds, monitoring mechanisms and fast summit follow ups. Yet its high compliance is consistent with the presence within the commitment of the one compliance catalyst — the invocation of a core international organization (in this case the WHO) — that has consistently been shown to raise compliance in the G8 and now in CARICOM too (see below and above). The other catalyst noted is international law, in this case the FCTC, which is referenced twice. In the G8, this catalyst lowers the compliance of the USA with health commitments, a result consistent with the lowest (and rare) score of -1.00 for the US here.

G8, 1980-2013

The G7/8 summit of leaders of the major market democracies, which started in 1975, has governed health at its annual summits continuously since 1979, save for a gap in 1994-5 (Kirton 2012). Indeed,

health as a subject in its public communiqués took 24% of the words in 2001, 22% in 2003 and an all time high of 26% in 2010. The G7 began with a focus on the health issue prominent among its own members, including cancer and research followed by HIV/AIDS. But it quickly came to focus on the infectious disease and health issues of great concern in Africa, notably HIV/AIDS, malaria, TB, polio and maternal and child health (Kirton and Mannell 2007, Kirton, Guebert, Kulik 2014). Amidst its major, effective health governance, it has given very little attention to NCDs.

Commitments

From 1980 through to 2008, the G8 made 234 health-related commitments (Kirton, Roudev, Sunderland, Kunz and Guebert 2010). From 2008 to 2013 it raised this total even more.

Compliance

Of the 54 commitments measured for compliance, the average score was +0.51 or 26% on the popular 100 point scale (Appendix C). This was led by Canada at +0.80. Compliance during this time was quite consistently strong, save for a drop into negative territory for 2010.

Causes

The causes of G8 health compliance potentially lie at many levels of analysis: the structure of the international system (including relative vulnerability and capability) and international institutionalization within and beyond the G8; national level factors; and individual agency, including how leaders craft their commitments to contain catalysts that induce compliance with them in the coming year. Recent studies of these multilevel causes across key issue areas found that the causes of G8 compliance differed by issue area.

1. In finance and development, compliance with the 42 assessed commitments from 1996-2004, showed that equalizing capability or vulnerability caused G8 finance ministers to deal with the same subject the year before and after the summit, but the presence of two catalysts — a timetable and priority placement — worked to increase compliance best of all by far (Kirton 2006). In climate change, average compliance with the 39 assessed commitments from 1987- 2006, was raised by priority placement but lowered by international law (Kirton, Roudev, Guebert 2008). US compliance was lowered by the core international organization of the United Nations Framework Convention on Climate Change (UNFCCC). Canadian compliance was raised by priority placement and the core IO (UNFCCC), but lowered by reference to a target, an agent and to international law.

In health three successive studies have been done. The first, on 30 assessed commitments from 1996-2005, found compliance was raised by a one year timetable and a core IO (the WHO) but lowered by other IOs (Kirton, Roudev and Sunderland 2007). The second, on 35 assessed commitments from 1996-2005, confirmed these findings, but added that compliance was lowered by a multi-year timetable and reference to the G8 finance ministers (Kirton, Roudev, Sunderland, Kunz 2008). The third, on the 46 assessed commitments from 1980-2009 found that a specific "cocktail" of catalysts caused the compliance of each country involved (Kirton and Guebert 2009).

G20, 2008-2014

The G20 summit, created in 2008, increasingly dealt directly with health issues of any kind culminating in a great surge of attention to Ebola at the ninth summit, held in Brisbane, Australia on November 15-16, 2014 (Kirton 2014, Kulik 2014). Since the start the G20 summit addressed the UN's Millennium Development Goals (MDG's), where the set of eight contained three on health, respectively on child health, maternal health and HIV/AIDS, malaria and TB. The development agenda also led the fifth summit, held in Seoul, South Korea in November 2010, to include NCDs

for the first time under human development, one of the nine pillars of the Seoul Development Consensus launched there (Kirton, Kulik and Bracht 2015).

Deliberation

At Washington in 2008, G20 leaders in two paragraphs of their concluding communique reaffirmed the importance of the MDGs and committed to addressing challenges such as disease (Appendix D). At London in April 2009, in two paragraphs, leaders reiterated their commitment to meeting the MDGs. At Pittsburgh in September 2009, with an increase in health-specific references in the five health-related paragraphs, leaders noted their concern about low income countries (LICs)' capacity to protect spending in areas such as health and their responsibility to invest in people by providing health care.

