

T Alafia Samuels et al.

Accountability for summits: the CARICOM NCD case

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Monitoring compliance with high-level commitments in health: the case of the CARICOM Summit on Chronic Non-Communicable Diseases

T Alafia Samuels,^a John Kirton^b & Jenilee Guebert^b

^a University of the West Indies, Cave Hill Campus, P.O. Box 64, Bridgetown, Barbados BB11000.

^b University of Toronto, Toronto, Canada.

Correspondence to T Alafia Samuels (e-mail: alafiasam@gmail.com).

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Abstract

The CARICOM Summit on Chronic Non-Communicable Diseases – the first government summit ever devoted to non-communicable diseases (NCDs) – was convened by the Caribbean Community (CARICOM) in Trinidad and Tobago in September 2007. Leaders in attendance issued the declaration of Port of Spain, a call for the prevention and control of four major NCDs and their risk factors.

An accountability instrument for monitoring compliance with summit commitments was developed for CARICOM by the University of the West Indies in 2008 and revised in 2010. The instrument – a one-page colour-coded grid with 26 progress indicators – is updated annually by focal points in Caribbean health ministries, verified by each country's chief medical officer and presented to the annual Caucus of Caribbean Community Ministers of Health. In this study, the G8 Research Group's methods for assessing compliance were applied to the 2009 reporting grid to assess each country's performance.

Given the success of the CARICOM Summit, a United Nations high-level meeting of the General Assembly on the prevention and control of NCDs was held in September 2011. In May 2013 the World Health Assembly adopted nine global targets and 25 indicators to measure progress in NCD control. This study shows that the CARICOM monitoring grid can be used to document progress on such indicators quickly and comprehensibly. An annual reporting mechanism is essential to encourage steady progress and highlight areas needing correction. This paper underscores the importance of accountability mechanisms for encouraging and monitoring compliance with the collective political commitments acquired at the highest level.

Introduction

The Caribbean Community (CARICOM) is composed of 15 member states and five associate members. Most of these are Caribbean islands; three are countries on the mainland of Central and South America.¹ CARICOM members have a combined population of 17 million and an average life expectancy ranging from 70 to 80 years except in Haiti, where it is 62 years.²

The Caribbean region has the highest burden of non-communicable diseases (NCDs) in the Americas.² In light of this, the Caribbean Cooperation in Health Initiative, approved by health ministers in 1986, made NCDs a priority concern.³ In their 2001 Nassau Declaration, the CARICOM heads of government identified human immunodeficiency virus (HIV) infection, NCDs and mental health problems as regional priorities, called for strategies for the prevention and treatment of NCDs and articulated principles and processes to preserve and enhance “the health of the Region which is the wealth of the Region.”⁴ In 2005, the Caribbean Commission on Health and Development reported that the number of deaths from diabetes, hypertension and heart disease combined was 10 times higher than the number of deaths from acquired immunodeficiency syndrome (AIDS) and declared NCDs a “super priority.”⁵

At the CARICOM Summit in July 2006, leaders received a report on “the macro-economic implications of non-communicable diseases.”⁶ Trinidad and Tobago agreed to host a special regional consultation on compliance with specific recommendations pertaining to tobacco, diet and physical activity.⁷ In October of the same year, Sir George Alleyne, director emeritus of the Pan American Health Organization (PAHO) – regional office for the Americas of the World Health Organization (WHO) – called for more attention to NCDs. He argued that although “impressive gains” had been made in stemming malnutrition and infant mortality, “obesity was of growing concern, even among children” and diabetes was the “steady cause of death” among many in the Caribbean.⁷ Sir George’s presentation spurred the decision to hold a summit devoted to NCDs. In February 2007, Prime Minister Denzil Douglas of St. Kitts and Nevis, in his capacity as CARICOM minister of health in the quasi-cabinet of the 18th Inter-sessional CARICOM Heads of Government Summit, urged CARICOM members to develop a “comprehensive regional strategic plan to respond to the chronic non-communicable diseases and the havoc they are wreaking on our Caribbean people.”⁸ Five months later, leaders agreed to participate fully in the CARICOM Summit on Chronic Non-Communicable Diseases,

to be held later in the year. Thus, the world's first summit of heads of government devoted specifically to NCDs was the product of over a decade of regional discussions.

