ON SEPTEMBER 19–20, 2011, heads of state, government officials, and representatives of non-governmental organizations (NGOs) met in New York City at an unprecedented high-level summit convened by the United Nations (UN) to discuss a critical new global agenda. The primary goal of the summit was to mobilize commitment to confront the worldwide threat posed by various noncommunicable diseases (NCDs)—cardiovascular disease, cancer, diabetes, and chronic respiratory disease—and their associated risk factors: tobacco use, unhealthy diet, insufficient physical activity, and harmful use of alcohol. Throughout 2012 and 2013, the World Health Organization (WHO) is leading a range of follow-up efforts to set global targets and an action plan for monitoring NCDs worldwide. In assessing the impact of the NCD Summit, it is critical to look ahead at its long-term implications. The summit represented significant opportunities and challenges that will cast a long shadow unless they are addressed in the upcoming months.

The UN NCD Summit generated high expectations worldwide. Between November 2010 and April 2011, the WHO prepared for the summit by holding five regional consultations led by its regional offices representing Europe, the Americas, South East Asia, Western Pacific, and Africa. Along with the Russian Federation, it also organized the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, held in Moscow in April 2011. The summit was only the second time that the UN General Assembly, representing all 193 member states, met to discuss a global health agenda. In 2001, the UN General Assembly Special Session on AIDS resulted in a declaration of commitment on HIV/AIDS.

The outcomes of the NCD Summit were disappointing. Although they yielded a commitment from UN member states to develop frameworks for monitoring NCDs and to identify indicators to assess national and regional strategies by the end of 2012 (Resolution 66/2), the summit did not lay down specific policy commitments for concerted action. International NCD coalitions and experts pressed for time-bound targets to make nations accountable, such as a 2040 goal for a tobacco-free world at a global commitment of $9 million and norms relating to taxation and industry regulation; these, however, proved elusive.1,2

The WHO’s political leadership of the summit neglected the complexities of the NCD agenda and the challenges in building political will for its endorsement at the UN Summit. The high-level meeting also demonstrated that the WHO lacks a clear framework or approach to NCDs. Yet the setback holds important lessons for the WHO in particular—the lead specialized agency for NCDs within the UN—and for the NCD agenda worldwide. To move forward, however, we must look at the politics of the process leading up to the summit itself.

The scale and scope of the problem of NCDs is tremendous. The UN secretary-general, in his opening address to the summit, delivered a “grim prognosis,” stating that NCDs represented a threat not only to health but also to global development and poverty eradication. NCDs are no longer perceived to be restricted to affluent societies. Of the 57 million global deaths due to NCDs, including 9.1 million before the age of 60 years, nearly 80% occurred in low- and middle-income countries. The world’s epidemiological and development profiles are now interlinked and complex.

Against this urgent background, why did the UN Summit fail to make strong commitments to targets that had been hoped for? The political negotiations in the weeks preceding the meeting foretold its ultimate fate. On August 16, 2011, three presidents of the founding NGOs of the NCD Alliance (a formal collaborative of four international federations representing cardiovascular disease, diabetes, cancer, and chronic respiratory disease) wrote a letter to UN Secretary-General Ban-Ki Moon that criticized political stalling on the NCD agenda. They chided that “sound proposals for the draft Declaration to include time-bound commitments and targets are being systematically deleted, diluted and downgraded.” They stressed the need to mobilize greater “political will” from heads of states to commit to
targets and concrete steps toward NCD prevention and control. The failure to mobilize political will, in large part due to neglect of the politics of process among key member states and other UN agencies, demands careful scrutiny.

The impetus to hold the NCD Summit came from the Caribbean Common Market Countries in 2007; subsequently, however, strong advocacy led by key UN member states has been lacking. The WHO focused on mobilizing regional declarations of faith to the NCD Summit in the months preceding the meeting, but national-level mobilization was neglected. This oversight had significant fallout when individual member states, acting on the basis of national priorities, supported or rejected proposed targets at the summit. The resulting trends and alignments are neither new nor unfamiliar to the WHO. Since 2003, the WHO’s successes with NCD-related mobilization, such as in the arena of the Framework Control on Tobacco Control (FCTC), have been regarded as landmarks in mobilizing global support for a new public health agenda.

However, commitments from countries such as China have recently slowed, as is evident from China’s delay in following up on its commitments to the FCTC. Other emerging economies such as Brazil and India who no longer qualify for international development aid and are unlikely to benefit from the promise of resources, have also been less energetic in promoting a global agenda for NCDs. European nations, the United States, and Canada are also reluctant to flag NCDs as a development challenge because this would probably divert the limited resources available for Millennium Development Goals—maternal and child health and communicable diseases, which are areas of historic concern to developed nations.