References to health dropped back to two paragraphs at Toronto in June 2010. Here, in the macroeconomic Framework for Strong, Sustainable, and Balanced Growth, leaders agreed to strengthen social safety nets including public health care. At Seoul in November 2010 health references surged to 10 paragraphs. In addition to reiterating support for the MDGs, leaders committed to identifying the links between health problems and life-long skills development, and the impact of non-communicable diseases. At Cannes in 2011, references declined to six paragraphs. Leaders recognized the importance of investing in social protection floors such as access to health care and safe and nutritious food. At Los Cabos in 2012, references decreased again to four paragraphs, focused mainly on the MDGs. But at St. Petersburg references returned to a new peak of 12 paragraphs. They covered issues such as hunger and malnutrition, the MDGs, and the long-term financing of health insurance.

Commitments

At its first eight summits, the G20 made no core health commitments, although it came close in one each at Cannes in 2011 and Los Cabos in 2012 (Appendix E). Health-related commitments dealt with the MDGs, access to health care and spending in the health sector. On access, the first commitment was made at Cannes, where leaders committed to tighten limits on central government and health insurance expenditures. The second came at Los Cabos, where leaders supported innovation in health care. From 2008 to 2013, leaders made 155 commitments on development, including ten reaffirming their commitment to meeting the MDGs.

On the road to Brisbane, health again appeared directly in the form of occupational health and safety. A deadly accident at a factory in Bangladesh led the Americans to put this issue on the G20 agenda. G20 Labor and Employment Ministers, in their meeting in Melbourne on September 11, 2014, addressed "work-related illnesses" in their communiqué and issued a separate G20 Statement on Safer and Healthier Workplaces.

At the summit itself, leaders produced 33 health commitments. Three came in their overall three page concluding communiqué on November 16th and 30 in their separately issued Statement on Ebola issued the day before. The 33 commitments on health was almost the highest number on any subject, one below macroeconomic policy which had been the G20 summits core concern from the start and the singular focus for its Australian host in 2014. Health was followed in turn by infrastructure with 28, development with 20, labour and employment with 19, and accountability and energy with 17 each. Then came trade with nine, climate change and financial regulation with seven each, microeconomic policy with six, and reform of international financial institutions (IFIs), gender, and crime and corruption with four each.

Of the 33 health commitments, 17 or about half were explicitly dedicated directly to the Ebola epidemic ravaging West Africa. But the other half contained commitments that were more relevant

to NCDs, even if they were not explicitly noted so by category or by name. Two promised to implement the International Health Regulations. Four committed to strengthen health systems in general to deal with "infectious diseases like Ebola." Six pledged to mobilize resources against the threat posed by infectious disease to strong, sustainable and balanced growth, thus forging an instrumental link from health to the G20's core economic goal. Two promised vigilance and responsiveness in general. One addressed anti-microbial resistance, a subject related to NCDs (Kelley 2011).

Compliance

G20 compliance with health-related commitments can be assessed by examining the scores for the three assessed commitments on the MDGs (Appendix F). Here compliance has been a low 57% (or +0.14 on the 200 point scientific scale). The first commitment, from the London Summit scored 0.00, the second, from Pittsburgh -0.05 and the third from Seoul +0.19.

Development of Global Governance

In their development of global governance outside the G20, in the context of health, G20 leaders made one reference to international institutions at Washington and one at Pittsburgh, both to the UN (Appendix D). Toronto made none. Seoul saw a spike to three references, again all to the UN. After another absence at Cannes and Los Cabos, there was a rise to four at St. Petersburg, with one each to the UN, IMF, WTO to the health dedicated WHO itself. Apart from one reference to the UN High-Level Plenary Meeting on the MDGs at Seoul, references to health-related institutions had been absent until St. Petersburg.

Causes

The key cause of the G20's long silence on health and the surge in November 2014 was shock activated vulnerability to new non-state threats, with the arrival of the deadly, economically devastating Ebola epidemic in West Africa and its spread to infect victims in the United States and Europe. A second much smaller shock was the Bangladesh factory fire that fuelled the G20's attention to workers' health. A second cause was multilateral organizational failure, as the WHO increasingly failed to control the spread of Ebola and even the World Bank, led by health expert Jim Kim was slow to respond. A third cause was leadership by a few heads of G20 governments, notably South Africa, the United Kingdom, the United States and the World Bank, which overcame the resistance of the Australian host to expand the agenda to add Ebola. The US and International Labour Organization led in the case of workers health. It remains unknown if these causes of G20 health performance apply to the component of compliance itself.

Some indication could come from the compliance with the five assessed (of the 58 overall) commitments made from 2009 to 2013 in the NCD-related area of food and agriculture (Kirton, Kulik and Bracht, 2014b). These five had average compliance of 75% in the four to fourteen months after the summit was held. This suggests that the G20 could be a much more effective governor of NCDs in the delivery domain than the MDG data indicate.