The CARICOM Summit was held in Port of Spain, Trinidad and Tobago, on 15 September 2007. The 11 heads of government and five ministers present agreed that “immediate collective actions were necessary to manage and control NCDs” and issued a 15-point summit declaration titled *Uniting to stop the epidemic of chronic NCDs* (also known as the declaration of Port of Spain),⁹ calling for policies and actions for the prevention and control of the four major NCDs and their common risk factors. Regional and multilateral organizations and the independent, authoritative scientific and academic community were represented at the CARICOM Summit, but there was inadequate representation of nongovernmental organizations. The financial resources to support the Summit were contributed by external actors, including Canada, yet funding for follow-up actions was meagre – less than 2% of the external funding for HIV infection and AIDS.

CARICOM Summit follow-up

Commitments are discrete, specific, publicly expressed and collectively agreed to statements of intent. They are understood to be a “promise” by summit members that they will undertake future action to move towards, meet or adjust to an identified target.²⁹ Whether summits succeed and their commitments are complied with depends largely on how quickly and often follow-up occurs. In this case, follow-up took place within a month of the Summit and repeatedly afterwards. In October 2007, CARICOM agriculture ministers discussed the impact of food and agricultural policies on NCDs and made 13 commitments to combat these diseases.¹⁰ At its November 2008 meeting, the Council for Human and Social Development (COHSOD) focused on the connection between health and education and noted the importance of physical activity and healthy school meals.¹¹

As mandated in the declaration of Port of Spain, the first Caribbean Wellness Day was celebrated on 13 September 2008 to commemorate the anniversary of the CARICOM Summit, with support from PAHO.¹² In July 2009, CARICOM heads of government endorsed the Caribbean Wellness Day slogan of “Love That Body.”^{12,13} and, during the six years since the CARICOM Summit, the majority of countries have celebrated Caribbean Wellness Day every year.

At the June 2009 meeting of the COHSOD, the chair pointed out that achieving the United Nations Millennium Development Goals (MDGs) by their 2015 deadline would result in reduced rates of NCDs. “The Strategic Plan of Action for the Prevention and Control of NCDs in Countries of the

Caribbean Community” was reviewed in November 2009, in a workshop attended by representatives of ministries of health from 10 CARICOM countries, the CARICOM Secretariat’s Health Desk and experts from PAHO and the University of the West Indies. The completed plan was tabled and endorsed at the 2010 COHSOD.⁵

In September 2010 and December 2011, regional NCD meetings were held in Trinidad and Tobago with funding from PAHO and the Inter-American Development Bank. At these meetings, NCD focal points within the health ministries and chief medical officers reviewed and evaluated compliance with the commitments acquired under the declaration of Port of Spain and shared plans to advance the NCD agenda nationally and regionally.

From the Caribbean to the United Nations

Following the 2007 CARICOM summit, CARICOM leaders, actively encouraged a broader range of countries and organizations to take action towards the control of NCDs. In 2008, Guyanese health minister and World Health Assembly president Leslie Ramsammy advocated for NCDs to be given a more prominent place on the global public health agenda and made the subject of an additional MDG.¹⁴

NCDs were on the agenda of the Fifth Summit of the Americas in Trinidad and Tobago in April 2009. Their leaders declared that they could “reduce the burden of non-communicable diseases (NCDs) through the promotion of comprehensive and integrated preventive and control strategies at the individual, family, community, national and regional levels and through collaborative programmes, partnerships and policies supported by governments, the private sector, the media, civil society organisations, communities and relevant regional and international partners.”¹⁵ They supported holding a United Nations (UN) high-level meeting on NCDs.