There were also early signs that the WHO lacked a clear roadmap for building political support through institutional means. A complex issue such as NCDs requires a harmonizing of interests even within the UN itself so that a partnership-centered vision can be presented at the summit and to member states. However, there was no obvious approach to build a unified vision within and among UN agencies and to plan concerted action. The WHO’s past experience in forging decentralized and intersectoral alliances to build political support and resources for a new global health agenda has also been limited. For instance, the WHO leadership in the initial UN-led campaign against AIDS lacked the breadth and flexibility to initiate an intersectoral and cosponsored approach that was later pioneered by the Joint United Nations Program on HIV/AIDS (UNAIDS, launched in 1996).

In view of the WHO’s past challenges, what were the options for other players to shape and support its mandate at the NCD Summit? Over the past decades, international NGO networks have acted as brokers of knowledge and policy across the traditional divides in international relations between developed and developing countries. In the case of the UN NCD Summit, NGO networks also failed to mobilize political will. NGO networks that have played a significant role in mobilizing political support are relatively recent (e.g., the NCD Alliance, founded in May 2009), and their leverage, not surprisingly, has been limited. They have also lacked partnerships outside the health sector (e.g., NGOs working in the spheres of food, transport, or environment) that would be critical for building support for the NCD agenda and its risk factors.

The leadership of the WHO, then, became the linchpin in determining the success of this summit. However, if we draw the right lessons from the summit, it can still be viewed as a watershed moment. In terms of mobilizing actions, the WHO needed to build national-level political commitment among member states prior to the summit and adopt a wider partnership-focused approach involving other UN agencies and funds. It also needed to ensure advocacy among national policymakers by international NGO networks that represent not only NCDs but also other intersectoring sectors. Although it largely failed to develop these important preparatory activities, it is possible that effective follow-up work can help to overcome existing obstacles. For example, a meeting of the UN Funds and Agencies on the Implementation of the Political Declaration was held later, on December 8, 2011, marking the beginning of the potentially important process of making NCDs eligible for funding.

The summit also represented a significant beginning because it prioritized NCDs on the global agenda. It identified the broadest interpretation of their risk factors by relating them to causes that originate in structural determinants—environmental, social, political, and behavioral factors—such as poverty, lack of education, and gender that increase vulnerability to NCDs and exacerbate challenges to development. The summit also prioritized a multilevel process and intersectoral responses to meet the challenge posed by NCDs, and endorsed the WHO’s key role in the process ahead: to provide leadership and the evidence basis for international action.

In view of this mandate, the most significant challenge for the WHO rests in mobilizing cross-cutting political support among a range of partners, and recognizing the critical role of the politics of process and consensus building with key political and social actors. Consensus building is complementary to—and should be pursued along with—the process of building evidence, setting targets, and implementation.

Over the coming months, the WHO will need to work intensively at the national level through its country offices, with a bottom-up approach that aims to actively reshape national level perspectives toward NCDs. In particular, it will need to communicate to national-level policymakers that, rather than seeing the NCD agenda as replacing an older continuum of UN approaches relating to the eradication of infectious diseases, they need to view it as representing a paradigm shift in public health policies. In developing countries where populations face a growing dual burden of disease, the WHO can build policy support for NCD prioritization by advocating comprehensive approaches. It may also be important to begin to rethink the sharp distinction that has been made between communicable and chronic disease. This distinction, like that between primary and secondary care, has already begun to be questioned in some forums, as was evident in the meeting of the International AIDS Society, in Rome in 2011.
which suggested that HIV and NCDs should be seen as sharing common needs and interests. The WHO will need to reinforce and build on these views and approaches to build national-level commitment to NCDs and to integrate them within preexisting health priorities.

The next steps are for the WHO to work through multiple partners, such as other specialized UN agencies and international NGOs, to persuade states that their own proximate, national interests are at stake in what might otherwise be perceived as a remote, “global” problem. The WHO will also have to build cross-cutting alliances with the private sector, which holds the potential to collaborate and act with responsibility and ingenuity but also has ominously deep-rooted stakes in maintaining the status quo. A key element is preparing for the political process and building commitment among member states, donors, and other UN partners. Plans for implementation and meeting global targets will rest on member states. The continued development of this political process will ultimately determine whether or not the global NCD Summit was a missed opportunity or a landmark event marking the beginning of an important new era in the politics of global health.

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This commentary was accepted February 27, 2012.

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K. Sivaramakrishnan researched, drafted, and analyzed the commentary. R. G. Parker provided analytical inputs regarding the global health policy process, its changing actors, and recent history, and also helped edit and frame the commentary.

Acknowledgments
We are grateful to Amy Fairchild and Ronald Bayer at the Center for the History and Ethics of Public Health, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, for their insightful comments during the drafting of this piece. We also thank K. Srinath Reddy at the Public Health Foundation of India for helpful discussions.

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