Conclusions: Strengthening Accountability for Effectiveness

How can intergovernmental summit's compliance-enhancing accountability mechanisms be strengthened and shared to better obtain the intended health, economic and environmental results? On the basis of the findings in this study, preliminary suggestions can be made through inductive inferences about the likely compliance enhancing effects of six major kinds of accountability mechanisms: 1. catalysts for compliance contained in the commitment; 2. iteration by leaders at their

subsequent summits; 3. ministerial reinforcement; 4. surrounding summit support; 5. secretariat support; and 6. autonomous assessment.

Catalysts

The first mechanism is the use of catalysts for compliance contained in the commitment itself. Here the leaders themselves as authoritative agents consciously craft their commitments in ways that embed specific catalysts designed to enhance compliance, while avoiding those that lower it. Since 2006 a list of 22 such catalysts and inhibitors has been identified and many have been tested for their impact on compliance in key issue areas (Kirton 2006) (Appendix B).

There is relatively strong evidence from the research reported in and conducted for this study that compliance with POS NCD commitments and with G8 health commitments is raised by some such catalysts, specifically by invoking a core international organization, and perhaps a one year timetable and specified agent, But compliance is lowered by invoking other international organizations and multi-year timetables.

Iteration

The second accountability mechanism is iteration, as the leaders themselves repeatedly return to the same commitment and subject at subsequent summits. They do so either on their own (spontaneous iteration) or through the use of the built in catalysts of remit mandates or authorized reports invoked in the initial, index year (built in iteration). The importance of such iteration in improving overall performance has been highlighted for both the G8 in general and for the G20 on energy and climate change (Bayne 1999, Van de Graaf and Westphal 2011: 29).

The current study allowed for tests of both spontaneous and built in iteration at the POS-CARICOM, HLM-Review, and the G8 summits, but not the G20 (where health appeared robustly only at the most recent summit in 2014). It tested for spontaneous iteration for the POS and G8. In the case of the post 2007 POS regular CARICOM summits, the subject of NCDs received one paragraph of attention in both 2008 and 2009, five paragraphs in 2010, three small paragraphs in 2011, none in 2012 and two in 2013. This cadence is generally consistent with the continuous, incremental annual improvement in compliance with the POS commitments during the seven years to 2013 and also with the overall modest level cumulatively achieved by 2013. In the case the G8, the virtually continuous and usually robust leaders attention to health at their annual summits from 1980 to 2013 is consistent with the and high average level of health compliance their governments produced each year after the commitment was made. It remains to be seen if the annual variations in health attention and specific commitments correspond with the annual variations in health compliance, and if so with what phases, lags and cumulative impacts.

Ministerial Reinforcement

The third accountability mechanism is ministerial reinforcement. Here within the same summit system the ministers directly responsible for the subject (in this case health) meet before, during or after the year the commitment was made, deal with the same subject (in this case NCDs or health), and perhaps explicitly monitor compliance with the commitments.

Here the preliminary evidence is inconclusive. In CARICOM, where POS cumulative compliance is low after seven years, health or related ministers met annually as part of CARICOM's Council for Human and Social Development (COHSOD). In the case of the G8, where health compliance is high one year later, health ministers have almost never met in a G7 or G8 format, and the G7-centric Global Health Security Initiative ministers (without Russia but with Mexico) met regularly only since 2001. Before they did, G8 health compliance averaged 80% (+0.59), while afterward it dropped to 75% (+0.49). However, in the case of the G20, in development, where summit-to-summit

compliance with the MDG commitments is low, ministers met only once (in 2011) (Appendix G). In food and agriculture, where compliance is high, G20 agriculture ministers met twice (in 2011 and 2012).

Surrounding Summit Support

The fourth accountability mechanism is surrounding summit support. Here other PSIs, especially those which contain many of the same members as the index PSI, take up the same subject and make the same commitments in a supportive (as opposed to a contradictory or antithetical) way.

In the case of the 2007 POS, this mechanism arose in the pathways from the POS, through the Commonwealth, SOA and Asia Pacific Economic Cooperation (APEC), through to the UN HLM in 2011 and its UN Review in 2014. However the impact of such surrounding summit support on raising compliance with the POS commitments appears to be weak or indirect. Before the UN HLM in September 2011, POS compliance in the first three years from 2008 to 2010 had increased by 23%, from 10% in 2008 to 33% by 2010. In the four years after the HLM from 2011 to 2014 POS compliance increased by only 12%, from the 33% in 2010 to 45% in 2013. After the UN HLM, the rate of POS compliance thus slowed down by about half. This could reflect several factors, such as the increased difficulty of covering "the last mile", and the failure of the HLM to mobilize any new money for the cause or institute robust accountability mechanisms of its own.

Secretariat Support

The fifth mechanism is secretariat support, as summit leaders use the official level institutions and organizations that they own or control to implement, monitor, report progress on and correct shortcomings in the implementation of the summit commitments they have made. They can do so formally through explicit mandates embedded in the commitment or indirectly by simply subsequently spurring or asking the secretariats to do the work.