NCDs were highlighted at the November 2009 Commonwealth Heads of Government Meeting, also held in Trinidad and Tobago. Participants specifically called for “the consideration of a Summit on NCDs to be held in September 2011, under the auspices of the United Nations General Assembly, in order to develop strategic responses to these diseases and their repercussions.”¹⁶ They also supported initiatives to promote accountability, specifically “the monitoring of NCDs in existing national health information systems” and the inclusion of NCD indicators as part of the monitoring of the MDGs.

In February 2010, CARICOM, Brazil and WHO jointly advocated for a UN high-level meeting on NCDs before UN permanent representatives in New York. In May 2010, UNGA approved a resolution, presented on behalf of CARICOM member states, to hold such a meeting.^{17,18}

At the Second CARICOM-Japan Ministerial Conference, held in September 2010, participants called for widespread support for the high-level meeting on NCDs.¹⁹ Participants at the UN Summit on the Millennium Development Goals, also held in September 2010, committed themselves to taking action at the national, regional and global levels to control NCDs and to ensuring the success of the UN high-level meeting.¹⁸

In July 2010, at the Thirty-first Regular Meeting of the Conference of Heads of Government of The Caribbean Community, UN secretary general Ban Ki-moon pledged his full support for the high-level meeting and commended CARICOM for raising the critical issue of NCDs.^{18,22} The problems posed by NCDs was brought up at the Seoul Summit of the Group of Twenty (G20) in November 2010²⁰ and dealt with during the Asia Pacific Economic Cooperation summit, which was held the same month in Yokohama, Japan. At this summit, leaders agreed on the necessity to “enhance” NCD control.²¹

The United Nations high-level meeting

On 19–20 September 2011, 113 member states, including 35 heads of state and government, attended the UN High-level Meeting on Non-communicable Diseases in New York City.²³ Participants discussed how to better address the burden of NCDs, which annually kills 9 million people under the age of 60 years. Following the meeting, WHO adopted the target of reducing premature mortality from NCDs by 25% between 2012 and 2025, and in May 2013, UN member states adopted an additional nine targets and 25 indicators during the 2013 World Health Assembly.²⁴ Documenting progress on these indicators in an easy-to-read document, similar to the one used to monitor compliance with the CARICOM’s commitments in relation to NCDs, can help to achieve the established targets. The accountability mechanisms developed for the CARICOM Summit show how and why this is so and suggest how compliance can be enhanced for this and other summits on NCDs and other health concerns.

Monitoring compliance

CARICOM and PAHO, as the joint secretariat for the Caribbean Cooperation in Health Initiative, were responsible for monitoring and evaluating compliance with the commitments acquired under the declaration of Port of Spain.⁹ These activities were central to advancing the NCD agenda. Before they could recommend a global summit on NCDs, CARICOM leaders needed to demonstrate that their regional summit had made a difference in their countries.

Compliance grid

In 2008, one of the authors (TAS) of this paper designed and implemented at the University of the West Indies a one-page reporting grid that was endorsed by the CARICOM heads of government and ministers of health (Table 1, available at: <http://www.who.int/bulletin/volumes/92/###/##-#####>). The grid, intended as a tool for monitoring CARICOM members' compliance with the commitments acquired under the declaration of Port of Spain, presented succinct information to show where countries stood in terms of NCD-related plans and budgets and of activities and policies surrounding smoking, nutrition, physical activity, health promotion, NCD surveillance and the treatment of NCDs. The grid was revised in 2010; the original 21 indicators were expanded to 26 and colour coding was added (Table 2, available at: <http://www.who.int/bulletin/volumes/92/###/##-#####>). This was done in collaboration with Fitzroy Henry, director of the former Caribbean Food and Nutrition Institute, now part of the Caribbean Public Health Agency. Countries update the grid annually.⁴ This task is usually performed by NCD focal points and validated by the chief medical officers in the ministries of health of CARICOM countries. Through this self-reporting, governments note the progress made by their ministries and societies in complying with the Declaration's 15 items, which translate into 27 commitments acquired under the CARICOM Summit. The updated grid is presented to CARICOM ministers of health every September and to the heads of CARICOM governments annually.

