



Caribbean Unity in Health  
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# EVIDENCE BRIEFS

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*The Evaluation of the 2007 CARICOM Heads of  
Government Port of Spain NCD Summit  
Declaration*

*May 2016*

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## Acronyms

BNR	Barbados National Registry
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCH	Caribbean Cooperation in Health
CDC	Centres for Disease Control and Prevention
CDRC	Chronic Disease Research Centre
CFNI	Caribbean Food and Nutrition Institute
CMO	Chief Medical Officer
COTED	Council for Trade and Economic Development
CROSQ	CARICOM Regional Organisation for Standards and Quality
CWD	Caribbean Wellness Day
FCTC	Framework Convention on Tobacco Control
M&E	Monitoring and evaluation
NCDs	Non-communicable diseases
PAC	Project Advisory Committee
PAHO	Pan American Health Organization
UNHLM	United Nations High-Level Meeting on Non-communicable Diseases
UWI	University of the West Indies
WHO	World Health Organization



# Preface

In September 2007 leaders of the Caribbean Community (CARICOM) held the world's first Heads of Government Summit on non-communicable diseases (NCDs) and produced the ground-breaking Port of Spain Declaration. CARICOM and the Pan American Health Organization (PAHO/WHO) were charged with evaluating the impact of the Declaration, and the work summarised in this document has been conducted on their behalf. The evaluation is led by the University of the West Indies (UWI), in collaboration with the Caribbean Public Health Agency (CARPHA), the Healthy Caribbean Coalition (HCC) and the University of Toronto. It is generously supported by the Canadian International Development Research Centre (IDRC).

The evaluation, which began in April 2014, has three main phases: undertaking new studies to investigate the impact of the Declaration; reviewing successes and challenges and agreeing, with CARICOM Governments, a regional strategy for accelerated implementation of measures to prevent and control NCDs; and disseminating the findings. This document presents the core findings from the first phase, which were considered at the regional implementation workshop, in Port of Spain, February 24<sup>th</sup> and 25<sup>th</sup> 2016.

There are nine chapters in the report. Chapters 1 and 2 introduce the Port of Spain Declaration on NCDs and the objectives of the evaluation. Chapters 3 to 8 are 'evidence briefs', each summarising a different aspect of the research. The briefs contain summary points, background, aims and methods, key findings, conclusions and recommendations.

Lastly, the most important section, Chapter 9, 'Accelerating implementation' is about the plan for action arising out of the findings. It represents the collective voice of those attending the implementation workshop and charts a way forward, highlighting priorities and concerted actions needed to really make a difference in the challenge to the NCD epidemic in the Caribbean.



Dr T. Alafia Samuels



Professor Nigel Unwin

On behalf of the Port of Spain evaluation research group.



# Executive Summary

## Evaluation of the 2007 CARICOM NCD Summit Declaration to accelerate implementation

The 2007 Port of Spain Declaration on non-communicable diseases is approaching its 10<sup>th</sup> anniversary. With its partners, the University of the West Indies has completed an evaluation of the successes and challenges in attaining the Declaration's commitments.<sup>i</sup> In February 2016 a major regional workshop brought together stakeholders from a broad range of sectors to review and validate the findings and make recommendations to accelerate further implementation.

### RESEARCH FINDINGS: THE HIGHLIGHTS



#### ***National and regional trends in NCD mortality, morbidity and risk factors***

- Mortality in the Caribbean from NCDs is the highest in the Americas. 40% of NCD deaths occur prematurely, in those under 70, and are potentially preventable.
- Heart attacks, stroke and diabetes cause most premature deaths, followed by cancers. Life expectancy varies from 61 years in Haiti to 75 years in Antigua and Barbuda, Barbados and the Bahamas.
- Hypertension is the leading risk factor for death.

Our diabetes prevalence is double global rates.

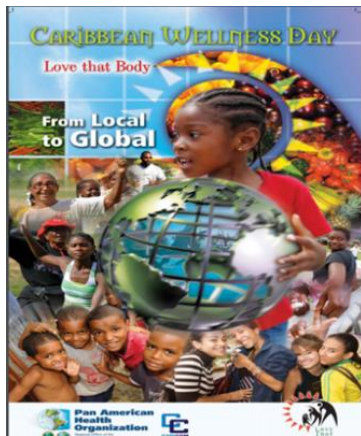
- NCD risk factors such as unhealthy food, physical inactivity, obesity and alcohol consumption are rising. There is higher obesity and diabetes in women; higher smoking and binge drinking in men.
- The World Health Organization (WHO) Framework Convention on Tobacco Control has been ratified, but implementation is lagging.



#### ***National policy responses to NCDs and lessons learned***

- NCDs need to be given a higher political priority.
  - There are widely differing levels of implementation of Summit Declaration mandates, related to country size, resources and burden of NCDs.
  - The all-of-society and all-of-government response required for NCDs needs strengthening.
  - Indicators with the **lowest** levels of implementation concern diet, schools and communications.
- Indicators with clear guidance for action and support from regional or international organisations have the **highest** levels of implementation. (See next section).

### ***International institutions' support for the Declaration***



Eight of the 27 commitments in the Declaration identified specific international institutions (both within and outside the Caribbean) expected to provide assistance.

- The performance of these institutions has been very variable. PAHO was identified as a particularly valuable resource.
- Successful implementation of Summit commitments has been associated with clear statements on what was required and assistance from these international organisations, e.g:
  - Caribbean Wellness Day supported by PAHO and CARICOM;
  - Prevalence and risk factor surveys supported by the Caribbean Epidemiology Centre/Caribbean Public Health Agency (CARPHA) and the Centres for Disease Control and Prevention; and
- The Framework Convention on Tobacco Control (FCTC) supported by PAHO/WHO.
- There is concern that there is less support for action by CARICOM members on nutrition now that the Caribbean Food and Nutrition Institute has been subsumed into CARPHA.

### ***International impact of the 2007 Port of Spain NCD Declaration***

- The Port of Spain Summit had significant influence on shaping global governance of NCDs and paved the way for the 2011 United Nations High-Level Meeting (UNHLM) on NCDs.
- 16 of 27 commitments made at the Summit were later reflected in at least one UNHLM commitment.
- A reduction in premature NCD mortality is one of the targets of the Sustainable Development Goals.

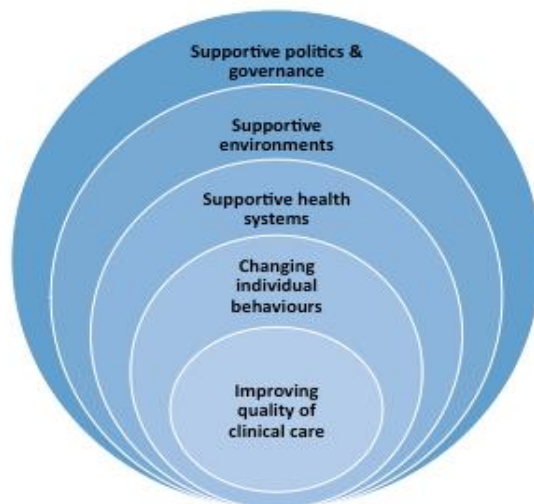
### ***Surveillance and monitoring***

- There are 21 different and overlapping NCD reports required by regional and international bodies.
- It is clearly a challenge to respond to these demands, especially in the smallest countries.
- Some key surveillance activities need better support and capacity building to ensure that countries make full use of the data collected.
- Data are not always shared between national and regional organisations.
- Despite these limitations, the Caribbean has made significant contributions to the global NCD agenda, including in surveillance, monitoring and evaluation.

### ***Investing in NCD prevention and control: potential role of tobacco and alcohol taxes***

- According to a study in three countries, Grenada, Jamaica and Trinidad and Tobago: revenue generated from further increasing taxes on tobacco and alcohol could exceed US\$ 37 million. This is 300% more than the estimated US\$ 12.6 million cost of World Health Organization 'best buy' NCD interventions for these populations.
- 2014 taxation on tobacco ranges from 17% in St. Vincent & Grenadines to 63% of sale price in St. Lucia. The PAHO/WHO target is 75% of sale price.
- Increased taxes will benefit health as consumption will fall, even allowing for the possibility of smuggling and illicit production.
- Other forms of taxation, such as taxes on sugar-sweetened beverages, should also be considered.

## STRATEGIES FOR MULTILEVEL NCD ACTION



### SUPPORTIVE POLITICS AND GOVERNANCE

***Establish the response to NCDs as an enduring key priority for regional and national policy makers***



- Re-energise regional leadership and support for the required multisectoral response, i.e.:
  - Schedule regular sessions on NCDs at CARICOM Heads of Government Conferences aligned with required UN/WHO reporting.
  - Revive the Regional NCD Secretariat, aligned with Caribbean Cooperation in Health IV, with clear mandates and deliverables of regional public goods to facilitate NCD prevention and control.
  - Fully engage relevant organs and institutions of CARICOM, such as the Council for Trade and Economic Development (COTED).
- Pursue a strategic alignment with Pacific Islands and Small Island Developing States (SIDS) to include food security and to address vulnerabilities to natural disasters and climate change.
- Further develop and support national leadership for multisectoral action on NCDs, including:
  - The presence of a dedicated NCD focal point in the Ministry of Health.
  - A National NCD Commission (or equivalent), whose remit and multisectoral membership supports the all-of-society response.
  - An inter-ministerial committee on NCDs/health to coordinate actions between Ministries, e.g. Health, Education, Trade, Agriculture, Urban Planning and Finance – the all-of-Government response.
- Invigorate public awareness and support for interventions:
  - Draft in a 'league of champions' to lobby leaders to towards sustainable political buy-in.



- Introduce social health insurance to facilitate quality health services, universal access and universal coverage for at least a basic package for all residents.
- Explicitly include health and its determinants as part the overseas development agenda and requests for development aid, where appropriate.

## **SUPPORTIVE ENVIRONMENTS**

### **Social/macro determinants of NCD risks requiring a multisectoral response**



#### ***Diet, food and food security: relevant policy on agriculture and trade***

- Explore options under the World Trade Organization to protect the local market from subsidised, cheap, high-calorie, nutritionally poor foods as part of a strategic plan addressing the critical role of agriculture and food production.
- Incentivise production of low cost, high-quality food.
- Ban import of trans fats.
- Introduce compulsory standards for nutritional labelling.
- Advocate for fiscal measures of taxation to reduce consumption of unhealthy products.
- Recognise that the “Rights of the Child to Health” includes the right to live in a non-obesogenic environment; institute a ban on the advertising and promotion of unhealthy foods in schools, as recommended by the United Nations Task Force on Childhood Obesity.

#### ***Reducing alcohol-related harm***

- Adopt a comprehensive regional policy on alcohol reduction with focus on young people.
- Implement zero tolerance towards drink driving.
- Ban or regulate alcohol marketing and ban sports sponsorship.
- Examine the option of further increasing taxes to decrease consumption and raise revenue.

#### ***Tobacco control***

- Concentrate on implementation of FCTC legislation for 100% smoke-free spaces, labels with sufficiently large and graphic warnings, banning tobacco sponsorship.
- Increase taxation to 75% of sale price; earmark these funds for health education and prevention.

#### ***Physical activity and the built environment***

- Develop the physical and social environment to promote activity by providing areas which are easily accessible, safe and well maintained, e.g. bicycle lanes and boardwalks.
- Challenge policies/barriers preventing the easy adoption of physical activity.
- Improve public transportation systems to decrease reliance on cars.

#### ***Promoting health in different settings, such as schools, workplaces and faith-based institutions***

- Review the Health and Family Life Education curriculum in schools to include the NCD agenda.
- Make physical activity mandatory from pre-primary to tertiary level.
- Ban advertising, promotion and sponsorship related to unhealthy foods that target children.
- Integrate interventions in the workplace as part of HR policy.
- Develop workplace wellness programmes and offer regular NCD screenings for employees.
- Adapt and adopt a model based on the Seventh-day Adventist health programme.
- Engage faith-based organisations’ reach within communities.



## ***Media and social communications, health promotion and advocacy***



- Explore and address social and cultural practices which militate against healthy living.
- Find dynamic ways to 'tell and sell the story' of NCDs. Strengthen and maximise use of social media.
- Identify sector champions.
- Continue to build the Regional Health Communications Network facilitated by the Caribbean Public Health Agency.
- Develop a communications toolkit with varied products for varied audiences.

## ***Investing in NCD prevention and control***

- Undertake work to better demonstrate the economic, social and health benefits of investing in NCD prevention and control, and use to increase public and private investment.
- Explore increased taxation to decrease, and conversely subsidies to increase, consumption, e.g. tax on sugar-sweetened beverages, subsidies on fresh fruit and vegetables.
- Earmark a proportion of increased tax revenue raised specifically for health/NCDs. Examine Jamaica's National Health Fund as an example of an investment to resource NCD programming that has survived political changes.

## **WORKING WITH PARTNERS**

### ***Civil society***

- Form local networks like country NCD Alliances, e.g. Trinidad and Tobago NCD Alliance.
- Improve and develop role as NCD advocates, strengthening communications skills.
- Advocate for alcohol reduction policies, communicating messages on the dangers of excessive alcohol consumption.
- Strengthen advocacy in pushing to implement the FCTC.
- Share good practices, ideas, information and experiences more effectively across the region.
- Contribute to a stock of NCD-related stories accessible to all (e.g. through the [onecaribbeanhealth.org](http://onecaribbeanhealth.org) website).
- Step up advocacy role in public education on NCD risk factors and the importance of diet and exercise.

### ***Private sector***

- Share good practices in product reformulation regionally, e.g. reduced salt in bread in Barbados.
- Support nutritional labelling.
- Promote wellness programmes and offer NCD screenings for employees annually (free or heavily subsidised). Such programmes should be offered based on aggregated data from screenings.
- Support marketing of healthy foods.

## **SUPPORTIVE HEALTH SYSTEMS**

### ***Regional bodies***

- The NCD response of regional bodies should be monitored. This includes reporting:
  - Number and amount of dedicated staff and budget; and
  - The amount set aside for NCD projects.
- Identify and deliver regional public goods to facilitate NCD programming in countries.
- Regional organisations should continue to enhance capacity building in reporting indicators.

## **SURVEILLANCE AND MONITORING**

- Rationalise NCD reporting to regional and international bodies (21 different reports required).
- Implement national multi disease registries.
- Revise the Port of Spain reporting grid, including definitions of indicators. Pilot and introduce in 2016.
- Ensure that data collection is standardised to facilitate WHO global NCD monitoring. Review WHO baseline estimates; establish nine country-specific voluntary NCD Global Monitoring Framework targets (and interim targets) to achieve outcomes for 2025.
- Commission and implement standardised morbidity reporting/collection of health facility-based data on NCDs (including diabetes and hypertension) and their complications at primary and secondary care level.

## **IMPROVING QUALITY OF CLINICAL CARE**

- Accelerate improvements in clinical quality of care especially for hypertension and diabetes, including in the workplace.
- Implement regional purchase of high-quality generic NCD drugs recommended by WHO.
- Introduce social health insurance to facilitate quality health services (see above).
- Introduce or enhance electronic medical records, with a focus on generating reports for action.
- Accelerate the implementation of the chronic care model and evidenced-based chronic care.

## Chapter 1: The 2007 Port of Spain NCD Declaration in context



PAHO

Mortality in the Caribbean from non-communicable diseases is the highest in the Americas. Four out of every 10 deaths from NCDs in the region occur in those under the age of 70, and are potentially preventable. A high prevalence of risk factors, especially overweight and obesity, low levels of physical activity, nutritionally poor diets, excess alcohol consumption and tobacco smoking, underlie the high burden of NCDs. Fuelling these risk factors are social and economic conditions that do not support physical activity and healthy food choices, creating an 'obesogenic environment'. Such conditions are in turn related to economic and cultural globalisation. In short, NCDs present a direct challenge to the continued economic and social development of the region; and with population aging, this challenge is growing.

The Caribbean has a rich history of collaboration in responding to health issues.