In the case of NCDs and health, there is a wide spectrum or such supportive secretariats available. One lies with POS, which had and used CARICOM and Pan-American Health Organization (PAHO). The UN HLM had and used its New York bureaucracy and the WHO. The G8 had no bureaucratic secretariat of its own but since 2009 increasingly created an Accountability Working Group to monitor compliance with leaders' development commitments, which included health in a major way. The G20, similarly devoid of a permanent secretariat, created a working group to report on its leaders' compliance with their development commitments only in 2013. Both the G8 and G20 have used the Organisation for Economic Co-operation and Development (OECD), which has sought to be an informal secretariat for them, but this been a partial, informal relationship at best.

Across the four summit institutions considered in this study, the available data show that those that complied the most with their health and NCD-related commitments (the G8 and G20) relied the least on a secretariat of their own. The G8's addition of an informal Accountability Working Group in 2009 saw health compliance drop from an average of 78% (+0.55) before to 65% (+0.30) afterward. Peer protection rather than peer pressure appears to have prevailed. The creation of CARPHA in 2010 reinforced rather than raised the rate of POS compliance, but its summit creation and mandate for NCD compliance was much less than that of the G8's Accountability Working Group.

Autonomous Assessment

The sixth mechanism is autonomous assessment or compliance by institutions or actors that the leaders do not control and do not ask to take on these tasks. Such autonomous accountability actors can be from advocacy organizations that have a professional responsibility to have the summiteers do

more. They can also be analytic actors with no professional responsibilities in regard to the results they produce.

Among the analytic actors, the longest and most comprehensive work has been that of the G8 Research Group, which has been monitoring and publicly reporting members' compliance with their priority commitments, including those on health, since 1996. In 2002 it began to issue interim (six months) compliance reports, and allowed government and other stakeholders to comment on and contribute to the interim and final compliance reports before their publication. Average G8 health compliance across the two later phases of autonomous analytical assessment (where data is available) has dropped from 82% (+0.64) in 1996-2001, to 74% (+0.47) in 2002-2013 (Appendix C). At first glance autonomous analytical assessment thus seems to deter rather than drive compliance.

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Appendix A: POS Indicator Compliance and Catalysts

#	Indicator	Average	SPD	CMT	Text	Catalyst	TTL Catalysts
1	CWD multi-sectoral, multi-focal celebrations	85%	2	27	We hereby declare the second Saturday in September "Caribbean Wellness Day"	Target	1
2	Global Youth Tobacco Survey	80%	2	25	[we declare] That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);	surveillance, specified agent, core international organization, international organization surveillance	4
3	Global School Health Survey	80%	3	25	[we declare] That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);	surveillance, specified agent, core international organization, international organization surveillance	4
4	Ongoing, mass Physical Activity or New public PA spaces	75%	2	18 & 19	[we declare] That we will promote policies and actions aimed at increasing physical activity in the entire population, e.g. at work sites, through sport, especially mass activities, as vehicles for improving the health of the population and conflict resolution #19 in this context we commit to increasing adequate public facilities such as parks and other recreational spaces to encourage physical activity by the widest cross-section of our citizens;		0
5	FCTC ratified	70%	2	2	[We declare] Our commitment to pursue immediately a legislative agenda for passage of the legal provisions related to the International Framework Convention on Tobacco Control;	international law	1
6	NCD Summit Convened	70%	4				
7	Minimum Data Set Reporting	70%	4	25	[we declare] That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);	surveillance, specified agent, core international organization, international organization surveillance	4

#	Indicator	Average	SPD	CMT	Text	Catalyst	TTL Catalysts
8	Surveillance: STEPS or equivalent survey	65%	5	25	[we declare] That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);	surveillance, specified agent, core international organization, international organization surveillance	4
9	NCD Plan	65%	4				
10	Multi-sector Food & Nutrition plan implemented	60%	2				
11	Smoke Free indoor public spaces	55%	6	3	[we] support the immediate enactment of legislation to limit or eliminate smoking in public places,		0
	Highest Average	73%	3.25				2.25
12	QOC CVD or diabetes demonstration project	50%					
13	Multi-sectoral NCD Commission appointed and functional	45%					
14	Mandatory PA in all grades in schools	45%		11&12	[we declare] That we will mandate the re-introduction of physical education in our schools where necessary, #12 [we declare that we will] provide incentives and resources to effect [the re-introduction of physical education in our schools]		0
15	Tobacco taxes greater than 50% sale price	40%		8	[we will] introduce such fiscal measures as will reduce accessibility of tobacco;		0
16	NCD Budget	40%					
17	Greater than or equal to 30 days media broadcasts on NCD control/yr (risk factors/treatment)	40%		24	[we will] embrace the role of the media as a responsible partner in all our efforts to prevent and control NCDs;	civil society	1
18	Advertising, promotion & sponsorship bans	30%		5&6	[we support the immediate enactment of legislation to] ban the advertising [of tobacco products to children] #6 [we support the immediate enactment of legislation to] ban the promotion [of tobacco products to children]		0