The ministers of health are given a detailed presentation on the status of compliance in their respective countries. In subsequent discussions, the ministers of the countries with the poorest performance are encouraged to improve and are offered assistance by other countries and agencies. Competition among countries over grid status is notable and leads to efforts to improve. For example, at the 2010 Caucus of Caribbean Community Ministers of Health, the health minister of Trinidad and Tobago reviewed the grid. When she noticed that her country had not conducted a STEPwise approach to surveillance (STEPS) NCD risk factor survey, she commissioned one right away.. The survey was completed and published in 2012.

The grid has been used at regional NCD meetings in September 2010 and December 2011 to compare the progress made by countries, set priorities, and identify areas of poor performance. It has spurred a focus on areas of lower performance and has generated an awareness of the need for regional initiatives.

Some of the data from the grid are publicly available. The grid itself was published in a newspaper supplement on 25 September 2011, soon after the UN high-level meeting.²⁵ Surveillance reports and legislation, such as the STEPS reports on NCDs, are made public Caribbean Wellness Day celebrations are covered widely in the regional media. Data on tobacco control are publicly available through the Framework Convention on Tobacco Control (FCTC) web site. Information on other NCD-related commitments is covered in internal health ministry documents and is not publicly available.

The grid has limitations. It is not used to monitor regional actions, as required under the declaration of Port of Spain, partly because it is not suitable for monitoring input from multiple regional entities. In addition, the data are self-reported by the people responsible for the NCD programme area, so respondent bias cannot be ruled out. Some indicators are not precisely defined and are open to interpretation. For example, in the health promotion indicator "...≥ 50% of public and private institutions with physical activity and healthy eating programmes," "physical activity programme" is not defined and each country can choose its own definition.

The grid illustrates the importance of holding leaders accountable for acting on their commitments and of conducting independent expert assessments. Summits generate declarations that politically bind national leaders to commitments they make personally, publicly and collectively. Independent analysis of compliance with these commitments reveals how well and under what conditions countries comply with them. It also makes it possible to see how compliance by CARICOM member countries has varied over time in different areas and what factors are associated with high and low compliance.^{4,26}

Compliance assessment results

The Healthy Caribbean Coalition's assessment

In March 2010, Trevor Hassell, chair of the Healthy Caribbean Coalition, summarized the contents of the grid to assess compliance with the commitments acquired during the CARICOM Summit (Table2).²⁷ He concluded that, almost three years after the Summit, compliance was modest and mixed.

Barbados, Guyana, Jamaica and Trinidad and Tobago showed the highest compliance; Haiti, Montserrat and Turks and Caicos showed the lowest.

The G8 Research Group's assessment

In 2011, two of the authors (JK, JG) assessed compliance with CARICOM Summit commitments using a standard method developed by the G8 Research Group,²⁶ which is the world's leading independent source of information, analysis and research on Group of Eight institutions, activities and members. The method built on the compliance methods first developed by Von Furstenberg & Daniels in 1993²⁸ and expanded on those developed by Kokotsis in 1999.²⁹ Full compliance with a commitment is assigned a score of +1; a score of -1 indicates a failure to comply with a commitment or that a country did the opposite of what was promised; an "inability to commit" or a "work in progress" is scored at 0.

The assessment revealed 27 concrete, discrete commitments emanating from the 15-point declaration of Port of Spain. Application to the 2009 reporting grid showed an overall average compliance score of merely +0.23, equivalent to 61.5%. The average score for the 15 full members of CARICOM was slightly higher, at +0.27 (63.5%). The average score for the five associate members of CARICOM was +0.08 (54%). When applied to the more up-to-date grid results generated for 2011 at the University of the West Indies, which included additional indicators, compliance remained mixed and the average score was +0.06 (53%). The countries with the highest implementation scores were, in order, Barbados (+0.64 or 82%), Trinidad and Tobago (+0.44 or 72%), Bermuda (+0.43 or 71.5%) and Dominica (+0.38 or 69%). The countries with scores below average were St. Vincent and the Grenadines (-0.45 or 27.5%), Anguilla (-0.61 or 19.5%) and Haiti (-0.83 or 8.5%).