- It was the first subregion to eliminate indigenous polio, measles and rubella transmission.
- The 2001 CARICOM Heads of Government Nassau Declaration brought countries together under the rallying slogan, "The health of the region is the wealth of the region".
- The 2005 Caribbean Commission on Health and Development report, set up following the Nassau meeting, identified that NCDs were one of the three major health problems facing the region and it was decided that health should be propelled to the heart of the development agenda.

Advocacy by Sir George Alleyne, former Director of PAHO and Chancellor of the University of the West Indies, and others, on the impact of NCDs promoted the need for both multisectoral interventions to address common risks and increased global attention. In September 2007 the CARICOM Heads of Government held the Summit, 'Uniting to Stop the Epidemic of NCDs', in acknowledgement of the threat

to health and socio-economic development posed by the burden of these diseases. That Summit resulted in the Port of Spain Declaration, containing 15 actionable mandates with 27 commitments.

Commitments include development of a governance framework; resource mobilisation; risk factor reduction; improved screening, disease management and surveillance; health promotion; and multisectoral collaboration. CARICOM and PAHO were identified as being responsible for the monitoring and evaluation of the Declaration.

The precedent set by the CARICOM NCD Summit led its leaders to advocate elevating this approach to the global level. It was thus a forerunner to the historic United Nations High-Level Meeting (UNHLM) on the Prevention and Control of Non-communicable Diseases in September 2011, a contribution recently acknowledged publicly by UN Secretary-General Ban Ki-moon.

This UNHLM catalysed global attention and action. Caribbean countries played key roles in the UN meeting: Jamaica was one of two co-facilitators and the President of Suriname was the first Head of State to speak. The UNHLM resulted in a political declaration on NCDs. As a result, in May 2013, the World Health Assembly adopted a Global Monitoring Framework, which contains nine NCD targets and 25 indicators to measure progress.

Caribbean countries' implementation of the Port of Spain Declaration has been monitored using a grid developed in 2008 and revised in 2010. It is completed every year by the NCD focal points in Ministries of Health, reviewed by Chief Medical Officers (CMOs) and presented to the annual caucus of CARICOM Health Ministers. The findings suggest that some elements of the Declaration have been implemented successfully, while others have seen little progress. The grid, and this approach to monitoring, have received international recognition through publication in the peer-reviewed Bulletin of the World Health Organization (WHO).

Given the central role of the Declaration in shaping NCD policy and programmes in the Caribbean and beyond, it is important to formally assess the degree of implementation, examine lessons learned and propose corrections that will accelerate more effective implementation.



## Chapter 2: Overview of the Port of Spain evaluation

The overall goal of the project is:

*To evaluate, seven years on, the implementation of the CARICOM NCD Summit Political Declaration in order to learn lessons that will support and accelerate its further implementation and will inform the attainment of the UNHLM NCD commitments.*

### **Funding sources**

This work has been made possible through a grant from the Canadian International Development Research Centre with considerable additional contributions of the time of research staff from UWI. Financial administration has been provided by UWI, Cave Hill Campus.

### **Contributors to the evaluation**

Principal Investigators are Prof Nigel Unwin and Dr T. Alafia Samuels of the Chronic Disease Research Centre, Tropical Medicine Research Unit, UWI. These colleagues are experienced public health professionals and epidemiologists with a strong interest and global track record in NCD research. The multidisciplinary project team includes:

- Public Health Group, (UWI), Cave Hill
- Chronic Disease Research Centre, (UWI)
- Department of Community Health and Psychiatry (UWI), Mona
- HEU, Centre for Health Economics, (UWI), St. Augustine
- Institute of International Relations, (UWI), St. Augustine
- G8 Research Group, University of Toronto
- Caribbean Public Health Agency
- Pan American Health Organization
- The Healthy Caribbean Coalition

The contributions of the many team members to the work described in this report are summarised at the end of the document.

The evaluation has benefited from the guidance of the Project Advisory Committee (PAC); a small group of regional and international experts in the fields of public health, policy analysis, economics, social science and implementation science.

Members of the PAC include advisers from Health Ministries within the region: Dr Tamu Davidson (Jamaica), Ms Yvonne Lewis (Trinidad), Dr Paul Ricketts (Dominica); and international advisers: Prof Ross Brownson, (Washington University in St. Louis), Prof Anselm Hennis (PAHO), Prof Venkat Narayan (Emory University), Prof Rachel Nugent (University of Washington), and Prof David Stuckler (Oxford University). According to their areas of expertise, PAC members were asked to review research protocols and were available to the research teams for further consultation.

## **Objectives**

In order to achieve the project goal, the work was divided into eight objectives. The first six involve undertaking new research to learn from progress to date:

1. *Determining the extent to which Declaration commitments have been implemented;*
2. *Describing trends in NCD mortality and risk factors from 2000 to 2013;*
3. *In-depth case studies in seven countries to determine effective implementation;*
4. *a- Documenting tobacco control measures and studying successful implementation;*  
*b- Estimating the potential for revenue generation for NCD prevention and control from taxes on tobacco and alcohol;*  
*c- Undertaking an evaluation of the implementation of Caribbean Wellness Day (CWD);*
5. *Determining to what extent regional and international bodies have met their Declaration commitments; and*
6. *Studying the Declaration's regional and international impact.*

Two further objectives concern supporting and accelerating implementation:

7. *Using lessons learned from this evaluation to detail an action plan and implementation strategy; and*
8. *Disseminating evaluation lessons learned nationally, regionally and globally to enhance implementation.*

The main feature of Objective 7 is the multisectoral technical workshop held in February 2016. It brought together regional stakeholders, including policy makers, health professionals, civil society and the private and public sectors to review the research findings and participate in the creation of an improved regional action plan for NCDs. This updated strategy will be presented to the CARICOM Heads of Government at their February 2017 meeting (revised from July 2016).

Objective 8 focuses on ensuring that the output from the evaluation is communicated throughout the region and beyond to support the implementation of the Port of Spain Declaration. The Healthy Caribbean Coalition, collaborating with UWI and with CARPHA through the Regional Health Communications Network, has developed the dissemination strategy necessary to target audiences ranging from CARICOM Heads of Government to the woman/man in the street. This process of engagement will utilise the project's website, social media, policy briefs, briefings of traditional mass media and participation in key regional and global policy meetings.

## ***The structure of the report***

Collaboration between research teams has been highly encouraged and the evaluation has benefitted from a process of cross-validation of findings. That process has produced an interdisciplinary assessment of the regional NCD response, giving a solid foundation of evidence on which to build recommendations. Reporting of the research has been arranged into the common themes identified during the process.

Chapter	Common theme	Specific objectives
3	National and regional trends in NCD mortality, morbidity and risk factors	2
4	National policy responses to NCDs and lessons learned	1, 3, 4a
5	Regional policy responses to NCDs and lessons learned	4c&5
6	The international impact of the 2007 Port of Spain Declaration	6
7	Arrangements for ongoing surveillance for NCD mortality, morbidity and the policy response	1&2
8	Financing NCD prevention and control in CARICOM: potential revenue from tobacco and alcohol taxes	4b

Each of these chapters specifies the objectives and methodologies used by the teams. They identify policy gaps and summarise the lessons learned. Each chapter then provides potential actions to contribute to supporting and accelerating implementation of the Port of Spain Declaration.



Shari John

## Chapter 3: National and regional trends in NCD mortality, morbidity and risk factors

### **Summary points**

- On average CARICOM members have lower life expectancy at birth than Central or Latin America countries, a reversal of the situation that existed 30 to 40 years ago.
- There are large variations in life expectancy and in NCD-related mortality between CARICOM members.
- An understanding of the determinants of these differences is needed to design, implement and evaluate interventions to reduce them.
- Much better use can be made of available data (e.g. from risk factor surveys). Collaboration between regional institutions and CARICOM Member States is needed.
- Morbidity data are very limited but potentially of great value. Standardised protocols for data collection, with regional support, training and capacity building are required.
- Available data show there is a heavy NCD burden among CARICOM members.
- With the exception of Haiti, NCDs cause:
  - 65% to over 80% of all deaths
  - 62% to over 80% of premature adult deaths (30 to < 70yrs)
  - Cardiovascular disease and diabetes cause the majority of premature deaths from NCDs, followed by cancers.
- There are high burdens of risk factors, including obesity, hypertension and diabetes.
- Risk factor patterns differ by gender: higher obesity and diabetes in women, higher smoking and excess alcohol consumption in men.

### **Background**

In order to target and evaluate interventions aimed at reducing the NCD burden, it is essential to be able to track:

- The incidence, prevalence and distribution of the major NCD *risk factors* (obesity, physical inactivity, unhealthy diet, excess alcohol consumption and smoking); and
- The incidence, prevalence, mortality and distribution of the major *NCDs* (cardiovascular disease, diabetes, hypertension, cancers and respiratory diseases).

### **Aims and methods**

1. To describe, within the limitations of currently available data, what is robustly known of recent trends in NCD mortality, morbidity and risk factors from the year 2000 to 2013 in the 20 CARICOM countries and territories;
2. To determine if the countries can achieve the WHO goal of reducing premature NCD mortality by 25%, by 2025; and
3. To identify gaps in current data on NCD mortality, morbidity and risk factors.



A wide range of routinely available data sources were consulted, including:

- The mortality databases at CARPHA, PAHO/WHO and the Global Burden of Disease Study;
- Population size and age structures from the UN Population Division and national census reports;
- Risk factor surveys, such as WHO STEPS surveys and their equivalents (e.g. Barbados Health of the Nation, and Jamaican Health and Lifestyle Survey), the Global School Health Survey and the Global Youth Tobacco Survey;
- Disease registers – in particular the Barbados National Register, the only population-based multi-NCD register in the Caribbean;
- Healthcare utilisation data; and
- The WONDER database held by the Centres for Disease Control in Atlanta, (used to compare trends in mortality between Caribbean countries, African Americans and White Americans in the United States).

The findings on mortality presented here also draw on a concurrent and complementary National Institutes of Health-funded project on disparities in health in the Caribbean and the United States.

In order to help identify gaps, CARPHA led a scoping exercise on available data and their quality at country level.

## ***Findings***

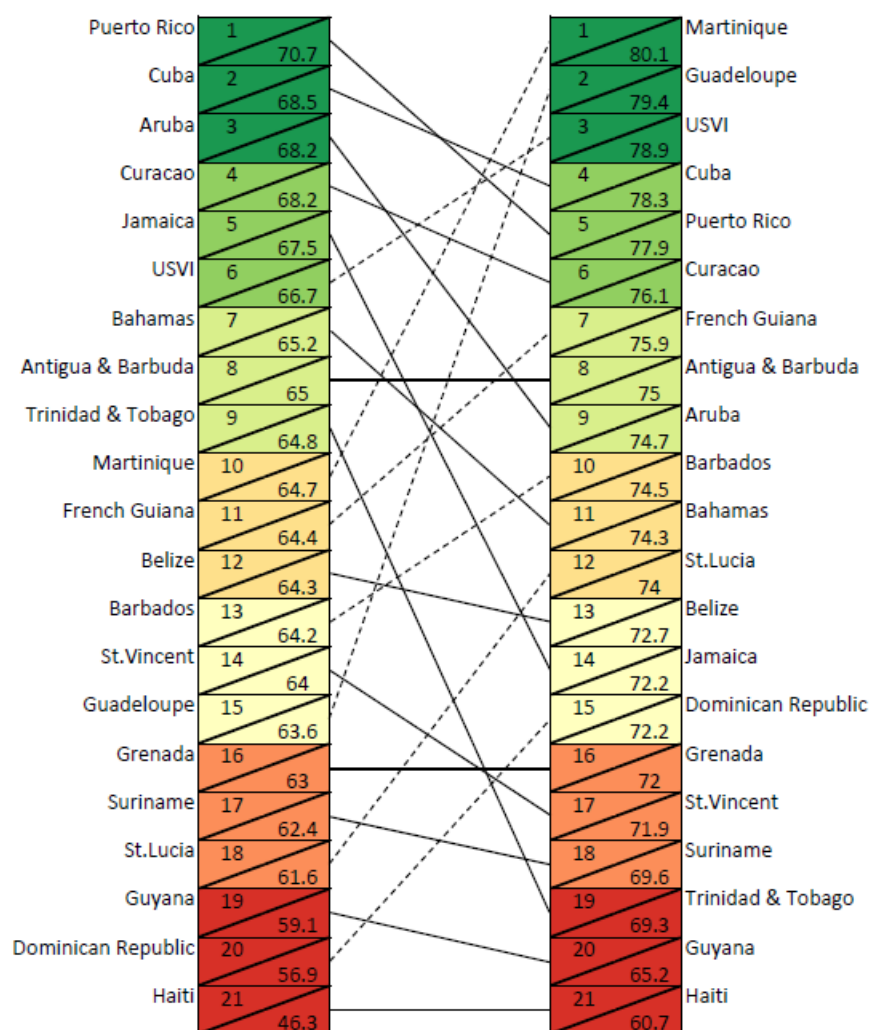
### ***Limitations, gaps and discrepancies in data***

- 13 of CARICOM's 20 members have performed at least one NCD risk factor survey among adults. While providing basic data, these surveys are an under-utilised resource and there remains great potential for further, comparative analyses. No countries had readily comparable risk factor data before and after the Port of Spain Declaration.
- Data on numbers of deaths by cause are available through PAHO and WHO mortality databases – but not all countries (e.g. Jamaica and Haiti) provided data to these sources during the time period of this evaluation.
- Poor death certification practices exist in many countries, and causes of death are often imprecisely described, e.g. 'essential hypertension'.
- Estimates of population size and structure for countries of 90,000 or more are available from the UN Population Division. For smaller populations census data need to be sought from individual countries.
- Small denominator populations in many CARICOM states (eight have fewer than 90,000 people) produce exaggerated rate variations after small absolute changes in numbers of cases.
- Findings (on absolute rates and trends) based on WHO/PAHO mortality databases can differ markedly from findings in the Global Burden of Disease Study (e.g. NCD mortality trends for Guyana and Trinidad and Tobago are different) – the latter using modelling to adjust for assumptions about data quality and underlying trends. Our preference here has been to use PAHO/WHO data, which are supplied by countries, as far as possible.
- Comparisons of data from contacts with health services are impeded by non-standardised reporting.
- Guyana and Trinidad and Tobago have passive reporting cancer registries while the Bahamas, Belize, Bermuda, Cayman Islands and Suriname have hospital-based registers; population-based cancer incidence data is available for Kingston & St. Andrew in Jamaica, and for Barbados.

### ***Trends in life expectancy and mortality from cardiovascular disease and diabetes***

On average CARICOM members have lower life expectancy at birth than Central or Latin America countries, a reversal of the situation that existed 30 to 40 years ago. The figure below shows absolute and relative changes in life expectancy for 21 Caribbean countries and territories between 1970 and 2010.

**Figure 3.1 - Changes in life expectancy in the Caribbean**

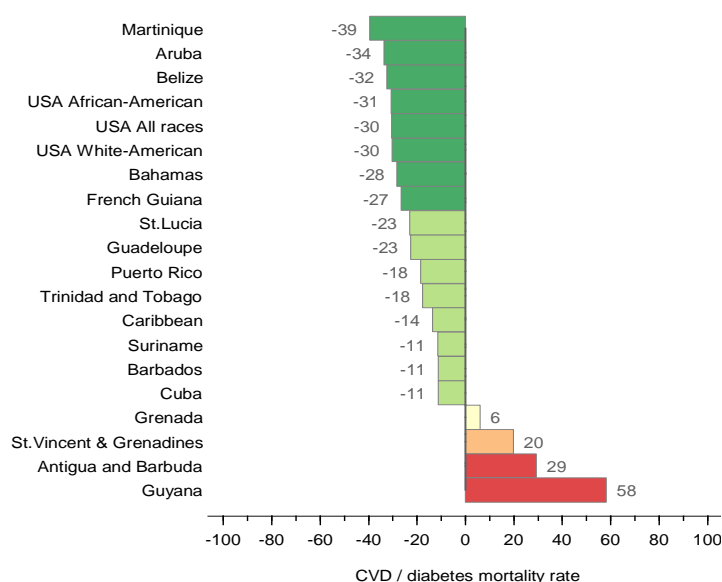


It is unclear what underlies these marked differences and this requires further investigation. Undoubtedly, differences in rates and trends in mortality from cardiovascular disease and diabetes will play a part, as together, these account for around 30 to approaching 50% of all deaths. In addition, it is well known that the incidence and mortality from these conditions can be lowered through changing underlying risk factors and the delivery of effective healthcare.