#	Indicator	Average	SPD	CMT	Text	Catalyst	TTL Catalysts
19	Chronic care model/NCD treatment protocols in more than 50% PHC facilities	30%					
20	Policy & standards promoting healthy eating in schools implemented	30%		13	[we will] ensure that our education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating;		0
21	NCD Communications plan	25%					
22	Madatory provision for PA in new housing developments	15%					
23	Trade agreements utilized to meet national food security & health goals	5%		16	[we declare] Our support for the efforts of the Caribbean Regional Negotiating Machinery (CRNM) to pursue fair trade policies in all international trade negotiations thereby promoting greater use of indigenous agricultural products and foods by our populations and reducing the negative effects of globalisation on our food supply;	specified agent	1
24	Trans fat free food supply	0%		15	[we declare] our strong support for the elimination of trans-fats from the diet of our citizens, using the CFNI as a focal point for providing guidance and public education designed toward this end;	specified agent	1
25	Madatory labeling of packaged foods for nutrition content	0%		17	[we declare] Our support for mandating the labelling of foods or such measures as are necessary to indicate their nutritional content through the establishment of the appropriate regional capability;		0
26	more than 50% of public and private institutions with physical activity and health eating programs.	0%					
	Average Lowest	24%					0.38
	Average Overall	48%					1.30

The AVE column reports the percentage of CARICOM members that have implemented the indicator based on 2014 data
In this analysis the catalyst 'core international oranization' is PAHO as it is the most central and external issue specific multilateral organization as the regional organization of the World Health Organization
The 'SPD' column indicates the number of years it took for the indicator to be implemented by 50% of the CARICOM members.

Appendix B: Compliance Catalysts

01 Priority placement (PP)
02 Past Reference to Summit (PPS)
03 Past Reference to Ministerial (PPM)
04 Target (TA)
05 Timetable single-year (TS)
06 Timetable multi-year (TM)
07 Self-monitoring (SM)
08 Remit mandate (RM)
09 Money mobilized (MM)
10 Specified agency (SA)
11 Institutional Body (IB)
12 Core International Organization (CIO)
13 Other International Organization (OIO)
14 Regional Organization (RO)
15 International Law (IL)
16 Ministers (Min)
17 International Organization Accountability Request (IOAR)
18 Civil Society (CS)
19 Private Sector (PS)
20 Country or Regional Specification (C/RS)
21 Surveillance (SUR)
22 International Organization Surveillance (IOS)

Appendix C: G8 Health Compliance (N=54)

	Health	Canada	France	Germany	Italy	Japan	Russia	UK	USA	EU	Average
1	1983-23	1			1				1		1.00
2	1997-26	1	1					1	1		1.00
3	1997-55	-1	-1	1	-1	0		1	1		0.00
4	1998-23	1	1	0	-1	0	-1	1	1	1	0.33
5	1998-24	1	1	-1	-1	-1	-1	1	1	1	0.11
6	1999-38	1	1	-1	1	1	0	1	1		0.63
7	1999-39	0	0	0	0	0	0	0	0		0.00
8	2000-36	1	1	1	1	1		1	1	1	1.00
9	2000-23	1		0	0	1	0		0	1	0.43
10	2000-37	1	1	1	1	1		1	1	1	1.00
11	2000-38	1	1	1	1	1		1	1	1	1.00
12	2000-76	1	1	1	0	1	-1	1	1	1	0.67
13	2001-26	1	1	1	1	0	1	1	0		0.75
14	2001-28	1	1	1	1	1	1	1	1	1	1.00
15	2002-11	0	0	0	0	0	0	0	0		0.00
16	2002-109	1	1						1		1.00
17	2002-110	0		0		0		0	0	0	0.00
18	2002-116	1	1	1	1	1	-1	-1	1		0.50
19	2002-117	1	0	0	0	1	0	1	0		0.38
20	2002-118	1	1	1	1	1	1	1	1	1	1.00
21	2002-119	1	0	0	1	0	0	0	0		0.25
22	2002-124	1	0	0	-1	0	0	1	1	1	0.33
23	2003-xx	1	1	1	1	1		1	1		1.00
24	2003-3	1	1	1	1	1	1	1	1	1	1.00
25	2003-10	1	1	0	1	1	1	1	1	1	0.89
26	2003-13	1	1	1	1	1	1	1	1	1	1.00
27	2003-14	1	1	0	1	1	0	1	1	1	0.78
28	2003-115	1	0	0	0	0		0	0	0	0.13
29	2004-(b)1	1	1	1	1	-1	-1	1	1	1	0.56
30	2004-(c)3	1	-1	1	-1	0	1	1	1	1	0.44
31	2005-5	-1				1	1		0		0.25
32	2005-38	0	1	0		1		-1	0	1	0.29
33	2005-40	1	1	1	1	1	1	1	1	1	1.00
34	2005-42	0	0	0	-1	1	1	0	1	1	0.33
35	2005-44	1	-1	1	-1	-1	-1	1	1	1	0.11
36	2005-46	1	0	0	0	1	1	1	1	1	0.67
37	2006-27	1	1	-1	1	-1	1	1	1		0.50
38	2006-31	1	1	0	0	1	1	0	1	0	0.56
39	2006-36	1	0	0	0	0	0	0	1	0	0.22
40	2006-43	1	0	1	-1	0	1	1	1	0	0.44
41	2006-247	0	0	0	0	0	0	1	0		0.13
42	2007-227	1	1	1	0	1	0	1	1	0	0.67
43	2007-229	1	1	1	1	1	1	1	1	1	1.00
44	2007-233	1	1	0	-1	0	-1	1	1	1	0.33
45	2007-244	1	1	0	0	1		1	1	0	0.63
46	2007-246	1	1	1	1	1	1	1	1	1	1.00