The low average score observed was largely due to the inclusion of indicators for compliance with commitments relating to food and nutrition policy. "Upstream" actions that create healthy food environments are likely to have greater impact than promoting behaviour change around diet and physical activity. Such actions are addressed by items 7, 8 and 9 of the declaration of Port-of-Spain and include a food supply free of trans-fats, trade agreements conducive to meeting national health goals, and mandatory labelling of packaged foods for nutrition content.⁹ These public and private sector policies and actions were monitored on the grid and received the worst compliance scores across all countries.²⁶

Factors influencing compliance

Assessing the factors that influence compliance, the ways in which governments comply with their summit commitments and the effects of accountability assessment is a complex and challenging task. Many factors – some well beyond the control of governments or their leaders – can undermine compliance.³⁰ Sudden events unrelated to NCDs can distract a country. For example, the 2010 earthquake in Haiti diverted the country's attention towards the immediate crisis. This weakened governance in the country and pushed NCDs down on the list of priorities. Even without the earthquake, however, compliance with Summit commitments would probably have been minimal. The global economic crisis that started in 2008 has aggravated matters. At the regional level, the recent creation of the Caribbean Public Health Agency as an international institution may have drawn potential financial support away from NCDs.

However, in the case of the CARICOM Summit, some key factors stand out. Countries with a higher gross national income (GNI), a higher gross domestic product (GDP) and a larger population – these are the standard measures of overall national capability – are more likely to follow through on their commitments than those with lower GNIs and GDPs or smaller populations. Commitments supported regionally, such as Caribbean Wellness Day, or internationally, such as commitments related to the FCTC, are also more likely to be fulfilled.⁴

More generally, there is mounting evidence, especially from G8 summits, that leaders in attendance can use the power of the chair to craft their commitments in ways that improve compliance. They can, for example, add accountability mechanisms.^{30–32} Independent assessments conducted by experts for G8 and G20 summits have been reported by the media, discussed by leaders' representatives at preparatory meetings, and publicly referred to and discussed by leaders at the summits.

In summary, the CARICOM Summit was successful in several ways. It was the first summit of heads of government to focus on the problem of NCDs and it resulted in multiple collective, multilateral commitments for implementation of policies and actions pertaining to NCD control. Although there is room for improvement, countries fulfilled some important commitments acquired at the Summit. The CARICOM Summit sparked interest in a global summit on NCDs and resulted in the UN high-level meeting on NCDs. An accountability mechanism based on annual reporting is critical for monitoring progress and highlighting areas in need of correction.

Competing interests:

None declared.

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Table 1. Original grid for the reporting of countries' compliance with the mandates of the declaration of Port of Spain, 2008