Figure 3.2 shows changes in age-adjusted mortality rates between 2000 and 2010 from cardiovascular disease and diabetes for Caribbean countries/territories, and provides a comparison with US African Americans and Whites. The 30% decline in rates seen in the best performing, including the US, is typical

of wealthier countries. The majority of the Caribbean countries are performing much less well, and in some, most notably Guyana, the rates are actually increasing.

**Figure 3.2 – Percentage changes in mortality rates from CVD/Diabetes 2000 to 2010**



Work to better understand what underlies these differences entails investigating the relative contributions of trends in risk factors and coverage of effective medical care to trends in mortality. A project of this type is currently underway in Barbados. Preliminary results suggest that improvements here have come from medical care, against a back-drop of worsening risk factors.

Cancers cause roughly 10 to 20% of all deaths, and a similar proportion of premature (30-69 years) deaths. Age-adjusted total cancer mortality shows little variation across the regions of the Americas, in contrast to cardiovascular diseases and diabetes. Among men in CARICOM Members States, prostate cancer has the highest incidence and highest mortality, followed by colorectal cancer. Among women, breast cancer has the highest incidence and mortality, also followed by colorectal cancer. Cervical cancer causes around 2% of all female deaths, an unacceptably high figure given that HPV vaccination, and screening and treatment should prevent the vast majority of deaths. Lung cancer rates in CARICOM members reflect relatively low rates of tobacco smoking (in the range of 10 to 20% in men, and 2 to 5% in women) and are much lower than in countries with a higher prevalence of smoking, including Cuba and the United States.

### ***Meeting the 2025 NCD mortality targets***

CARICOM members are signed up to WHO's global action plan on NCDs, and one of the targets for 2025 is a 25% reduction in premature (30 to 69 years) mortality from these disease. Based on available PAHO data, and using Global Burden of Disease Study estimates for Jamaica and Haiti, only eight of the 20 CARICOM members are currently on course to meet this target.

### ***Incidence of disease***

There are very limited, robust NCD incidence data from CARICOM members. The most comprehensive example is from Barbados, with an active population-based register that covers cancers, myocardial infarction (heart attack) and stroke. Incidence data is also available for cancers in Kingston and St Andrew in Jamaica.

### ***Prevalence of diabetes, hypertension and risk factors***

Prevalence data since the year 2000 among adults 25 years and older were available for 12 CARICOM members, and this included eight surveys that have been completed within the past five years. As expected, there is high prevalence of overweight and obesity (from around 1 in 2 adults in some countries to 4 out of 5 in others); diabetes (from around 1 in 10 to 1 in 4 adults), and hypertension (from 1 in 5 to over 1 in 2). Both obesity and diabetes tend to be significantly higher in women than in men, with, on average, women being twice as likely to be obese and 60% more likely to have diabetes.

Risk factors which are more common in men than women are smoking and binge alcohol drinking, with roughly 1 in 5 men across most countries reporting binge drinking and 10 to 20% of men being current tobacco smokers. Rates tend to be half that or even lower in women. Fresh fruit and vegetable intake is low in both men and women, with less than 15% in any country eating the recommended 5 or more portions a day.

There are very limited data to enable trends in risk factors to be explored. Data from Jamaica (surveys in 2000 and 2008) and Barbados (surveys in 2007 and 2012) suggest that obesity and physical inactivity may be increasing, but there may also be a rise in fresh fruit and vegetable consumption in Barbados. These tentative conclusions require further evaluation.

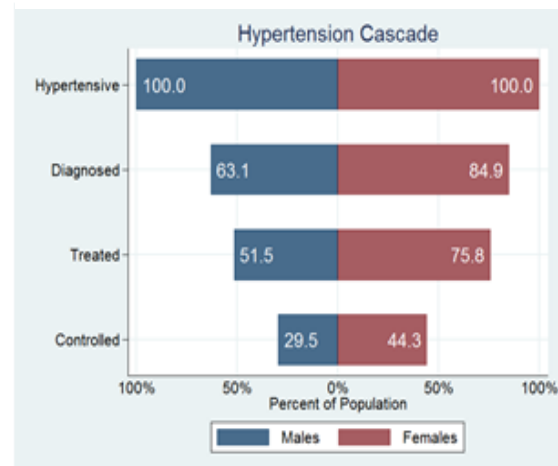
### ***Control of diabetes and hypertension***

Where the data have been analysed, there is clear evidence of marked room for improvement in the detection and management of hypertension and diabetes. Figure 3.3 shows detection and control of hypertension in men and women in Barbados in 2012. The overall prevalence of the disease in Barbados is around 40%, with detection and control being consistently worse in men compared to women.

### ***Risk factors in young people***

Data were available for 18 out of 20 CARICOM Member States from one or more Global School Health Surveys, or one or more Global Youth Tobacco Surveys. Three general conclusions are highlighted: in every country, less than a third of school children meet the recommended levels of physical activity, with girls being less active than boys; childhood obesity (based on the WHO definition) exceeds 10% in 7 of 11 countries with data, peaking at 18.2% among males and 23.6% among females in the Bahamas in 2013; and the prevalence of any tobacco and alcohol use in these 13 – 15 year olds is approximately the same as in adults.

**Figure 3.3 - Hypertension detection, treatment and control in Barbadian adults**



### ***The social determinants of health***



There are very limited data available on the frequency of risk factors or diseases by social determinant or markers of socio-economic position, such as education, occupation and race/ethnicity. The main exception is that data are typically presented by gender, and as noted above there are major differences in risk factor patterns between men and women. In addition, one available study from Belize has found significant differences in mortality between the four main ethnic groups there.

Undoubtedly, much more could be done with readily available data on the distribution of risk factors and risk of death by certain social determinants: for example, analysis of data by educational level from STEPS surveys, and mortality by ethnicity in those countries with large, differing ethnic groups – such as Trinidad and Tobago, Guyana and Suriname.

### ***Conclusions and potential actions***

#### **Data analysis**

- Make better use of available data to describe and monitor the NCD burden. This includes further analyses, for example, of the social and economic distribution within countries of routinely available risk factor survey data and mortality data.
- Provide training to country epidemiologists in analysis of the social and economic distribution of risk factors and disease, using their own risk factor data and facilitated by the University of the West Indies.
- Further investigate the basis of differences in trends in NCD mortality within CARICOM, and between CARICOM and other parts of the Americas, in order to design, implement and evaluate interventions to reduce these disparities.

#### ***Data availability and quality***

- Use a standardised format across CARICOM for the collection of health facility-based data on NCDs (including diabetes and hypertension) and their complications at primary and secondary care level.
- Increase the number of NCD registries within the region in order to monitor trends in incidence, complication rates and case fatality to guide and evaluate interventions.
- Continue to provide training to physicians and coders to improve the quality of death certification.

#### ***Data reporting***

- Rationalise NCD data requests (currently 21 different reports). See Chapter 7 on Surveillance.

## Chapter 4: National policy responses to NCDs and lessons learned



Simon Drvaric

### ***Summary points***

- There are widely differing levels of policy development and implementation in response to the Declaration: no country has met all of the indicators but all have met at least one.
- Indicators with the lowest levels of implementation concern the macro determinants of diet and physical activity, such as food labelling, trade agreements on food, and exercise and healthy eating programmes.
- Indicators with the highest levels of implementation are those where the action needed is clear (i.e. there are protocols or 'blueprints') and there is support from regional or international organisations. Examples include: Caribbean Wellness Day, WHO STEPS risk factor surveys and the WHO's Framework Convention on Tobacco Control (FCTC).
- While 13 out of the 14 independent CARICOM countries have ratified the FCTC, only a small minority have fully implemented smoke-free public places, banning tobacco advertising, and health warnings on cigarette packs, and none have taxation at 75% of the retail price.
- Achieving true multisectoral action, between government, civil society and the private sector, and within government between different ministries, requires appropriate facilitating structures to be in place and to be properly resourced.
- Leadership and support is required from the highest level of government, and in many (arguably most) settings NCDs still lack the political priority they need. Mechanisms should be established within governments and at the level of CARICOM to keep considerations of health, wellness and the importance of NCDs at the forefront of cabinet decision-making.

## ***Background***

This study concerns actions taken by individual countries and territories in response to the epidemic of non-communicable diseases. It aims to identify existing policies towards NCD prevention and control, gaps in policy responses, and the factors promoting and hindering successful policy development and implementation.

## ***Aims and methods***

1. Two complementary approaches were taken. Firstly, data from an annually completed questionnaire grid which provides a 'snap shot' of government responses to NCDs were used. Responses were collated from 2008 to 2014. This grid, which has 26 indicators and contains information from all 20 CARICOM countries, is the main method of monitoring government responses to the Declaration and is completed annually by the NCD focal point within the Ministry of Health.
2. The second approach was to undertake detailed case studies in seven countries: Antigua and Barbuda, Belize, British Virgin Islands, Grenada, Jamaica, St Kitts and Nevis and Trinidad and Tobago. The countries, which reflect a range of socio-economic conditions, were chosen according to criteria such as population size, geography and status (at least one mainland country and one UK Overseas Territory).

### *In this research:*

- The policy response to NCDs was explored through in-depth, semi-structured interviews.
- Interviews were conducted with key informants from a range of backgrounds, including Chief Medical Officers; government ministry staff; Chairs of NCD Commissions; and representatives of the private sector and civil society organisations.
- Policy documents were identified and abstracted.
- Together, the interviews and document reviews enabled an analysis of formulated policy and an assessment of if, or how well, the policy had been implemented.

In addition, compliance with the Framework Convention on Tobacco Control was investigated. PAHO routinely collects data on FCTC compliance in independent countries, and these data were reviewed for the 14 independent countries of CARICOM. A special study was undertaken for the six UK Overseas Territories, to determine their level of compliance with key aspects of the FCTC, such as smoke-free public places and banning tobacco advertising.

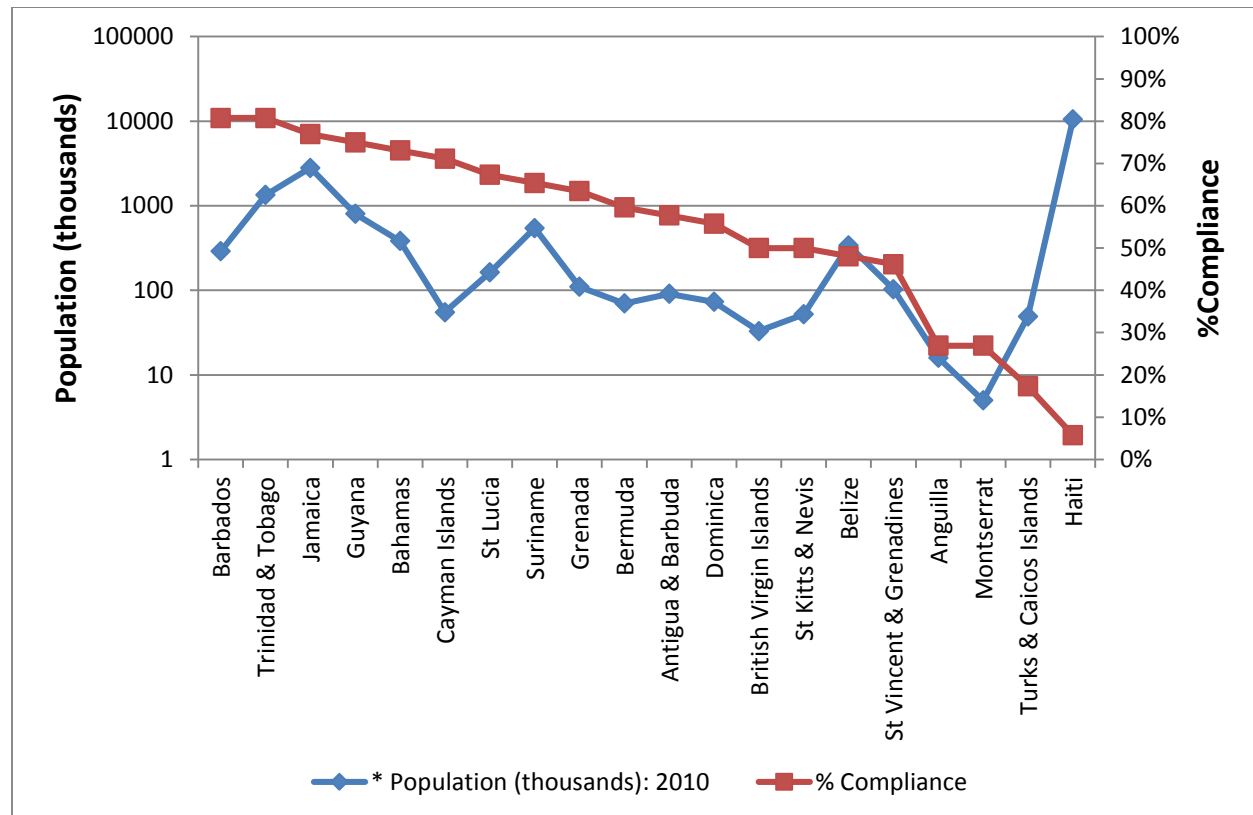
## ***Findings***

### ***Section 1a – National policy responses and predictors based on the monitoring grid***

- Across the 20 CARICOM members 58% of commitments are reported to have been met.
- There are considerable differences in levels of compliance. Substantial gaps remain.
- Every CARICOM member has implemented at least one indicator but none has implemented all.
- No single indicator has been implemented by every member.
- Risk factor surveillance and Caribbean Wellness Day show the highest levels of implementation and nutrition the lowest.

- Seven indicators have particularly poor compliance, with less than 50% of members having either complied or reported to be in the process of doing so. Six of these indicators concern the macro determinants of diet and physical activity: banning trans fats, food labelling, trade agreements on food, and physical activity and healthy eating programmes.
- Banning tobacco advertising, promotion and sponsorship also has poor compliance.

**Figure 4.1-The relationship between population size (left axis) and compliance with Port of Spain commitments (right axis)**



#### ***Factors associated with indicator implementation***

- As has been noted, indicators containing specific reference to an activity mandated by a regional or international organisation were more likely to be met. Examples include the Framework Convention on Tobacco Control and Caribbean Wellness day.
- In general, countries with a higher per capita Gross Domestic Product, with larger populations (see figure), and a higher burden per capita of NCDs have a better history of implementation. Haiti is the outlier.
- The top four implementers have relatively high female participation in the workforce and a relatively high proportion of female Members of Parliament.

### ***Section 1b – National policy responses on tobacco control based on FCTC monitoring***

- While 13 out of the 14 independent countries in CARICOM have ratified the FCTC (Haiti is the only country that has not), there remains relatively poor compliance with its articles. For example, based on the most recently available data (for 2014) for the independent countries:
  - Four have adequate policies on smoke-free public places;
  - Three have requirements for health warnings on cigarette packets;
  - One has compliant policy on banning tobacco advertising; and
  - None tax tobacco products at 75% or more of the retail price.
- In the six UK Overseas Territories, four had adequate policies on smoke-free public places, one has a requirement for health warnings, and one is compliant on banning advertising.
- Only in the provision of services for smoking cessation was compliance notably higher, albeit still short of what is required for full compliance with the FCTC. Six independent countries and three Overseas Territories have a smoking cessation service in which the cost is covered.