47	2007-264	1	1	1	0	0	1	1	1	0	0.67
48	2008-118	1	1	1	1	0	0	1	1	-1	0.56
49	2008-127	0	-1	-1	-1	0	-1	1	1	-1	-0.33
50	2009-147	1	1	0	-1	1	0	1	1	1	0.56
51	2009-151	1	0	0	0	1	0	1	0	-1	0.22
52	2010-11	1	-1	1	-1	-1	-1	-1	-1	-1	-0.56
53	2010-14	1	0	0	-1	1	0	-1	1	1	0.22
54	2010-18	1	0	1	-1	-1	0	1	1	-1	0.11
	Average All	0.80	0.52	0.40	0.14	0.43	0.19	0.68	0.74	0.54	0.51

Compiled by Caroline Bracht, November 16, 2011.

Appendix D: G20 Performance on Health, 2008–2013

	Words		Para-graphs		Documents		Decisions	Delivery	Development of Global Governance	
	#	%	#	%	#	%	#	N=0 (N=3)	Internal	External
2008 Washington	3	3.2	2	2.8	1	100	0 (1)	N/A	0	1
2009 London	59	0.9	2	2.1	1	33.3	0 (2)	N/A (0.30)	0	0
2009 Pittsburgh	284	3.0	5	4.5	1	100	0 (1)	N/A (–0.05)	0	1
2010 Toronto	139	1.2	2	1.4	1	50	0 (0)	N/A	0	0
2010 Seoul	643	4.1	10	4.6	4	80	0 (1)	N/A (0.19)	2	3
2011 Cannes	470	2.9	6	3.0	3	100	1 (2)	N/A	1	0
2012 Los Cabos	250	1.9	4	2.7	2	100	1 (2)	N/A	1	0
2013 St Petersburg	1340	11.2	12	6.8	5	45	0 (1)	N/A	4	4
Average	412.88	3.6	5.4	3.5	2.3	76.03	.25 (1.25)	N/A (0.14)	1	1.1

No health specific compliance reports were completed. The compliance data within the brackets represents assessments completed on the Millennium Development Goals which include health related commitments.

Appendix E: G20 Commitments by Issue 2008-2013

Issue	TTL	2008 W	2009L	2009P	2010T	2010S	2011C	2012LC	2013SP	2014B
Macroeconomic Policy	354	6	15	28	14	29	91	71	66	34
Microeconomics	8	0	0	0	0	0	0	0	2	6
Financial Regulation	246	59	45	23	12	24	38	18	20	7
Trade	97	5	14	6	9	17	15	10	12	9
IFI Reform	113	14	29	11	4	16	22	8	5	4
Employment and Labour	82	0	4	3	0	4	8	18	29	16
Social Policy	9	0	1	1	2	1	3	1	0	0
Information and Communication	0	0	0	0	0	0	0	0	0	0
Environment	5	0	0	0	0	1	3	0	1	0
Climate Change	48	0	3	3	3	8	8	5	11	7
Energy	95	0	0	17	1	14	18	10	19	16
Development	155	4	15	9	8	22	17	10	50	20
Infrastructure	28	0	0	0	0	0	0	0	0	28
Food, Agriculture, Nutrition	58	0	0	3	2	2	36	4	11	0
Health	33	0	0	0	0	0	0	0	0	33
Education	4	0	0	3	0	0	1	0	0	0
Gender	6	0	0	0	0	0	0	2	0	4
Crime and Corruption	67	3	0	3	3	9	5	7	33	4
Terrorism	1	0	0	0	0	0	0	0	1	0
Non-proliferation	0	0	0	0	0	0	0	0	0	0
Regional Security	0	0	0	0	0	0	0	0	0	0
Natural Disasters	0	0	0	0	0	0	0	0	0	0
Democarcy	0	0	0	0	0	0	0	0	0	0
Human Rights	0	0	0	0	0	0	0	0	0	0
UN Reform	0	0	0	0	0	0	0	0	0	0
Accountability	73	4	3	15	3	4	5	13	9	17
G8/G20 Governance	32	0	0	3	0	2	12	3	12	0
Total	1514	95	129	128	61	153	282	180	281	205