Mandate	ANG	ANT	BAH	BAR	BEL	BER	BVI	CAY	DOM	GRE	GUY	HAI	JAM	MON	SKN	STL	SVG	SUR	TRT	TCI
National focal point	√	√	√	√	√	√	√	√	√	√	√	x	√	√	√	√	√	√	√	√
NCD plan	X	–	±	√	±	√		X	±	√	√	x	√	–	√	±	–	–	√	–
NCD summit convened	X	–	X	√	X	√	±	X	√	±	√	x	√	–	X	X	–	–	√	–
Intersectoral NCD commission appointed and functional	X		X	√	±	√	√	X	x	√	√	x	±	–	X	√	–	–	√	–
NCD communications plan	X	–	±	±	±	√	–	X	±	±	√	x	±	–	X	–	–	–	√	–
FCTC ratified	X	√	√	√	√	–	*	√	√	√	√	x	√	*	X	√	X	√	√	*
Tobacco taxes > 50% sale price	X	–	X	√	X	–	–	±	X		√	x	√	–	X	X	X	√	–	–
Smoke-free indoor public places (government, health, education)	X	–	X	±	±	√	√	√	–	√	√	x	±	–	X	√	X	–	√	–
Advertising, promotion and sponsorship bans	X	–	X	±	X	√	√	√	–	X		x	√	–	X	X	X	–	√	–
Financial resources dedicated to NCD prevention and control	X	–	X	–	±	X	–	X	±	X	±	x	√	–	X	–	X	–	–	–
Workplace wellness initiatives	X	–	√	√	√	√	–	√	±	±	√	x	√	–	±	±	±	–	√	–
Healthy schools programmes	√	–	√	–	√	√	–	±	±	±	√	±	√	–	–	±	±	–	√	–
National food-based policy nutrition policy developed and in use	√	√	√	±	√	X	√	X	√	√	X	x	√	√	√	X	√	X	√	√
Caribbean Wellness Day multi-sectoral, multi-focal celebrations	√	√	√	√	√	√	√	√	√	√	√	x	√	√	√	√	√	√	√	√
Ongoing, mass physical activity or new public physical activity spaces	X	–	√	√	√	√	–	±	–	√	√	–	√	–	√	√	√	–	√	–
Surveillance: STEPS or equivalent survey	X	–	√	√	±	√	√	X	√	±	±	x	√	–	√	±	–	–	±	–
Surveillance: Minimum data set	X	X	X	X	X	X	X	√	X	X	X	x	√	X	X	X	X	X	X	X
Surveillance: Global Youth Tobacco Survey	X	√	√	√	√	–	√	±	√	√	√	√	√	–	–	√	√	√	√	–
Surveillance: Global School Health Survey	√	–	√		±	–	√	±	–	√	√	x	√	–	±	√	√	–	√	–
Chronic care model / NCD treatment protocols	X	–	√	±	±	±	–	±	X	±	±	x	√	–	X	√	–	–	–	–
Quality-of-care cardiovascular disease or diabetes demonstration project	±	–	√	√	±	±	±	√	X	√	√	±	√	–	±	√	–	–	–	–

ANG: Anguilla; ANT: Antigua and Barbuda; BAH: Bahamas; BAR: Barbados; BER: Bermuda; BVI: British Virgin Islands; CAY: Cayman Islands; DOM: Dominica; FCTC: Framework Convention on Tobacco Control; GRE: Grenada; GUY: Guyana; HAI: Haiti; JAM: Jamaica; MON: Montserrat; NCD: non-communicable disease; SKN: St. Kitts and Nevis; STEPS: STEPwise approach to surveillance; STL: St. Lucia; SUR: Suriname; SVG: St. Vincent and the Grenadines; TCI: Turks and Caicos; TRT: Trinidad and Tobago.

Note: The symbols are to be interpreted as follows: √: accomplished; ±: in process/partially implemented; X: not accomplished; *: not applicable; –: missing information.

Table 2. Revised grid for the reporting of countries' compliance with the 15 mandates of the declaration of Port of Spain, 2010