### ***Section 2 – National policy responses, their facilitators and barriers in seven case studies***

#### ***Barriers and facilitators to policy success***

- NCD prevention is not a priority on the larger political agenda for most countries.
- Although all seven countries had a form of multisectoral NCD Commission, translating their recommendations into policy did not happen without an NCD focal point or a Minister of Health pushing the agenda.
- Implementation of certain policies was not possible due to other existing government agreements, such as World Trade Organization rules on tariffs.
- Successful policy implementation needed multiple factors to come together like:
  - A push within cabinet and sufficient resources to enforce enactment; and
  - Collaboration between ministries regarding policy (such as on food and nutrition in schools, and around food security) coupled with the necessary human resources for roll out.

#### ***Multisectorality***

- Multisectoral collaboration is needed in wider society and within government.
- By having whole-of-society partnerships, with NGOs and the private sector being given a 'seat at the table' and made central to the NCD response, public awareness of the NCD agenda is increased.
- NCD Commissions are the main vehicle proposed for supporting whole-of-society partnerships. In smaller countries, with limited human resources, having one Commission that supports multisectorality for health and wellness can be more feasible than one focused on specific disease groups.
- One of the biggest barriers was the lack of high-level political will to support multisectorality. Where ministries and other sectors worked in silos, opportunities to integrate health, education, and nutrition were lost.



### ***Health promotion***

- Most countries with a dedicated health promotion unit, especially if there was also an NCD champion on board and sufficient resources, were able to deliver health promotion programming and education to the general public.
- However, multiple barriers, like the aforementioned limited resources and lack of a designated focal point, have impeded health promotion initiatives, such as Caribbean Wellness Day.
- Where there is no functioning health promotion unit, reliance is then on NGOs, community health workers, and the private sector for programmes in schools as well as in the larger public sphere, and the NCD response is suboptimal.

### ***Risk factors***

- There has been progress in tobacco control. The ratification of the FCTC has led to legislation being in place or drafts in progress. Clear guidance has enabled a straightforward policy transfer to legislate and implement a ban on smoking in public places, for example.
- However, stakeholders across the seven countries reported a host of barriers to addressing NCD risk factors:
  - Awareness of healthy eating in the population was regarded as generally low, with the increasing availability of nutrition-poor fast food a concern.
  - The most pressing issues for policymakers were: food insecurity, reliance on food imports, and many people having limited means to purchase healthy foods.
  - Diet and physical activity health promotion were often seen to be hampered by short-term and/or external funding.
  - Alcohol as a risk factor has scarcely been addressed, partly because it is a major export product and has links with the tourism ('sand, sun and alcohol') industry.

### ***Healthcare***

- There is insufficient emphasis on NCD prevention efforts in primary care and too much attention paid to tertiary care and medical technologies.
- For larger countries such as Belize, the delivery of care in the countryside does not match that provided in urban centres.
- Small countries pointed to the challenge of providing specialised treatment with limited human resources.
- While most stakeholders are aware of treatment guidelines, the actual use of such guidelines is unknown.

### ***Surveillance***

- Stakeholders highlighted the need for an electronic medical records system and the establishment of registries.
- There is a lack of human resources and skills within Ministries of Health – and NGO partners – to undertake epidemiological or evaluation research. Building local capacity rather than relying on private external consultancies is necessary.
- Lack of monitoring was also described as hindering successful policy transfer across the region.

## ***Conclusions and potential actions***

- A comparison of findings from the case studies and the monitoring grid show that the grid, which is completed by country NCD focal points, tends to overestimate compliance and that reporting on some indicators may not be consistent between countries. There is a need therefore to firm up definitions and reporting for the grid indicators – this is examined in Chapter 7 - Surveillance.
- Surveillance data are currently inadequate to identify trends in the major NCD risk factors in most CARICOM Member States. Recommendations on improving surveillance (Chapters 3 and 7) are needed to better facilitate evaluations of the impacts of policies on NCD prevention and control.
- The importance of addressing the macro determinants of diet came out strongly in the case studies. Compliance is lowest in these areas because this requires regional cooperation, and the relative lack of this to date on these issues is covered in Chapter 5.
- NCD Commissions, or their equivalents, require resources to facilitate their meetings and their work. They should be supported by government, but independent in the advice they give.
- Mechanisms need to be established *within* government to foster working between Ministries: e.g. of Health, Education, Agriculture, Urban Planning and Finance. One possible mechanism is a cross-ministry committee/task force that reports to cabinet - and has a budget.
- Detailed policy guidance, with support from regional bodies in adapting and implementing that guidance, is required. 'Model policies' for use within the region should be developed for currently under-implemented areas, such as reducing alcohol-related harm.
- NCDs tend not to be given high political priority. This is reflected in the fact that at all the CARICOM conferences of Heads of Government since 2007 there has been little discussion of this epidemic. NCDs should become a regular and substantive agenda item, and the CARICOM Secretariat should support and strengthen the role of the Prime Minister responsible for health in the CARICOM quasi 'cabinet'.

#### **4b. National policy responses: examples of good practices**

Below are some examples of innovative approaches that were brought to the attention of the researchers. It is clear that there are many more, and others have been invited to suggest programmes and interventions from their own settings. These examples will be featured on the Port of Spain evaluation website ([www.onecaribbeanhealth.org](http://www.onecaribbeanhealth.org)).

##### **Antigua and Barbuda**

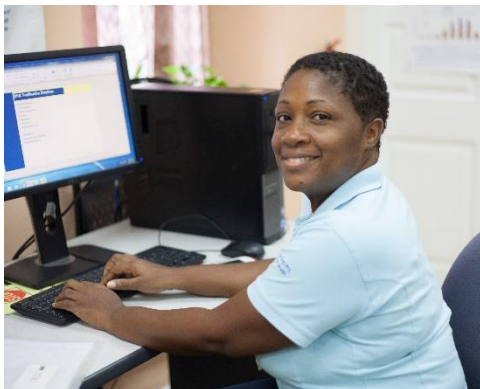


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The CARICOM Regional Food & Nutrition Security Policy was developed in 2010 and its sister policy in Antigua and Barbuda was launched in 2012 to improve the nation's health and diet and to address some of the issues around food security. These issues include the idea that affordability, rather than lack of health awareness, often drives food choices and there is a reliance on food imports, despite steps being taken to encourage local 'backyard' food production.

At least one key informant highlighted collaborative work between the Ministries of Health, Agriculture and Education in implementing the *Zero Hunger Challenge* initiative, designed to promote food security, especially among socially and economically vulnerable groups. The programme has now been expanded to encourage production and consumption of local foods as a healthier alternative.

##### **Barbados**



The Barbados National Registry (BNR) for NCDs is unique in the Caribbean as the region's only active, population-based, multi-disease registry. This surveillance system consists of three registries for stroke, heart attacks and cancer which provide statistics on incidence, mortality and survival rates for the entire population.

Conducted by the Chronic Disease Research Centre on behalf of the Ministry of Health, the Registry is a key resource in the NCD response both in Barbados and across the region and is used to monitor trends, and inform clinical practice, epidemiological research and health policy. For example, BNR data was instrumental in the decision to establish a Stroke Unit at the Queen Elizabeth Hospital and will help evaluate the impact of the new unit on stroke mortality. This is one example of the BNR team's timely and accurate collection of data contributing to the prevention, control and treatment of NCDs in Barbados. The high-quality database, with its regular reporting, can also estimate future disease impact and investigate interventions and preventative measures, showing what works. And what does not.

For more information go to: <http://www.bnr.org.bb/cms/>

## **Belize**

The country's National Health Insurance (NHI) Scheme is overseen by the Social Security Board that purchases primary care services from private and government providers on behalf of its members. These providers are monitored closely and evaluated before their service contracts can be renewed. The Ministry of Health plans to roll out the NHI model to 50% of the country during 2016, with numerous health personnel being trained and acquainted with new protocols to ensure that they understand how the system works.

Having first been established in the south of Belize, the intervention was extended to the north and by 2015 was reported to have reached some 35-40% of the population. Key informants state that the scheme has helped to finance new clinics and provided an opportunity to review and update protocols for the management of NCDs and risk factors. This process is being completed with assistance from CARPHA.

For more information go to: <http://www.socialsecurity.org.bz/nhi/>

## **British Virgin Islands**



In BVI there have been major efforts to increase activity among the population. A key intervention has been the *10,000 Step Challenge*, coordinated jointly by the Ministries of Health and Youth and Sport and the BVI Olympic Committee, with funding from the International Olympic Committee. Several groups and organisations have enrolled in the challenge in a bid to make walking and physical exercise the norm.

In addition, a ground-breaking initiative to improve the level of nutrition and physical activity among hundreds of the nation's primary school children was launched in October 2015. The behaviour change intervention, implemented by the Ministry of Education and Culture, promotes five targeted daily behaviours, like consuming a wide variety of foods; eating breakfast, fruits and vegetables; reducing intake of fats, salts and sugary snacks and drinks; and engaging in physical activity. Schools are encouraged to find creative ways of reinforcing positive changes, such as healthy lunch contests, walking and cycling clubs, adventure outings and the development of school gardens.

For more information go to: [http:// www.onecaribbeanhealth.org /bvi-striving-for-healthier-happier-pupils/](http://www.onecaribbeanhealth.org/bvi-striving-for-healthier-happier-pupils/)

## **Jamaica**



Jamaica has made great strides in its response to the NCD epidemic, including a landmark National Health Fund which, since 2008, has been partially financed by a special consumption tax charged on tobacco products, thus fulfilling one of the mandates of the 2007 POS NCD Declaration.

The nine-member Jamaica Coalition on Tobacco Control has been highly active in the vanguard of progress on smoking, pushing hard for the implementation of the WHO's FCTC, to which Jamaica is a signatory. In

addition, the civil society group has lobbied for legislative change and was instrumental in the promulgation of Jamaica's tobacco control regulations, which became effective in July 2013.

These regulations called for 100% smoke-free public spaces and work places (both indoor and outdoor) and the labelling of tobacco products with graphic health warnings covering 75% of the packet. Following a review, the health warnings were reduced to 60% of the packet and further amended regulations were passed in June 2014.

In March 2015, as part of further efforts to implement the FCTC, the Government raised taxes on tobacco products by 14.2%, the first increase in five years. More comprehensive tobacco legislation is also being drafted.

For more information go to: <http://www.onecaribbeanhealth.org/civil-society-in-jamaica-spearheading-progress-in-tobacco-control/>

### ***St Kitts and Nevis***

This country has shown that adapting programmes to take local factors into account can be successful. There was an active decision by the Government not to form an NCD Commission. It was thought that there should not be several vertical bodies for different health issues in a small country with limited human resources: the same people would tend to be members of all the commissions.

Instead, an Alliance for Health Action, which comprises stakeholders from different sectors such as NGOs, Government and the business community, was set up. The Chairperson works with the Ministry of Youth and is a representative of a youth organisation.

It is reported that the Ministry of Health has been keen to make the Alliance central to national NCD-related discussions to promote a whole-of-society response, reinforcing the idea that the epidemic is not simply a matter for the health sector alone.

### ***Trinidad and Tobago***



Trinidad and Tobago has made a degree of progress in dealing with alcohol and tobacco consumption. Breathalysers have been used widely since 2009 and the National Alcohol and Drug Abuse Prevention Programme has helped establish many Alcoholics Anonymous support groups around the country. Following work by a very active multisectoral Partners' Forum (2011-13), legislation prohibiting smoking in public places has been passed recently.

There is also active civil society participation in the national challenge to NCDs. For example, Caribbean Wellness Day has spawned the *Get Moving* campaign that sees hundreds of people taking to the streets of the Port of Spain suburb of Diego Martin every Sunday to get fit. The roads are closed to traffic between the hours of six and nine in the morning and have been every week since 2008, as individuals and families arrive en masse to exercise: walking, running, cycling and roller blading, meeting their neighbours and having fun.

For more on the *Keep Moving* campaign go to <http://www.onecaribbeanhealth.org/keep-on-moving-in-port-of-spain/>



## Chapter 5: International<sup>1</sup> Institutions' support for the Declaration

### **Summary points**

- Of the 27 commitments made by CARICOM members at the 2007 Port of Spain Summit, eight identified specific international institutions (both within and outside the Caribbean), which were expected to provide assistance.
- Several other international organisations also have internal mandates to support CARICOM members in measures to prevent and control NCDs.
- Successful implementation of Summit commitments has been associated with clear statements on what was required and support from these international organisations, e.g.:
  - Caribbean Wellness Day supported by PAHO and CARICOM; and
  - Prevalence and risk factor surveys supported by the Caribbean Epidemiology Centre/CARPHA and the Centres for Disease Control and Prevention.
- The poor performance by CARICOM members on commitments related to the macro determinants of nutrition, described in Chapter 4, demonstrates the need for greater coordinated intervention from relevant CARICOM agencies.
- There is concern that support for action by CARICOM members on nutrition is weaker now that the Caribbean Food and Nutrition Institute has been subsumed into CARPHA.

### **Background**

The Port of Spain Declaration mandated eight separate international organisations, including several in the Caribbean, to assist CARICOM members in meeting commitments. In addition, other bodies that were not specifically named were expected to help because of their institutional goals and mandates (such as the Healthy Caribbean Coalition, a civil society alliance).

**Table 5.1 International institutions with identified/potential roles in meeting Declaration commitments**

<b>Institutions / organisations named in POS Declaration</b>	<b>Other highly relevant institutions</b>
CARICOM CARICOM/PAHO Joint Secretariat PAHO/WHO WHO Framework Convention on Tobacco Control PAHO bodies <ul style="list-style-type: none"> <li>- Caribbean Food and Nutrition Institute</li> <li>- The Caribbean Epidemiology Centre (CAREC)</li> </ul> CARICOM bodies <ul style="list-style-type: none"> <li>- Caribbean Regional Negotiating Machinery/Office of Trade Negotiations</li> <li>- Caribbean Agricultural Research and Development Institute</li> </ul> Regional universities	Healthy Caribbean Coalition NCD Alliance CARICOM bodies <ul style="list-style-type: none"> <li>- CARICOM Regional Organisation for Standards and Quality</li> <li>- The Council for Trade and Economic Development</li> </ul> Caribbean Development Bank Inter-American Development Bank Caribbean Association of Industry and Commerce Inter-American Institute for Cooperation on Agriculture United Nations bodies <ul style="list-style-type: none"> <li>- UN Educational, Cultural and Scientific Organization</li> </ul>

<sup>1</sup> 'International' here is used to refer to both global and Caribbean entities.

The media	<ul style="list-style-type: none"> <li>- World Health Assembly</li> <li>- Food and Agricultural Organization</li> <li>- UN Environment Programme</li> </ul>
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### ***Aims and methods***

1. To determine the extent to which international institutions assisted CARICOM members in meeting Summit commitments; and
2. To identify the strengths and limitations in the support provided by international institutions and opportunities for improvement.

Two main approaches were used to meet these aims. One was a review of relevant documents from the institutions listed in table 5.1, and the second, a series of in-depth interviews of key informants at the following institutions:

- Caribbean Public Health Agency
- Healthy Caribbean Coalition
- Caribbean Agricultural Research and Development Institute
- Caribbean Cooperation in Health (CCH) Secretariat
- Office of Trade Negotiations
- Caribbean Regional Organisation for Standards and Quality
- University of the West Indies.

### ***Findings***

#### ***Institutional support and success in implementation***

Table 5.2 ranks the 26 indicators by implementation in 2014. As described in the chapter on national policy responses, indicators that suggest specific actions (e.g. Caribbean Wellness Day, the Global School Health Survey) *and* that were also strongly supported by international institutions had higher levels of implementation.

Among the top performers in the table, 12 out of 15 had support from regional organisations, mostly PAHO. In addition, the majority had road-maps, models or blueprints such as WHO's Framework Convention on Tobacco Control; Caribbean Wellness Day supported by PAHO; and risk factor surveys with institutional assistance from regional or international bodies. Among the bottom 10, there are recurring themes of programmes involving communications, schools and nutrition. These areas lack clearly defined road-maps, models or blueprints and institutional support requires strengthening.

It is highly significant that there has been little progress on the three indicators directly related to improving the macro determinants of nutrition, given that the epidemics of obesity, diabetes and associated diseases in the Caribbean are significantly driven by poor diet. This is linked to relatively low levels of national food production, a reliance on food imports and the influences of economic and social globalisation, including the activities across CARICOM members of transnational food and beverage corporations.