Appendix F: G20 Development Compliance, 2008-2013, N=39

Commitment	AVE	ARG	AUS	BRA	CAN	CHI	FRA	GER	IND	INDO	ITA	JAP	KOR	MEX	RUS	SAU	S.AF	TUR	UK	USA	EU
2008W-5	0.80	1	1	1	1	1	1	1	0	0	1	1	1	1	1	0	0	1	1	1	1
Summit Ave	0.80	1.00	1.00	1.00	1.00	1.00	1.00	1.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00	0.00	0.00	1.00	1.00	1.00	1.00
2009L-75-76	0.30	-1	1	1	1	-1	1	1	0	0	0	1	0	0	1	0	-1	-1	1	1	1
2009L-78	0.00	-1	0	0	0	0	1	1	-1	-1	0	0	-1	0	0	0	0	0	1	0	1
Summit Ave	0.15	-1.00	0.50	0.50	0.50	-0.50	1.00	1.00	-0.50	-0.50	0.00	0.50	-0.50	0.00	0.50	0.00	-0.50	-0.50	1.00	0.50	1.00
2009P-88	-0.05	-1	1	-1	0	0	0	1	-1	-1	-1	0	0	0	0	0	1	-1	1	1	0
2009P-89	0.88				1		1							1	1	0		1	1	1	
2009P-97	-0.05	-1	0	-1	1	0	0	0	-1	-1	0	1	0	0	0	0	0	-1	1	0	1
Summit Ave	0.10	-1.00	0.50	-1.00	0.67	0.00	0.33	0.50	-1.00	-1.00	-0.50	0.50	0.00	0.33	0.33	0.00	0.50	-0.33	1.00	0.67	0.50
2010T-20	0.15	0	0	0	1	0	1	1	0	-1	0	1	0	-1	0	-1	-1	0	1	1	1
2010T-51	0.95	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1
Summit Ave	0.55	0.50	0.50	0.50	1.00	0.50	1.00	1.00	0.50	0.00	0.50	1.00	0.50	-0.50	0.50	0.00	0.00	0.50	1.00	1.00	1.00
2010S-122	0.65	-1	1	0	1	1	1	1	1	0	1	1	1	-1	1	0	1	1	1	1	1
2010S-47	0.25	0	0	1	0	1	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0
2010S-55	0.35	1	1	-1	1	1	1	0	0	-1	0	0	1	0	0	0	1	1	1	0	0
2010-S-56	0.65	1	1	-1	1	-1	1	1	1	1	1	0	1	1	0	1	1	1	1	1	0
2010S-57	0.65	0	1	1	1	1	1	1	0	1	1	1	1	1	-1	0	1	1	1	-1	1
2010S-77	0.30	0	0	0	1	1	1	1	-1	-1	1	1	1	0	0	0	0	0	1	1	-1
2010S-107	0.40	0	1	1	0	1	0	1	1	1	0	0	1	0	-1	-1	0	1	1	0	1
2010S-108	1.00	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2010S-109	0.00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2010S-110	0.45	-1	1	0	1	-1	1	1	1	1	1	1	1	0	-1	0	0	0	1	1	1
2010S-111	0.05	0	0	0	0	0	0	1	1	-1	0	-1	1	0	0	0	0	0		0	0
2010S-112	-0.25	-1	0	0	-1	0	0	1	0	-1	-1	-1	0	0	-1	-1	1	-1	0	0	1
2010S-113	0.47	0	1	1	1	1	1	1	0	1	-1	0	-1	-1		1	0	1	1	1	1
2010S-116	-0.40	-1	0	0	-1	-1	0	0	-1	0	0	-1	0	-1	0	-1	-1	0	0	0	0
2010S-117	0.30	0	1	0	1	1	1	1	0	0	1	0	-1	-1	-1	0	0	0	1	1	1
2010S-118	0.15	0	0	0	1	0	1	1	0	-1	1	0	-1	-1	0	0	0	-1	1	1	1
2010S-119	0.63	1	1	1	0	1	0		1	1	0	1	1	0	0	1	0	1	1	0	1
2010S-120	0.00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2010S-121	0.19	-1	0	0	1	-1	0	1	0		0	0	1	0	0	0			1		1
2010S-123	0.00	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2010S-124	-0.05	-1	0	-1	1	-1	1	1	0	-1	0	0	1	0	0	-1	0	0	0	0	0