Mandate number	NCD progress indicator	ANG	ANT	BAH	BAR	BEL	BER	BVI	CAY	DOM	GRE	GUY	HAI	JAM	MON	SKN	STL	SVG	SUR	TRT	TCI
Commitment																					
1, 14	NCD plan	X	X	±	√	±	√	√	√	√	√	√	x	√	–	√	√	±	±	√	X
4	NCD budget	X	±	X	√	X	X	X	√	±	X	±	x	X	–	X	√	X	X	√	X
2	NCD Summit convened	X	√	X	√	X	√	√	X	√	±	√	x	√	–	X	√	X	√	√	X
2	Multi-sectoral NCD commission appointed and functional	X	X	X	√	±	√	√	X	±	√	√	x	±	–	X	√	X	±	√	X
12	NCD communications plan	X	X	±	±	X	√	X	√	±	±	√	x	±	–	X	±	X	±	√	X
Tobacco																					
3	FCTC ratified	*	√	√	√	√	*	*	√	√	√	√	x	√	*	√	√	√	√	√	*
3	Tobacco taxes > 50% sale price	X	X	X	√	X	–	X	±	X		√	x	√	–	±	X	X	√	X	X
3	Smoke-free indoor public places	X	√	X	√	±	√	√	√	±	√	√	x	±	–	X	√	X	±	√	X
3	Advertising, promotion and sponsorship bans	X	X	X	√	X	√	√	√	X	X	±	x	√	–	X	X	X	±	√	X
Nutrition																					
7	Multisector food and nutrition plan implemented	√	√	√	√	±	X	√	X	√	√	√	x	√	√	√	X	√	X	±	±
7	Trans-fat-free food supply	–	–	–	–	X	–	–	X	X	–	–	–	±	–	–	X	X	X	X	X
7	Policy and standards promoting healthy eating in schools implemented	–	√	–	√	±	√	X	±	±	–	±	–	√	–	±	X	X	X	±	X
8	Trade agreements used to meet national food security & health goals	–	–	–	–	X	–	–	X	–	–	±	–	X	–	–	X	X	X	√	X
9	Mandatory labelling of packaged foods for nutrition content	–	X	–	–	X	±	–	±	±	–	±	–	X	–	–	X	X	±	X	X
Physical activity																					
6	Mandatory physical activity in all grades in schools	–	–	–	√	√	±	±	√	√	–	±	–	±	–	–	X	X	X	√	√
10	Mandatory provision in new housing developments	–	–	–	√	√	–	–	X	X	–	X	–	x	–	–	X	X	X	X	X
10	Ongoing, mass physical activity or new public physical activity spaces	X	√	√	√	√	√	X	√	√	√	√	–	√	–	√	√	√	√	√	X

		ANG	ANT	BAH	BAR	BER	BVI	CAY	CWD	DOM	FCTC	GRE	GUY	HAI	JAM	MON	NCD	PHC	SKN	STEPS	STL	SVG	SUR	TCI	TRT	
Education / health promotion	15	Multisectoral, multifocal CWD celebrations	√	√	√	√	√	√	√	√	√	√	√	x	√	√	√	√	√	√	√	√	√	√	√	√
	10	≥50% of public and private institutions with physical activity and healthy eating programmes	–	X	–	–	X	–	X	X	X	–	±	–	–	–	–	±	X	X	±	X	±	X	X	X
	12	Media broadcasts on NCD control (risk factors, treatment) > 30 days a year	–	√	–	√	X	√	X	±	±	–	√	–	√	–	√	±	X	X	√	X	√	X	√	X
Surveillance	11, 13, 14	STEPS or equivalent survey	X	X	√	√	√	±	√	±	√	√	±	x	√	–	√	±	X	±	√	±	√	±	√	±
		Minimum data set reporting	X	X	√	√	√	√	√	√	√	±	±	x	√	X	√	√	√	√	√	√	√	√	√	X
		Global Youth Tobacco Survey	X	√	√	√	√	X	√	±	√	√	√	√	√	–	±	√	√	√	√	√	√	√	√	X
		Global School Health Survey	√	√	√	±	±	–	√	±	√	√	√	x	√	–	±	√	√	√	√	√	√	√	√	X
Treatment	5	Chronic care model / NCD treatment protocols in ≥50% PHC facilities	X	√	√	±	±	±	±	±	X	±	±	x	√	–	X	√	X	X	√	X	√	X	√	X
	5	Quality-of-care cardiovascular disease or diabetes demonstration project	±	–	√	√	±	±	±	√	X	√	√	±	√	–	±	√	X	√	√	√	√	√	√	X

ANG: Anguilla; ANT: Antigua and Barbuda; BAH: Bahamas; BAR: Barbados; BER: Bermuda; BVI: British Virgin Islands; CAY: Cayman Islands; CWD: Caribbean Wellness Day; DOM: Dominica; FCTC: Framework Convention on Tobacco Control; GRE: Grenada; GUY: Guyana; HAI: Haiti; JAM: Jamaica; MON: Montserrat; NCD: non-communicable disease; PHC, primary health care; SKN: St. Kitts and Nevis; STEPS: STEPwise approach to surveillance; STL: St. Lucia; SVG: St. Vincent and the Grenadines; SUR: Suriname; TCI: Turks and Caicos; TRT: Trinidad and Tobago.

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