Making real strides in improving diet is beyond the scope of individual members and requires regional cooperation, particularly between CARICOM bodies, such as OTN, CROSQ and COTED.

**Table 5.2 – Port of Spain Summit grid indicators, 2014, with associated regional organisational support**

Rank	Indicator	Regional organisations	2014 score
1	Multisectoral, multifocal celebrations for Caribbean Wellness Day	PAHO, CARICOM	85
2	Global School Health Survey	CDC	80
3	Ongoing mass physical activity or new public physical activity spaces		75
4	Minimum data set reporting	CARPHA	70
5	NCD plan	PAHO, CARICOM	65
6	Multisector food and nutrition plan implemented	PAHO/CFNI	60
7	FCTC ratified (N/A for five UK Overseas Territories)	WHO/PAHO/FCTC	93
8	NCD Summit convened		70
9	Smoke-free indoor public places	WHO/PAHO/FCTC	55
10	STEPS or equivalent survey	CARPHA	65
11	Quality-of-care cardiovascular disease or diabetes demonstration project	PAHO	50
12	NCD budget		40
13	Global Youth Tobacco Survey	CDC	80
14	Multisectoral NCD Commission appointed and functional	CARICOM	45
15	Tobacco taxes >50% sale price	WHO/PAHO/FCTC	40
16	Advertising, promotion and sponsorship bans on tobacco	WHO/PAHO/FCTC	30
17	Policy and standards promoting healthy <i>eating in schools</i> implemented		30
18	Mandatory physical activity in all grades in <i>schools</i>		45
19	Chronic care model/NCD treatment protocols in ≥ 50% public healthcare facilities	PAHO, CDC	30
20	NCD <i>communications</i> plan		25
21	≥30 days media <i>broadcasts</i> on NCD control/year (risk factors and treatment)		40
22	Mandatory provision for physical activity in new housing developments		15
23	Trade agreements used to meet national <i>food</i> security and health goals	Regional actions by CARICOM	5
24	Trans fat-free <i>food</i> supply	Regional actions by CARICOM	0
25	Mandatory labelling of packaged <i>foods</i> for nutrition content	Regional actions by CARICOM	0
26	≥50% of public and private institutions with physical activity and <i>healthy eating</i> programmes		0

**Table 5.3 – Summary of key findings related to individual institutions or institutional arrangements**

<b>Strengths</b>	<b>Limitations</b>	<b>Opportunities</b>
<b>CARICOM Secretariat</b>		
Informal relationships with governments in the region	Health Desk has only one officer. Lack of coordinated action across sectors to address NCDs	More strategic approach across bodies within CARICOM, particularly related to improving food security and nutrition
<b>CARICOM/PAHO Joint Secretariat</b>		
Great concept, with potential for coordinated, strategic action	Very limited activity to date	Establish a fully functional Secretariat, focus on addressing macro determinants of NCDs
<b>PAHO/WHO</b>		
Excellent technical resource that has supported CARICOM members in surveillance, policy development and implementation	Demands for data from PAHO/WHO add to those made by CARICOM and CARPHA	Rationalise data requests in order to reduce the reporting burden on individual countries
<b>WHO/FCTC</b>		
Clear policy guidance, enabling successful ‘policy transfer’	Despite ratification of the FCTC there remain areas that are poorly implemented, including banning advertising and sponsorship	Increase focus on implementing the FCTC.  The approach of providing detailed guidance and monitoring could be used for other risk factors
<b>CARICOM Bodies – e.g. COTED, OTN, CROSQ, COHSOD</b>		
Regional intergovernmental bodies covering areas relevant to the macro determinants of NCDs	A lack of multisectoral coordination between the different bodies  Regional standards that are voluntary (e.g. on cigarette packet labelling) may have very limited impact	Establish mechanisms for intersectoral coordination within CARICOM. Opportunities through commitments to Sustainable Development Goals
<b>Regional universities</b>		
Good technical resource, have made major contribution to defining disease burdens and risk factors	Research almost exclusively limited to countries with a main university campus, and has been largely descriptive	Support more CARICOM members in undertaking policy-relevant operational research, communicate findings to policy makers, greater emphasis on translation, so that research changes policy and practice
<b>Caribbean Public Health Agency</b>		
Brings a strategic coherence to addressing regional public health issues. Provides technical help on surveillance e.g. STEPS surveys	Some loss in human resource capacity to support nutrition programmes; some overlap with functions of PAHO	Future opportunities to better coordinate and define its complementarity with PAHO, and to strengthen its support for regional NCD programmes
<b>Healthy Caribbean Coalition</b>		

Regionally and internationally well-known and respected; large membership of national and regional civil society and private sector organisations	Limited human and financial resources	Increased advocacy across whole-of-society via dissemination of Port of Spain findings  Promote greater coordination of civil society responses <i>within</i> countries
<b>Caribbean Association of Industry and Commerce</b>		
Umbrella body for private sector in the region	Limited engagement with NCD process	Could play a much greater role, such as in promotion of workplace wellness programmes
<b>Caribbean Development Bank</b>		
The regional development bank, lending to 19 out of the 20 CARICOM members	While health is mentioned in its strategic plan, little specific attention is paid to projects around improving health or reducing the burden of NCDs	A greater focus on health in its programmes for funding – possibilities for explicitly linking health and economic development
<b>Inter-American Development Bank</b>		
A major development funder for Latin America and the Caribbean. It has funded health projects	Membership does not include the small Caribbean countries; and health is not mentioned in its key strategic goals	Possibility of relating health to its current strategic focus – including social inclusion and inequality, gender equality and environmental sustainability



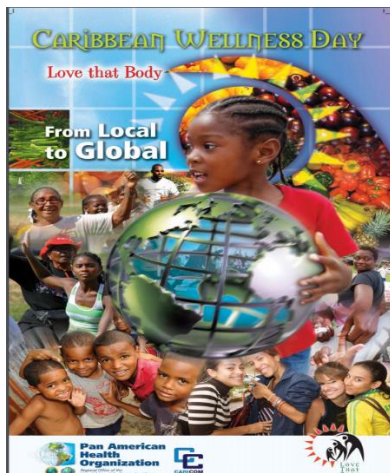
## 5b. Caribbean Wellness Day

Given that the establishment of Caribbean Wellness Day was one of the most innovative mandates emerging from the Port of Spain Declaration, it is worth analysing its successes and challenges.

### Summary points

- Caribbean Wellness Day has been observed in 19 out of 20 CARICOM countries, with more than half celebrating it every year.
- There has been successful involvement of the private sector and civil society, fostering an all-of-society response to NCDs.
- Caribbean Wellness Day focal points need access to an annually updated toolkit to guide their activities.
- A survey of CWD's impact on the general public is needed to help take the wellness message to previously unreached groups.
- A formal framework for monitoring and evaluating the efficacy of CWD is needed.
- There should be greater collaboration and improved networking between Member States on CWD, facilitated at regional level.

### Background



Caribbean Wellness Day was the only completely new mandate emerging from the 2007 Port of Spain NCD Summit Declaration and represents a 'public call to action'. It is intended to engage a range of actors (civil society, the private sector, government and the man and woman in the street) to foster a regional multisectoral response and encourage people to commit to a healthier lifestyle.

Both CARICOM and PAHO were given the responsibility of developing and advancing Caribbean Wellness Day: supporting events, branding, messaging, establishing a social media presence and disseminating materials. The first CWD was observed in September 2008. Haiti is the only CARICOM country to never have marked the day.

### Aims and methods

1. To document the development, deployment and uptake of CWD (2008-2014), a mixed method approach was used, including in-depth, semi-structured, qualitative interviews; quantitative content analysis and surveys (completed by NCD focal points from 15 CARICOM Member States, CWD coordinators, and representatives from nine civil society and five private sector organisations).

Such methods allowed the team to draw conclusions on the scope, successes and challenges of CWD.

Participants in the various activities also included seven principal regional informants from institutions like CARICOM, PAHO, CARPHA and the University of the West Indies. Areas examined

were: structure, funding, intersectoral partnerships, promotion, branding, spread and uptake, evaluation and reporting.

2. To document media penetration, a search for CWD content on the internet (2006-2014) was conducted using Google, online newspaper articles and social media content from the respective countries.

## ***Findings***

### ***Development, deployment and uptake: (from qualitative interviews, quantitative content analysis and surveys)***

- NCD focal points have been pivotal in the implementation of Caribbean Wellness Day, collaborating with regional and national organisations/participants.
- Regionally produced CWD materials, such as the slogan, logo, posters, stickers and fact sheets were well-received in Member States and most commonly used by government officials.
- Civil society and private sector participants often adapted these materials for local use.
- CWD activities typically included: health fairs, exhibitions, healthy eating demonstrations, sponsored walks, mass public exercise sessions and health screening.
- Events were often concentrated in and around city centres but efforts were made to venture into other settings, like workplaces, schools and churches/mosques etc.

## ***Participation***

- CWD has been a catalyst for significant multisectoral engagement in the NCD response and a number of civil society organisations and private sector actors said that it has led to the deepening of their involvement.
- These sectors have played a key role in proposing events, mobilising people and bringing critical human resources. Their main activities on CWD are still generally health promotion and providing health screening services.
- Most participants from the private sector and civil society saw it as a national rather than regional initiative and countries tended to work in relative isolation from each other, with little collaboration between Member States.
- Peak participation occurred in 2010 and 2011, with significant contraction in 2012. Participation levels have bounced back but have not reached previous highs.
- Attendance of CWD events varied from approximately 200 participants to over 3000.
- Several countries have extended events beyond a single day. The Bahamas, Belize and Guyana celebrate Caribbean Wellness Week, and others, like Trinidad and Tobago, host related events throughout the whole month of September and beyond.

## ***Media penetration***

### ***Internet***

- 249 individual items or hits were noted for the internet search of “Caribbean Wellness Day” (2006 – 2014).
- There was a 10-fold increase in CWD website content from 2007 to 2014.
- Much of the content (109 of the 249 items) was generated by PAHO, CARICOM, CARPHA, and the Healthy Caribbean Coalition websites, suggesting that the level of penetration of CWD content was relatively superficial and not widespread.
- Facebook (used as a proxy for assessing penetration at community level) accounted for only 1% of all CWD internet content. The same content was being posted and shared several times on only a few pages. It seems this content was being consumed by the same audience over and over again and not reaching a wide cross section of the community.

### ***Print***

- There were 169 newspaper articles on CWD identified for this analysis. They mainly touched on activities hosted, the Port of Spain Declaration and NCD risk factors.
- There was limited discussion of CWD as a catalyst for behaviour change or multisectoral action.

### ***Challenges***

- Lack of funding for Caribbean Wellness Day was highlighted as a major obstacle by organisers.
- Very few substantive and ongoing evaluations have been completed. The current monitoring and evaluation (M&E) process relies mainly on narratives recording the day’s activities.
- M&E of Caribbean Wellness Day thus far has not included investigation of the general public’s level of engagement, knowledge, attitudes or behaviour in relation to the wellness message.
- The championing of CWD often falls to a few key Ministry of Health staff and if those staff move on, or are absent, celebrations may be cancelled altogether.

### ***Lessons learned***

- CWD has been successful in encouraging greater multisectoral links in the NCD response. In one case the CWD committee became the nucleus of the National NCD Commission.
- It has raised awareness of NCDs in the general community on the day itself. (But it is unclear how deep this engagement really is).
- Regional organisations have played a seminal role in creating an environment which fosters collaboration and networking between countries. More should be done.

### ***Conclusions and potential actions***

- Although CWD has the advantage of high-level political support, there is a need for greater financial backing.
- CWD focal points should have access to an annually updated tool kit to guide their activities.
- A survey of CWD's impact on the general public is required to help deliver the wellness message to groups not previously reached.
- The scope of CWD celebrations should be widened to make them more inclusive both geographically and demographically.
- A formal framework for monitoring and evaluation of CWD is required.
- There should be improved networking between Member States, facilitated at regional level to help ensure CWD fulfills its potential as a strategic component of an effective NCD response.

## Chapter 6: International impact of the 2007 Port of Spain NCD Declaration



### ***Summary points***

- The 2007 Heads of Government Port of Spain Summit had significant influence on shaping global governance of non-communicable diseases and paved the way for the 2011 United Nations High-Level Meeting (UNHLM) on NCDs.
- Elements of the diplomatic process by which the Summit led to the UNHLM included:
  - The long-term regional-to-global ambition of those promoting the Summit and supportive Caribbean leaders;
  - Financial support from outside the region; and
  - Skilled diplomacy towards the UN, including WHO.
- 16 of the 27 commitments made at the Port of Spain Summit were later reflected in at least one UNHLM commitment.
- Summit commitment implementation has met resistance in the shape of sectors such as the tobacco and alcohol industries lobbying to protect their interests and the dominance of trade concerns over concerns about health.



## **Background**

*The journey from the Port of Spain Summit to the United Nations High-Level Meeting on NCDs*

## **Milestones**

The road to the 2007 Summit and then to the UNHLM was a long one. Sir George Alleyne, Chancellor of the University of the West Indies and Director Emeritus of PAHO, played a significant role in promoting the multisectoral approach to preventing and controlling NCDs, and ensuring their current place on the global agenda.

- 2001: The CARICOM Nassau Summit issues the famous Declaration, “The health of the region is the wealth of the region” and calls for the establishment of a task force “to propel health to the centre of the development agenda”.
- 2005: The task force, the Caribbean Commission on Health and Development (CCHD), chaired by Sir George, and made up of distinguished public health professionals and economists, with representatives from major key regional organisations, delivers its report.
- Its central message, presented to CARICOM cabinets and then widely disseminated, is that NCDs and obesity represent one of the three major health problems in the Caribbean. Lobbying for a regional NCD meeting begins in earnest.
- 2007: The CARICOM Heads of Government Port of Spain Summit is held, a global first.
- April 2009: Summit of the Americas in Port-of-Spain, including 14 CARICOM members, reaffirmed the WHO/PAHO and CARICOM policies and plans for NCD prevention and control.
- July 2009: 30th Conference of CARICOM Heads of Government in Guyana agreed to advocate for a UN General Assembly Special Session on NCDs.
- November 2009: The Commonwealth Heads of Government Meeting in Port of Spain, attended by 12 CARICOM leaders, issues a special declaration on NCDs, and calls for a UN General Assembly NCD Summit.
- February 2010: UN briefing on NCDs is followed by Caribbean diplomats systematically lobbying their colleagues.
- May 2010: UN General Assembly agrees to an HLM on NCDs in September 2011.
- September 2011: UN High-level Meeting, the foundation for the international community’s whole-of-global-governance approach to NCD prevention and control is held.
- 2014: the UNHLM Review takes place.
- 2015: UN Sustainable Development Goals are ratified and include an NCD component as part of the 2030 Agenda for Sustainable Development.

## **Findings**

### ***A closer look at the NCD Summit: ‘Uniting to Stop the Epidemic of chronic non-communicable diseases’***

The Port of Spain Summit, convened at the Crown Plaza Hotel on September 15, 2007, was hosted by Trinidad & Tobago, and chaired by Barbados Prime Minister and CARICOM Chair Owen Arthur. Heads of state or senior officials from all the CARICOM countries attended.

The Summit focused on prevention. Commitments were made to improve physical activity, nutrition and healthy diets, scale up preventative treatment and education and to curtail smoking. The leaders added a final mandate declaring the second Saturday in September as Caribbean Wellness Day.

However, there were no specific commitments to reduce the harmful effects of alcohol abuse. Instead, the one commitment related to alcohol referred to using tax revenues from drink sales to fund NCD prevention and control programmes and the work of national NCD Commissions.

### ***From the CARICOM Summit to the global UNHLM on NCDs***

After the Summit, it was clear to the CARICOM leaders that their regional approach should be replicated on the global stage. Considerable lobbying was needed to capture the attention of the UN Secretary-General and have him support a meeting on NCDs at the level of Heads of State and Government.