Commitment	AVE	ARG	AUS	BRA	CAN	CHI	FRA	GER	IND	INDO	ITA	JAP	KOR	MEX	RUS	SAU	S.AF	TUR	UK	USA	EU
2010S-125	1.00	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2010S-126	0.00				1								-1							0	
Summit Ave	0.31	-0.05	0.50	0.18	0.52	0.27	0.55	0.71	0.27	0.14	0.32	0.18	0.43	-0.05	-0.10	0.05	0.29	0.33	0.71	0.36	0.50
2011C-266	0.40	-1	1	0	1	0	1	1	-1	0	1	1	1	0	0	0	0	0	1	1	1
2011C-267	0.26	-1	0	0	1	0	-1	-1	1	0	1	1	1	-1	1	1	1	-1	1	1	
Summit Ave	0.33	-1.00	0.50	0.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00	1.00	1.00	-0.50	0.50	0.50	0.50	-0.50	1.00	1.00	1.00
2012LC-6	0.85	0	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0	1	1	1	1
2012LC-40	0.70	0	1	1	1	0	1	1	0	1	0	1	1	0	1	1	0	1	1	1	1
2012LC-88	0.80	1	1	1	1	1	1	1	1	1	0	1	1	1	0	0	0	1	1	1	1
Summit Ave	0.78	0.33	1.00	1.00	1.00	0.67	1.00	1.00	0.67	1.00	0.33	1.00	1.00	0.67	0.33	0.67	0.00	1.00	1.00	1.00	1.00
2013-107	0.50	0	1	0	1	0	1	1	1	0	0	1	1	0	0	0	0	0	1	1	1
2013-240	0.25	-1	1	-1	1	0	1	1	0	0	1	1	0	0	-1	-1	-1	1	1	1	1
2013-264	-0.25	-1	1	-1	-1	-1	1	1	1	1	0	-1	-1	-1	0	-1	-1	-1	1	-1	0
Summit Ave	0.17	-0.67	1.00	-0.67	0.33	-0.33	1.00	1.00	0.67	0.33	0.33	0.33	0.00	-0.33	-0.33	-0.67	-0.67	0.00	1.00	0.33	0.67
		ARG	AUS	BRA	CAN	CHI	FRA	GER	IND	INDO	ITA	JAP	KOR	MEX	RUS	SAU	S.AF	TUR	UK	USA	EU
Overall Issue Average N=39	0.35	-0.16	0.60	0.19	0.65	0.23	0.64	0.75	0.18	0.08	0.33	0.46	0.43	0.02	0.14	0.07	0.13	0.24	0.86	0.57	0.67
Overall Compliance Ave. N=128	0.42	0.04	0.66	0.35	0.6	0.33	0.62	0.65	0.33	0.21	0.43	0.4	0.54	0.33	0.3	0.08	0.35	0.2	0.76	0.54	0.64

Appendix G: The G20 Summit System

Members

G7 Countries:	United States, Japan, Germany, United Kingdom, France, Italy, Canada
BRICS Countries:	Russia, China, India, Brazil, South Africa
MIKTA Countries:	Mexico, Indonesia, Korea, Turkey, Australia
Other Countries:	Saudi Arabia, Argentina
International Org′ns:	EU, IMF, World Bank

G20 Summits

United States, 2008: November 14–15, Washington DC, United States
United Kingdom, 2009: April 1–2, London, England
United States, 2009: September 24–25, Pittsburgh, United States
Canada, 2010: June 26–27, Toronto, Canada
Korea, 2010: November 11–12, Seoul, Korea
France, 2011: November 3–4, Cannes, France
Mexico, 2012: June 18–19, Los Cabos, Mexico
Russia, 2013: September 5-6, St. Petersburg
Australia, 2014: November 15-16, Brisbane, Australia
Turkey, 2015: November 15-16, Antalya, Turkey
China, 2016: TBD

Ministerial Meetings

Finance,	1999-
Employment and Labour	2010, 2011, 2012, 2013, 2014
Agriculture	2011, 2012
Development	2011
Trade	2012, 2014
Foreign Affairs	2012, 2013
Energy	2015
Other:	
Tourism (Informal Link):	2010, 2011, 2012, 2013,

Civil Society Engagement Groups

B20	Business	2010
L20	Labour	2010
Y20	Youth	2010
T20	Think Tank	2012
C20	Civil	2013
YES	Young Entrepreneurs Summit	2010-
G20	Girls	2010-