There were three parallel streams:

- The political process initiated by the Heads of Government at CARICOM to bring WHO on board;
- The technical process where the understanding of NCDs and their importance was impressed upon significant players; and
- The shaping of a strategic plan.

This history indicates the importance of NCD champions with a long-term, regional-to-global ambition, supportive national leaders, a vibrant civil society and a strong evidence and educational base to persuade those leaders to act.

### ***Impact***

But exactly how much did the Port of Spain Summit and Declaration influence regional and international institutions, especially the United Nations High-Level Meeting on Non-communicable Diseases in 2011? This question has been examined using a framework developed and applied by the University of Toronto's G8 Research Group for assessing the performance of international institutions. Impact is explored across three broad categories:

- Regional intergovernmental institutions in the Caribbean;
- Global intergovernmental institutions, notably the UN at its HLM in 2011 and 2014 Review;
- Regional and international civil society and private sector organisations and actors.

### ***Global institutions: the impact of the Summit on the agenda-setting and policies of the UNHLM***

- The political declaration of the UNHLM contained just one paragraph in the preamble that noted the UN's appreciation of various regional initiatives undertaken to prevent and control NCDs. The first initiative listed referred to the Port of Spain Declaration: 'Uniting to stop the epidemic of chronic non-communicable diseases.' Therefore, although the mention was limited, it was prominently placed.

### ***Commitments of UNHLM 2011***

- A little over half of the UNHLM commitments matched at least one of the 27 Port of Spain Declaration commitments: 116 (56%) out of 205. A significant 44% did not. Reciprocally, 16 (59%) of the POS Summit commitments were reflected in the UNHLM 2011 at least once.
- In terms of the frequency and strength of the UNHLM match to each Port of Spain commitment, four had a high-frequency match: strengthening the regional response to NCDs; screening and managing NCD risk factors; increasing physical activity; and research and surveillance for risk factors. There were four commitments with a medium-frequency match, seven with a low-frequency match, and 11 with no match at all.
- The first UNHLM 2011 commitment assessed for compliance concerned accelerating implementation of the FCTC, including measures to reduce consumption and availability of tobacco. It matched similar Port of Spain commitments.

### ***Multisectoral interventions and civil society and relevant sectors***

- Another UN commitment measured for compliance involved implementing multisectoral interventions to reduce the impact of the common NCD risk factors through education and the involvement of relevant sectors, civil society and communities. Compliance for CARICOM members with UNHLM 2011-43 received a first-year score of 61%.

### ***The Caribbean contribution to global NCD monitoring and programming***

It should be noted that the region has played a key role in supporting innovation in the global challenge to NCDs in a number of ways. The table below highlights several instances.

**Table 6.1 – Examples of innovative CARICOM responses to NCDs with a global impact**

NCD minimum data set	<ul style="list-style-type: none"><li>• Developed in the Caribbean in 2003</li><li>• Piloted in 2006</li><li>• PAHO and WHO now involved</li></ul>
Caribbean Wellness Day/ Week	<ul style="list-style-type: none"><li>• First celebrated in 2008, as mandated by the Port of Spain Summit</li><li>• Now the World Economic Forum and PAHO have embarked on promotion of 'Wellness Week' inspired by the success of Caribbean Wellness Day</li></ul>
NCD Commissions or analogous bodies	<ul style="list-style-type: none"><li>• In 2005 (two years before the Declaration), Bermuda was the first country to have such a Commission. Barbados followed in 2007</li><li>• Mandated by the Summit in 2007, now 12 of 20 CARICOM countries have had NCD Commissions or similar bodies. In 2014 WHO recommended the formation of National Commissions to the global community.</li></ul>

### ***Conclusions and potential actions***

- Regular sessions on NCDs should be held at CARICOM conferences of Heads of Government, perhaps every three years and aligned with UN reporting, such as WHO'S 2025 global NCD targets and the 2030 Sustainable Development Goals.
- Interministerial council meetings, possibly convened every two years, should review and improve implementation of the various regional and international summits' commitments.
- As NCDs constitute only one of the 169 targets in the SDGs, with no specific links to any others, new actions from and for the Caribbean are now needed.

- Such actions could include a streamlined monitoring mechanism that efficiently meets the needs of all key actors, and additional processes for the continuous comprehensive assessments of compliance with NCD-related commitments. These assessments should involve an exploration of fiscal, economic and whole-of-society co-benefits.
- The revenue raised through increases in tobacco and alcohol taxation (Chapter 8) would enable these recommendations (and others) to be implemented.

## Chapter 7: Surveillance and monitoring

### ***Summary points***

- There are too many overlapping demands for reporting being made from several agencies. Collaboration is needed to reduce the demands on individual countries while still meeting agencies' requirements.
- Some key surveillance activities need better support and capacity building to ensure that the countries make full use of the data collected. This applies in particular to STEPS NCD surveys, where many have been done but few analysed beyond providing limited summary data.
- Regional organisations should continue to enhance training and capacity building in reporting NCD indicators.
- There needs to be greater collaboration between regional and international organisations on monitoring, (For example, working with the UN Children's Fund on nutrition surveillance and the UN Environment Programme on climate change).
- National data audits and sharing of data across sectors for UN NCD global monitoring requirements and Sustainable Development Goals should be authorised.
- A strategic alignment can be pursued with Pacific Islands and Small Island Developing States (SIDS) to include environmental indicators in the NCD indicators.

### ***Background***

The overarching goal of surveillance is to analyse NCD risk factors, morbidity and mortality. This section of the report aims to critically review and document non-communicable disease reporting required from Member States in order to:

1. Identify gaps in current data on NCD mortality, morbidity and risk factors, and thus indicate areas for further data collection, collation and analysis;
2. Rationalise NCD reporting to meet the needs of all stakeholders; and
3. Define the data requirements, including definitions for all indicators, to more fully evaluate the POS Declaration in future and update of the annually completed Port of Spain questionnaire-grid which provides a 'snap shot' of government responses to NCDs.

### ***Findings***

- There are a raft of reporting requirements for countries to meet, such as:
  - PAHO/WHO mechanisms, like the NCD Global Monitoring Framework emerging from the 2011 UN High-Level Meeting on NCDs;
  - The Sustainable Development Goals;
  - The Caribbean Public Health Agency; and
  - The Port of Spain NCD Declaration grid.
- It is clearly a challenge to respond to these monitoring and surveillance demands, especially in the smallest countries. Certain reports require data that are not available or would have to be sourced from non-health agencies.

- Some countries have difficulty in accessing detailed census data, making it impossible to accurately report population rates and calculate age-sex-ethnic-specific rates needed to monitor inequalities.
- Data are not always shared between national and regional organisations.
- Despite these limitations, the Caribbean has made significant contributions to the Global NCD agenda, including in the areas of surveillance, monitoring and evaluation and the development of a minimum data set collected and reported on at national level. (See Table 6.1).

**Table 7.1: NCD reporting requests to countries**

Frequency of Reporting	Reports	Surveys with sampling frame
<b>Annually</b>	1. POS grid (UWI) – August 2. Mortality data (CARPHA to PAHO) 3. CCH 4 (Caribbean Cooperation in Health)	
<b>2 yearly</b>	4. WHO Global Report on the Tobacco Epidemic 5. WHO FCTC Parties Progress Report 6. WHO Global Information System on Alcohol and Health 7. WHO Mental Health Atlas 8. PAHO report on Plan of Action for the Prevention of Obesity in Children and Adolescents	
<b>3 yearly</b>	9. WHO country capacity survey 10. PAHO risk factor regulatory capacity monitoring tool 11. WHO Global Status Report on Road Safety 12. PAHO/WHO Global Monitoring Framework	13. Nutrition Survey 14. PAHO NCD country survey 15. PAHO Services & Coverage
<b>5 yearly</b>	16. WHO Global Information System on Resources for the Prevention and Treatment of Substance Use Disorders 17. PAHO coverage of micronutrient supplementation programmes	18. STEPS NCD risk survey or equivalent 19. GYTS (Global Youth Tobacco Survey) 20. GSHS (Global School Health Survey), 21. GATS (Global Adult Tobacco Survey) 22. Nutritional indicators

***Smoothing the process: rationalising and strengthening future surveillance and reporting***

The burden of reporting has been recognised and various steps have been taken to ease the process for countries in the region.



### ***Revision of the Port of Spain monitoring grid***

- Since 2008, NCD focal points in the Ministry of Health have completed the monitoring grid each year. Since 2009 it has been a checkbox report.
- The mechanism has been improved by more clearly defining the indicators being monitored.
- The grid uses questions from other surveys, reducing duplication.

### ***PAHO/WHO streamlining efforts***

There is a substantive reference manual from PAHO/WHO, *Compendium of Indicators for Monitoring Regional and Global Non-communicable Disease Response in the Americas*. The specific objectives of the Compendium are to:

- Support the process of revising national indicators to meet regional and global NCD reporting requirements aligned with PAHO/WHO plans;
- Provide standardised terminology across indicators and NCD control programmes;
- Encourage consistent use of indicators to monitor and evaluate programmes; and
- Provide guidance for the development of comprehensive NCD and risk factor surveillance and evaluation plans, including selection of indicators to measure progress in specific areas.

### ***Data from non-health sources***

- Much of the data for NCD reporting depends on data from other sectors.
- Other UN and international agencies may be collecting data relevant to surveillance of the multifactorial determinants of NCDs, e.g. the Economic Commission on Latin America and the Caribbean, the United Nations Children's Fund and others.
- There is need to explore sharing data with these organisations.

### ***Conclusions and potential actions***

#### ***For Heads of Government:***

- National data audits and sharing of data across sectors for United Nations global monitoring requirements and the Sustainable Development Goals should be authorised.
- Joint programmes with Ministries of Education to monitor and address key NCD risk factors such as childhood obesity should be authorised and funded.

#### ***For regional bodies:***

- CARPHA and PAHO should continue to enhance training and capacity building in reporting on NCD indicators.
- The University of the West Indies and the Chronic Disease Research Centre should enter into agreements with countries to procure and use STEPS data for disparities analysis within and between states.
- They should also play a strong role in building the capacity of country epidemiologists.
- The Port of Spain Declaration mandates a regional NCD plan. The current plan, 2011 – 2015, needs updating for 2016 – 2025. This should be aligned with the current PAHO plan but adapted to reflect CARICOM specificities and indicators.
- The NCD response of regional bodies should be monitored. This includes reporting:

- Number and amount of dedicated staff and budget; and
  - The amount set aside for NCD projects.
- References to health/NCDs/the Port of Spain Declaration etc. in regular Heads of Government Summit outcome documents should be monitored.
- Outcome documents from all the CARICOM ministerial bodies should be analysed for mention of health, NCDs, alcohol and tobacco sales, consumption and taxes, the environment, nutrition and international trade.
- There should be greater alignment with other SIDS who are also vulnerable to natural disasters and climate change which both have a bearing on food security and nutrition: environmental indicators can be included in NCD indicators.

***Countries should:***

- Try to ensure that data collection is standardised to facilitate WHO global NCD monitoring. This can apply to collecting data from 18 year olds for global WHO STEPS surveillance, which will align with a significant number of STEPS indicators.
- Cut down on time and effort by combining material collection exercises. For example, conduct Global Youth Tobacco Surveys and the Global School Health Surveys at the same time in the same venues.
- Review and validate the baseline estimates WHO holds for their country's 25 NCD Global Monitoring Framework indicators.
- Establish nine country-specific voluntary NCD Global Monitoring Framework targets and interim targets (e.g. for 2018, 2021) to achieve outcomes for 2025.

## Chapter 8: Financing NCD prevention and control in CARICOM: potential role of tobacco and alcohol taxes



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### ***Summary points***

- There is significant potential for revenue generation from increased taxes on tobacco and alcohol. Depending on the tax rate assumed, the revenue generated would be in excess of \$US37 million in the three study countries of Grenada, Jamaica and Trinidad & Tobago.
- With increased taxes, consumption will fall since the price elasticity assumptions used are all negative (smuggling is assumed to be triggered once the tax-induced fall in consumption is more than 10%).
- Both excise revenues and total revenues will increase with raised taxation on tobacco and alcohol.
- Other forms of taxation, not modelled in this study, such as taxes on sugar-sweetened beverages should also be considered.
- The evidence suggests that targeted taxation can lead to reduced consumption of unhealthy products *and* significantly contribute to the cost of interventions to respond to NCDs.

## ***Background***

Several of the 27 commitments of the 2007 Port of Spain Declaration on NCDs concern the need to take action on alcohol and tobacco. The Declaration refers to the introduction of fiscal measures to reduce the accessibility of tobacco. It also recommends that the public revenue derived from tobacco and alcohol should be used for, among other things, preventing chronic NCDs, promoting health and supporting the work of National NCD Commissions.

HEU, Centre for Health Economics, investigated the potential for raising additional tobacco and alcohol tax revenues, which could be used to fund NCD prevention and control efforts.

The study used a tax simulation model and drew from the experiences of Grenada, Jamaica and Trinidad & Tobago in their collection and utilisation of revenues from pre-existing tobacco and alcohol taxes.

It sought to answer the following questions:

- What is the potential for revenue generation from the imposition of specific taxes on tobacco and alcohol products in CARICOM Member States?
- Will such taxes have an impact on consumption?
- Will the taxes raise revenue, as well as control the use of these products?
- How will total revenue levels change with the introduction of specific tobacco and alcohol taxes?
- What will be the tax level required to raise revenue while avoiding smuggling?

## ***Aims and methods***

1. In the three countries information was gathered on:
  - The nature of the industries;
  - The current situation with respect to tobacco and alcohol tax structures/rates; and
  - The degree to which tobacco and alcohol tax revenues are collected.
2. The WHO Tobacco Tax Simulation Model (TaXSiM) was used to analyse and assess tobacco and alcohol taxation policy, the potential to raise revenues from taxing them and the degree to which consumption is affected by an applied tax.

## ***Data collection***

The data were extracted from a variety of sources in the public and private sectors. These include: Ministries of Finance; central statistical offices; customs and excise departments; local producers/manufacturers; distributors; supermarkets and the International Wine and Spirits Report.

## Findings

The overall results indicate that governments can increase tax revenue while decreasing consumption of cigarettes and alcohol.

The table below refers to Grenada, Jamaica and Trinidad and Tobago. It shows that a tax hike which induces a 5% fall in consumption is expected to create US\$20.20 million in additional revenues, while a tax-induced 10% fall in consumption will produce an increase in revenues of US\$37.34 million.

### 8.1 – Excise revenues resulting from a tax-induced fall in consumption of 5% and 10%

Country, Consumption Change	Cigarettes \$Mn	Beer \$Mn	Rum \$Mn	TOTAL in Local Currency \$Mn	TOTAL in US Dollars <sup>2</sup> \$Mn
Grenada, 5 %	0.40	2.18	0.69	EC\$3.27	1.21
Grenada, 10%	0.73	4.20	1.36	EC\$6.29	2.33
Jamaica, 5%	693.00	382.00	218.30	J\$1,293.30	10.75
Jamaica, 10%	1,278.00	709.45	395.19	J\$2,382.64	19.81
Trinidad and Tobago, 5%	40.00	2.99	9.74	TT\$52.73	8.24
Trinidad and Tobago, 10%	73.90	5.51	17.60	TT\$97.01	15.20
<b>TOTAL, 5%</b>					<b>20.20</b>
<b>TOTAL, 10%</b>					<b>37.34</b>

The study reports that the cost of WHO core ‘best buys’ (effective interventions in response to NCDs) in upper middle-income countries is US\$3.00 per year per capita. These ‘best buys’ include counselling and drug therapy for those at high risk of cardiovascular disease, reduced salt intake, and bans on tobacco and alcohol advertising. For Grenada, Jamaica and Trinidad and Tobago, with a combined population of 4.2 million, the target would be US\$12.6 million.

Estimates of the additional revenue from tax increases that will result in a fall in consumption of 5% and 10% would easily cover the cost of this core set of ‘best buys’.

In each country, the study uses a range of specific examples to assess reduction in consumption. For instance, in Grenada to achieve a 5% fall in consumption of cigarettes, excise taxes should be increased to 117% of the CIF value. The analysis also shows that total government revenues will grow by 8.7% and excise tax revenues will be expected to increase by 11.12%. Cigarette revenues are maximised at an excise tax rate of 228% of the current CIF. Baseline (2014) excise tax rates are presented in the table below.

With beer in Jamaica, a 5% reduction in sales will require a 54% increase in the average excise tax per case of beer with the average price per case increasing by 10%. The revenue maximising tax per case was

<sup>2</sup>The applied exchange rate for the Eastern Caribbean Dollar (EC\$) is 2.70 for US\$1. For the Trinidad and Tobago dollar (TT\$), the applied rate is \$6.40 while for the Jamaican dollar (J\$) it is \$120.31. (December 29, 2015)

found to be J\$2,065.00. With a baseline rate for beer of J\$409.00, there is substantial room for increased taxation on this product.

For rum in Trinidad and Tobago, to induce a 5% reduction in sales the excise tax must be raised by 12%. Total tax revenues, as well as excise tax revenues, will increase. The rise in total tax revenues will be 5% and the increase in excise tax revenues 6%.

Total taxes are maximised when average excise tax per 9 litre case of rum is TT\$560.00, 64% above its baseline level of TT\$341.00.

## 8.2 – Baseline (2014) Excise Tax Level for Cigarettes and Alcohol

<i>Country, Product</i>		<i>Baseline, Average excise tax per unit (2014)</i>
Grenada	Beer	EC\$1.39 per 6.6 litre case
	Rum	EC\$25.38 per 9 litre case
	Cigarettes	100% of CIF
Jamaica	Beer	J\$409.05 per 6.6 litre case
	Rum	J\$5,006.40 per 9 litre case
	Cigarettes	J\$210 per pack (20s)
Trinidad and Tobago	Beer	TT\$28.05 per 6.6 litre case
	Rum	TT\$341 per 9 litre case
	Cigarettes	TT\$ 3.80 per pack (20s)

For the three countries, smuggling would be triggered when consumption is expected to fall by 10% or more, which would not be the case with the increases proposed.

### ***Potential for other forms of taxation***

Taxes on tobacco and alcohol have been the main targets for increased taxation to reduce consumption with some countries using the money raised to directly fund NCD programmes. However, there are other products that contribute to the rise of these diseases that can also be taxed effectively.

Studies show that taxes on sugar-sweetened beverages may decrease consumption and potentially reduce diabetes and obesity. Mexico became the first Latin American country to introduce a soda tax of one peso (six cents) per litre in January 2014. The tax is estimated to have decreased consumption by an average of 6% over the first year: it started off with a small effect but by 12 months after implementation consumption was down by 12% compared to the previous year. Even greater falls in consumption were found in people of lower socio-economic status. The country also applied a 10% price increase to high-calorie snacks.



In 2015 the Government of Barbados introduced a 10% excise tax levy on sugar-sweetened beverages such as carbonated soft drinks, juice drinks and sports drinks. It hopes that the policy will generate over BD\$10 million in revenue. Barbados is the first Caribbean country to implement this kind of policy. An evaluation of the impact and acceptability of the tax is being led on behalf of the Government by UWI, and is partially funded by IDRC as part of this project.

The Government of Dominica, in November 2015, also announced a 10% tax increase on sweets, chocolates and sweetened beverages.

### ***Challenges***

It has been clearly shown that increases in taxes on tobacco and alcohol can generate additional revenues for governments and can lead to a decrease in consumption. However, although it may appear obvious that politicians and policy-makers should pursue this strategy, certain conditions must be met.

#### ***Is it politically feasible?***

Although the evidence points to the efficacy of further increasing taxes on alcohol and tobacco to reduce NCDs, does the political will to do this exist in any given country? Are there worries that the general public might react badly to paying more for their rum, beer and cigarettes? Is it simply too risky to potentially rock the boat if funding for the challenge to NCDs can be quietly found elsewhere?

Governments in the region have had different approaches to taxation of cigarettes as opposed to alcohol. All countries except Haiti have ratified the Framework Convention on Tobacco Control, many have smoke-free public spaces, and have already increased taxation on tobacco to reduce consumption.

However, compliance with the FCTC is sketchy: the Framework recommends that tobacco taxes are 75% of sales price and CARICOM countries are falling short of this.

With alcohol, there is great reluctance to tax a product that is an integral part of the economy of many countries. It is how their primary product of sugar cane is used, now that the European Union has sharply reduced its import of sugar from the region.

#### ***Culture as a barrier?***

In terms of cultural influences, the use of alcohol may be seen to be less harmful to health than tobacco. Rather, the prominence of alcohol at many social and cultural events in the Caribbean is widely accepted. In addition, the brewing of the locally stillled 'bush rum' or 'babash' is often not penalised, although it is illegal, as well as likely to contribute to the prevalence of NCDs. This was reported to be an issue by key informants in one of the three case study countries.

#### ***What about the tobacco and alcohol lobby?***

A major barrier to moving forward with a tax strategy lies with the strength and influence of key stakeholders and lobby groups in the tobacco and alcohol industries. They often have 'loud voices' and 'deep pockets', which they are ready to use in an attempt to put a stop to, or minimise, taxes on their products, which will reduce consumption and reduce their profits.

## ***Conclusions and potential action points***

### ***Advocacy and sensitisation***

- It is imperative that advocacy, sensitisation and awareness-raising are used to get the idea of increasing taxes on alcohol and tobacco to help tackle NCDs firmly on the political and public agenda.
- Presenting the evidence in a format that is easily understood, palatable and promotes clear objectives can influence 'buy in' and acceptance of the proposed measures.
- The use of the appropriate dissemination methods is an integral part of the packaging this message. Media outlets can help to reach a wide audience. Consultation sessions to discuss initial findings and to share tax proposals will also encourage approval of the intended actions.

### ***Using hypothecated (earmarked) taxes to fund a multisectoral response***

- If revenue raised from an increase in taxes on alcohol and tobacco is to really make a difference in the response to NCDs, it will be necessary to use it across multiple sectors, not just in the sphere of health. For example, the promotion of healthy diets and exercise as part of an overall wellness initiative requires cooperation between Ministries of Health, Education, Industry, Sport and Agriculture.
- It is also strongly recommended that a comprehensive costing for treating NCDs and related prevention and education programmes be undertaken, so that governments have a better understanding of the context within which decisions on taxing and funding can be made.
- Jamaica has had experience with these earmarked taxes in its National Health Fund, and certainly the rest of the region could benefit from this.

### ***Evaluation of impact***

- Once a taxation strategy has been implemented, its impact should be monitored and evaluated. Does an intended reduction in consumption of tobacco and alcohol actually occur?
- Literature in the field suggests a long-run decrease in consumption with the imposition of taxes. However, this does not rule out the evaluating of short-run outcomes, making adjustments as and when necessary. Moreover, if tax receipts are earmarked for specific programmes, transparency and accountability must be integral to the process. In this way, the payers of the tax may be more willing to embrace the price increases imposed.

## Chapter 9: Accelerating implementation



Shari John

The evidence briefs explored above provide a fairly comprehensive snap shot of the state of play concerning the NCD response in the Caribbean; where there have been notable successes and where we need, collectively, to do better.

This chapter sets out the next stage of the journey towards tackling the epidemic of NCDs in a more focused and effective way in which gaps and challenges are not just noted, but actively addressed. At the implementation workshop, February 24<sup>th</sup> and 25<sup>th</sup> 2016, in Port of Spain, a vivid and varied group comprising Ministers, journalists and experts in health, economics, agriculture, social security and the built environment among others, thrashed out the key elements of a plan for action to build momentum and serve as a rallying point to re-energise the NCD response.

As a truly multisectoral gathering, the workshop drew on a wide range of experience and expertise to develop a multifaceted and rounded draft plan that embraced the need for all-of-society and all-of-government to turn its attention to NCDs.

The evidence briefs were used as a solid stepping stone to examine areas of critical concern and the participants were split into work groups to address specific issues, help to validate and interpret the research findings and to build on them.

It is worth recapping some of the major conclusions and observations contained in previous chapters of this report. In discussing key interventions that would accelerate action, the gathering focused on several

overarching themes that define the nature and challenges of an effective NCD response. These included recognising that:

- NCDs are still given relatively low political priority, both within countries and regionally and this has acted as a barrier to policy development and implementation:
  - It is critically important to get the NCD message on the radar of the Heads of Government, Ministers (including of Foreign Affairs), Permanent Secretaries and relevant technical officers with a clear communications plan;
  - Within countries a 'champion' is required at the highest (cabinet) level of government to further the NCD agenda;
  - The response to NCDs needs to be a substantive, regular agenda item at Heads of Government conferences.
- Within countries two distinct mechanisms are required to promote an all-of-society response:
  - NCDs Commissions or their equivalent to coordinate all-of-society, government, civil society and private sector actions; and
  - An all-of-government mechanism (e.g. Interministerial Task Force or committee) for coordinating the activities of the different ministries of government.
- Similar mechanisms are required at a regional level:
  - The joint NCD Secretariat, led by CARICOM/PAHO to provide leadership in driving regional actions in support of NCD prevention and control; and
  - The role of the Prime Minister responsible for health in the CARICOM quasi 'cabinet' should be strengthened.
- Specific funding is required to support the national and regional NCD response.
- Port of Spain 2007 Declaration commitments are most likely to be met when clear guidance on action exists and where regional organisations assist with implementation (e.g. the Framework Convention on Tobacco Control).
- Smaller countries, in particular, lack capacity to develop and implement policy. Further development of detailed 'model' policies and assistance in adaptation and implementation is required.
- Although the majority (13) of Member States have conducted at least one NCD risk factor survey, much greater investment is needed in surveillance if trends in risk factors are to be monitored, vulnerable groups identified and the potential impact of policy interventions assessed.



Shari John

*Opening Ceremony, Implementation Workshop*

*From left: Mrs Jessie Schutt-Aine, PAHO/WHO Caribbean Subregional Programme Coordinator, Dr Rudy Cummings, CARICOM Health Desk, Hon Terrence Deyalsingh, Minister of Health, Trinidad and Tobago, Dr Zee Leung, IDRC Representative, Dr T. Alafia Samuels, Principal Investigator, POS Declaration evaluation*

The work groups discussed specific areas where gaps and challenges existed and needed to be addressed. Their conclusions formed the basis of the draft plan for action which emerged from the meeting.

Seven critical issues were identified.

- i. Diet, food and food security: relevant policy on agriculture and trade;
- ii. Reducing alcohol-related harm;
- iii. Tobacco control;
- iv. Promoting health in different settings: workplaces (including the health sector), schools, faith-based institutions etc;
- v. Investing in NCD prevention and control;
- vi. Media and social communications, health promotion and advocacy; and
- vii. Physical activity and the built environment.



Relatively detailed work plans were developed for each issue and log frames produced containing the following information:

- Desired outcomes;
- Actions, including specific policy measures to achieve the outcomes:
  - Legislation, regulation, taxation
  - Advocacy and communications
  - Toolkit, e.g. blueprints, models;
- Partners to implement the actions; and
- Monitoring indicators.

Participants were also asked to:

- Confirm the technical, financial and political content of their recommendations;
- Identify the necessary priorities to be included in the action plan; and
- Identify key 'best buys', i.e. five or so things to be addressed by Heads of Government and Ministers of Health.



Shari John



## ***Delving into the work plans***

### **Diet, food and food security: relevant policy on agriculture and trade**

#### ***Issues***

- More than 85% of adults in CARICOM Member States do not meet recommended levels of fruit and vegetable intake.
- This is heavily influenced by a reliance on food imports, terms of trade that limit Member States' abilities to promote local agriculture, and marketing by transnational food corporations.
- There are limited examples of collaboration between Ministries of Agriculture and Health to improve local food supply. One example of positive collaboration is in Antigua and Barbuda.
- There is virtually no evidence of progress on the Port of Spain commitments related to the macro (upstream) determinants of nutrition (e.g. trade arrangements, banning trans fats, food labelling), while childhood and adult obesity rates continue to rise.
- Food taxes and subsidies have a potential role to play, with Barbados and Dominica both having recently implemented a tax on sugar- sweetened beverages.

#### ***The way forward***

A key set of recommendations emerged from the group, predicated on the agricultural sector exploring opportunities where trade mechanisms can make a real difference. The overarching objective was seen as promoting the sustainable production, processing, distribution, preparation, commercialisation and consumption of safe, affordable, nutritious, high-quality Caribbean food commodities and products. To achieve this objective would require:

- A Caribbean strategic plan/policy which addresses the role of agriculture and food production in the NCD response: with agriculture a key sector of a multidisciplinary team involved in NCD discussions/Commissions; and a reshaping of agricultural policies to increase focus on NCDs.
- Improved analysis and documentation of the impact of various programmes related to food and nutrition, e.g. school feeding programmes.
- Greater understanding of food consumption patterns and drivers.
- Improved systems for food surveillance: a necessary requirement for evidence-informed planning.
- Incentivising the production of low cost, high-quality domestic products.
- Introducing compulsory standards for nutritional labelling.
- Increasing the quality and availability of food and promoting healthy eating.

The actions to arrive at this improved state of affairs are shared in full in the workshop report, along with process indicators, monitoring and evaluation mechanisms etc. However, several concrete interventions are noted here:

- Adapt, develop and apply innovation and appropriate technologies to deliver high-quality products to the market.
- Assist in capacity building of farmers to support better production planning.
- Explore innovative partnerships for supporting local farmers and fishermen.
- Promote urban and peri-urban sustainable agriculture (such as home gardens).
- Promote policies that prevent over-fishing.

- Develop an overarching regional school nutrition policy, introducing school feeding programmes, and encouraging more water consumption.
- Introduce nutritional labelling of packaged foods: encourage all retailers to display nutritional content.
- Mobilise consumer focus groups.



## Reducing alcohol-related harm

### *Issues*

- Reducing alcohol-related harm was not explicitly addressed in the 2007 Port of Spain Declaration.
- Developing and implementing policy on alcohol-related harm is seen as politically ‘challenging’ and perceived as contrary to economic interests (local production and tourism) and interfering with individual pleasure.
- There are limited examples of where positive policies are being pursued: one exception is the implementation of breathalysers for drink driving in Trinidad and Tobago.
- Increased taxation on alcohol could be an effective approach to both reducing consumption and raising revenue for NCD prevention and control, provided it is done in a way that does not create problems with smuggling or local illicit production.

## ***The way forward***

The key facets considered here involve banning sponsorship by alcohol producers, increasing the use of breathalysers to prevent drink-driving, and controlling alcohol sales. It was also acknowledged that lessons could be learned from the regional tobacco experience where the vast majority of countries have signed up to the Framework Convention on Tobacco Control and have seen a degree of (admittedly variable) progress in terms of policy implementation.

There were a series of objectives aimed at achieving the overall recommended outcome: a 10% reduction of harmful use of alcohol. These included:

- Strengthening health systems to respond to this issue;
- Adopting a comprehensive regional policy on alcohol reduction with focus on young people; and
- Strengthened information systems and surveillance.

And concrete interventions proposed involved:

- Designating a national focal point to coordinate all actions related to alcohol across multiple ministries.
- Standardising the regional minimum alcohol purchasing and drinking age.
- Ensuring zero tolerance towards drink driving: employing sanctions and education in the school curriculum.
- Harmonising and enforcing drink driving laws.
- Reviewing alcohol licensing systems.
- Banning or regulating alcohol marketing in the Caribbean and banning sports sponsorship.
- Building capacity for civil society organisations to better advocate for alcohol reduction strategies.
- Communicating messages on the dangers of excessive alcohol consumption to the general public.
- Harmonising alcohol indicators for more effective regional reporting and establishing baselines for monitoring.
- Integrating screening and interventions for alcohol problems in primary healthcare.
- Facilitating Alcoholics Anonymous groups and links with health services: establishing referral systems.
- Developing clinical guidelines on management of alcohol problems.

## **Tobacco control**

### ***Issues***

- While all except one of the full CARICOM members have ratified the FCTC (it does not apply to the UK Overseas Territories), implementation is lagging: e.g. tax as a percentage of sale price, smoke-free indoor places, and in particular advertising, promotion and sponsorship bans. Only six out of 15 full members are able to report implementation in at least one of these areas.
- A regional standard on cigarette packet labelling was agreed, but is voluntary and has only been implemented in two countries.
- Increased taxation on tobacco products is an effective approach to reducing consumption and raising revenue, so long as smuggling is controlled.

## ***The way forward***

The need to concentrate on implementation of legislation for 100% smoke-free spaces, labels with sufficiently large and graphic warnings; introducing increased taxation and banning tobacco sponsorship were highlighted. In addition, the importance of taking advantage of the technical assistance available through the FCTC Secretariat was stressed. It was deemed necessary to use a regional approach to policy formulation and advocacy, which could be adapted to reflect national circumstances.

Recommendations included:

- Having a tobacco control focal point and/or unit in each country.
- Encouraging the greater involvement of civil society for tobacco control advocacy.
- Modernising the approach to education using social and commercial marketing to support tobacco control.
- Greater support offered from CARICOM re: tobacco control.
- Pursuing taxation and earmarking funds from taxation for health education and prevention activities.

Specific objectives and actions to achieve them were highlighted, such as:

- Encouraging full FCTC implementation within a five-year time frame, including, for example, bans on smoking in public places and graphic health warnings (using the CARICOM agreed standards) on tobacco products.
- Each country to increase tax on tobacco by at least 50%.
  - The legal and administrative instruments for raising taxes should be identified within one year.
- Regional campaign on dangers of smoking and the impact of second-hand smoke launched and evaluated.



Shari John

## **Promoting health in different settings: workplaces, schools, faith-based institutions**

### ***Issues***

- No CARICOM member has met the indicator of having more than 50% of public and private institutions adopting healthy eating and physical activity programmes.
- A minority of Member States report policies in place to promote healthy eating in schools (six members) or mandatory physical activity in schools (nine members), however, there is a lack of monitoring and evaluation to determine whether these policies are actually implemented, or whether they are having any impact.
- In smaller countries in particular, where there is limited government capacity for health promotion activities, private and civil society organisations have key roles to play.

### ***The way forward***

There was a range of recommendations centred on investing in new programmes and strengthening existing interventions.

- Schools



- Review, update and standardise the Health and Family Life Education (HFLE) curriculum to include the NCD agenda.
- Place more focus on promoting health within tertiary education settings.
- Promote physical activity rather than only organised sports in school physical education programmes.
- Workplace
  - Explore the involvement of the public sector.
  - Integrate interventions in the workplace as part of HR policy.
  - Strengthen current weakness where many workplace interventions target the obese rather than addressing wellness and population health.
  - Develop toolkits to help establish sustainable workplace programmes.
- Faith-based organisations
  - Engage this sector in a more structured way, using their reach within communities.

Concrete actions to achieve these objectives would include:

- Banning advertising, promotion and sponsorship related to unhealthy foods targeting children.
- Conducting an evaluation of the nutritional value of school meals.
- Training school canteen staff in child nutrition.
- Educating food vendors, parents and students on healthy food options.
- Making physical activity mandatory from pre-primary to tertiary level.
- Diversification of physical activity options within schools.
- All workplaces to offer NCD screenings for employees annually (free or heavily subsidised) and wellness programmes should be offered based on aggregated data from screenings.
- A model based on the Seventh Day Adventist health programme can be used by faith-based and civil society organisations.



Simon Drvaric



## **Investing in NCD prevention and control**

### ***Issues***

- Taxation on tobacco, alcohol, and certain food and drink items (e.g. sugar-sweetened beverages) can both decrease consumption and raise considerable revenue for NCD programmes.
- It is estimated that the revenue that could be raised from tobacco and alcohol taxation would be up to 3 times greater than what is required to implement NCD 'best buys' recommended by WHO. Raising tax on alcohol is seen as politically difficult, however.
- A key issue is the political feasibility of ensuring that additional tax revenues from unhealthy products are protected for NCD activities.
- Consideration of how the additional funds are used should include:
  - Universal health coverage and access;
  - WHO 'best buys' for prevention and control: and
  - Increased surveillance, monitoring and evaluation.

### ***The way forward***

It was seen as imperative to focus on the centrality of 'investing' in the NCD response, rather than 'financing' it, given that this encompassed both the need to increase resources and the fact that such resourcing would be of great benefit to the region and an investment in its health and socio-economic development. Participants were keen to make the business case to increase investment in health and NCDs.

The following recommendations were made:

- Obtain more data to demonstrate the benefits of investing in health and NCDs.
- Increase public and private investment in NCD prevention and control.
- Examine Jamaica's National Health Fund as an example of an investment to resource health programming that has survived political changes.
- Build meaningful partnership with (and among) government and civil society to address NCD needs and issues.
- Explore the approach of increased taxation to decrease consumption.
- Apply tax on added sugar - explore how this can be done without having a disproportionate impact on the economically disadvantaged. One way would be to bring down the cost of healthy food.

A range of actions to help achieve these aims was suggested, including:

- Establishing a regional NCD fund at CARPHA.
- Examining the range of subsidies currently applied, increasing those that promote better health.
- Draft in a 'league of champions' to lobby leaders and try to secure sustainable political buy-in.
- Create public awareness of the need for taxation for health investment and garner support.

## Media and social communications, health promotion and advocacy



Courtesy of Priscilla Prevost

### ***Issues***

- Only 5 out of 20 CARICOM members report having an NCD communications plan.
- There is the opportunity for more coordinated region-wide campaigns, including on Caribbean Wellness Day.
- Media and social communications have a key role in raising awareness about addressing NCD risk factors and helping to shape public opinion to make change politically possible.
- There is social communications expertise in the region, but it is expensive, and funding is not often available.

### ***The way forward***

Key considerations for this group involved exploring innovative ways to extend the breadth and depth of communications on NCDs, which can be used in a more dynamic way to 'tell and sell the story'.

The following recommendations were made:

- Caribbean Wellness Day should be better marketed and related activity encouraged throughout the year.
- Explore and address social and cultural practices, which militate against healthy living.
- Strengthen and maximise use of social media.
- Observe the communication trends of young people to guide interventions.

- Explore innovative and effective ways to communicate and demonstrate relevance to the public for greater buy-in.
- Identify sector champions.
- Continue to build the Regional Health Communications Network facilitated by CARPHA.
- Expand partnerships, including with the private sector, to optimise available resources for advocacy.
- Promote the business case for supporting the NCD response (emphasising the relationship between health and economic productivity).

A series of practical actions were highlighted:

- Provide briefs/talking points on priority public health issues for key audiences.
- Provide a template of an NCD communications action plan for partners.
- Develop a communications toolkit with a number of products for a number of audiences.
- Identify prospective stakeholder groups with a common agenda.
- Conduct stakeholder meetings.
- Promote individual empowerment – and provide information – so people have the tools to make healthy choices.
- Develop innovative social media tools, such as an app for calorie counting local foods.

## Physical activity and the built environment



Simon Drvaric

### Issues

- There are marked gender differences in levels of physical inactivity: women are significantly less active than men.
- Only three CARICOM members have met the commitment of mandatory provision of spaces for physical activity in new housing developments.
- The determinants of physical activity in Caribbean countries are incompletely understood, and important questions include:
  - What other types of changes to the built environment, in addition to provision within new housing developments, will facilitate increased physical activity?
  - What is the potential role of 'active transport' (e.g. walking or cycling)?
  - How do we ensure that the opportunities provided by changes to the built environment result in higher levels of physical activity?
  - How do we evaluate whether changes to the physical environment do, in fact, result in changes in physical activity?
  - What can be learned from major physical activity promotion campaigns, such as the *10,000 Step Challenge* in the British Virgin Islands?

### ***The way forward***

The overarching goal was seen to be developing the physical and social environment to promote physical activity in adults and children by providing areas which are easily accessible, safe and well-maintained. Several recommendations were made, including:

- Championing a fully multisectoral response to address this critical issue.
- Encouraging a political environment that promotes physical activity.
- Challenging policies/barriers preventing the easy adoption of physical activity.
- Improving public transportation systems to decrease reliance on cars.
- Encouraging civil society and communities to take more responsibility for owning and maintaining green spaces.
- Creating spaces in the environment to promote physical activity like bicycle lanes, run/walk/cycle events, boardwalks.

A number of practical actions were recommended, such as:

- Discouraging use of cars by increasing parking fees and providing central parking facilities.
- Compiling and sharing a list of best practices, using fora like regional meetings and journals.
- Encouraging the use of already available opportunities for increased exercise, e.g. beaches, parks, steps at work.
- Providing hiking and biking trails.
- Ensuring that educational and care facilities for children provide space for physical activity.
- Encourage young people to participate in youth clubs that promote physical activity.
- Subsidise public transport for children.





### ***Next steps***

Taken in their entirety, the work group conclusions are the starting point for a fairly comprehensive plan for action in which priorities, goals and objectives across seven critical areas are explored and recommendations as to how they may be realised laid out in some detail.

Given the nature of the workshop and the concentration on multisectorality, recommendations emerging from the meeting necessarily focus on an all-of-society and all-of-government NCD response. While this is one, absolutely fundamental, aspect of the response, it is important to remember other areas, including aspects of surveillance to guide action, coverage and access to effective health care, and technical support.

Relevant areas highlighted in these evidence briefs include recommendations to improve surveillance on mortality and morbidity and detection of diseases such as hypertension (Chapters 3 and 4); improving primary healthcare (Chapter 4); regional and international support for Declaration commitments (Chapters 5 and 6); and broader surveillance and monitoring (Chapter 7).

All the information, ideas and strategies presented in these evidence briefs and discussed at the implementation workshop will contribute towards a cogent strategy for action with ambitious but realistic goals.

The strategy, and a short list of priority actions, will be presented to the February 2017 CARICOM Heads of Government Meeting. This timing should have particular resonance as it will coincide with the 10th anniversary of the Declaration, as well as heralding the next UN High-level Meeting on NCDs scheduled

for 2018. The Heads list of 'asks' will be complemented by a set of 'asks' specifically tailored to Health Ministers and to CMOs.

The timetable of activities is broadly as follows:

- Finalisation of evidence briefs and the completion of a detailed and comprehensive research report.
- Strategy for action honed and finalised.
- Priority shortlists for CMOs, Health Ministers and Heads of Government confirmed.
- Strategy and priority list consulted on and agreed with:
  - Regional CMOs in April 2016.
  - Regional and global Health Ministers at the World Health Assembly in May 2016.
  - CARICOM Council for Human and Social Development (COHSOD) meeting in September 2016.
  - CARICOM Heads of Government Meeting in February 2017
- Ongoing engagement with the Caribbean Cooperation in Health process due to be completed by September 2016.
- Further dissemination and focus on accelerated implementation at the CARPHA 2017 Health Research Conference, which it is proposed will focus on the multi-sectoral responses required for the prevention and control of NCDs.

In the run up to the 2017 CARICOM Heads of Government Meeting there will be a concerted effort to get buy-in for the strategy and, especially, for the 'key asks', from a range of actors and sectors. Beyond the meeting, which should mark the intensification of the regional challenge to NCDs, more work will be done to strengthen multisectoral partnerships and mobilise support to help ensure that the Caribbean NCD response has even greater success.



# Acknowledgements

The following individuals contributed to research that is summarised in the evidence briefs 3 to 8, with names given in alphabetical order. Team leaders for the work are in **bold**.

## Chapter 3

Ms Alvarado, **Dr Andall-Brereton**, Prof Hambleton, Ms Holder, **Dr Samuels**, Prof Unwin

## Chapter 4

Dr Bailey, Ms Bishop, Dr Bracht, Dr Guell, Dr Harewood, Dr Harris, **Dr Kirton**, Ms Koch, Dr Kulik, Dr Leveridge, **Dr Murphy**, Dr Rollock, Dr Samuels, **Prof Unwin**

## Chapters 5 and 6

Ms Bartholemew, Ms Bishop, Dr Bracht, Ms Hippolyte, **Prof Kirton**, **Prof Knight**, Ms Koch, Dr Kulik, Dr Murphy, **Dr Samuels**

## Chapter 7

Dr Andall-Brereton, Prof Kirton, Ms Koch, Ms Kontio, Ms Lloyd, Dr Rickets, **Dr Samuels**

## Chapter 8

Mr Gabriel, Dr La Foucade, Ms Metivier, **Prof Theodore**

## Chapter 9

**Ms Tull** and the team

## Writing the briefs

This was led by Ms Tull, with input from Ms Bishop, Dr Samuels and Prof Unwin. Comments on drafts of the briefs, or work that contributed to the briefs, were received from researchers listed above, plus Prof Alleyne, Prof Hassell, Dr Hospedales, Ms Hutton, Minister Innis, and Dr Martin.

**Photo credits:** Simon Drvaric, Shari John and PAHO

Please visit <http://www.onecaribbeanhealth.org/about-the-team/> for more details on project team heads below:

Dr Madhuvanti Murphy: National policy responses: qualitative data collection and analysis

Professor Emeritus Karl Theodore: Tobacco and alcohol taxation

Professor W. Andy Knight: Regional policy responses to NCDs; international impact of the Declaration

Professor John Kirton: National and regional policy responses to NCDs; international impact of the Declaration

Dr C. James Hospedales: Regional mortality and morbidity; dissemination

Sir Trevor Hassell: Dissemination

Dr Godfrey C. Xuereb: Documenting tobacco control measures, studying successful implementation

## Principal Investigators



### **Dr T. Alafia Samuels, Principal Investigator**

Dr Samuels is currently Director of the Chronic Disease Research Centre and Deputy Dean for Graduate Studies and Research in the Faculty of Medical Sciences at the University of the West Indies.

Through work in Public Health in Jamaica and then with PAHO and CARICOM, Dr Samuels has international project management experience within the Caribbean and excellent links to a range of institutions, including most national Ministries of Health.

Dr Samuels is currently a member of the Barbados National Non-communicable Diseases Commission, and the leader of the Healthy Campus Initiative, a workplace wellness programme at UWI, Cave Hill.

She is the principal author of the Barbados Ministry of Health Strategic Plan of Action for the Prevention and Control of NCDs 2015-2019 as well as the CARICOM Regional NCD Plan 2011-2015. She developed and implemented the POS evaluation grid, and has reported yearly to the annual Caucus of Caribbean Community Ministers of Health on the status of NCD programmes in the region 2008–2015.

Holding her medical degree from UWI, and an MPH (Masters in Public Health), and a PhD in Chronic Disease Epidemiology, both graduate degrees were awarded with honours from Johns Hopkins University.



### **Professor Nigel Unwin, Co-Principal Investigator**

Professor Unwin is an experienced public health professional and epidemiologist with a strong interest and track record in research on non-communicable diseases. He is highly experienced in working on, and leading, international public health research projects.

Much of his research has been, and continues to be, into the burden, prevention and control of diabetes and cardiovascular disease, including in low- and middle-income country settings.

He has worked with the International Diabetes Federation and the World Health Organization (WHO), including two years with the Diabetes Group at WHO in Geneva. During his time at WHO he was part of the core writing team for 'Preventing chronic diseases: a vital investment'. In 2006 he returned from WHO to Newcastle University as Professor in Epidemiology.

In August 2010 the exciting opportunity arose to contribute to establishing graduate programmes in Public Health at UWI, Cave Hill, and in August 2014 he moved to the Chronic Disease Research Centre. After over 5 and half years at UWI, he left the full time employment of the University to be based, for personal reasons, in the UK again. On the first of April 2016 he became visiting Professor of Population Health Sciences at the Chronic Disease Research Centre, UWI, and in the UK is Strategic Lead for Global Health Research at the Centre for Diet and Activity Research, University of Cambridge.

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<sup>i</sup> Funded by Canada's International Development Research Centre, the evaluation has been carried out on behalf of the Caribbean Community (CARICOM) and the Pan American Health Organization (PAHO).