CARICOM 2nd Annual

Meeting of NCD Focal Points & Chief Medical Officers

MEETING REPORT

PORT OF SPAIN

REPUBLIC OF TRINIDAD & TOBAGO

DECEMBER 11TH - 13TH 2011

Supported by

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 8
INTRODUCTION 10

SUNDAY DECEMBER 11th 2011

SESSION 1: NCD FP Field Training (POS #10)

Expected Outcomes 12
Promoting population-based physical activity in Trinidad & Tobago 12
Ms. Yvonne Lewis
Impact of the "ciclovia" on Physical Activity of Diego Martin Residents 13
Dr. Shelly Mohan
Lessons Learned from 4 years of "ciclovia" in Diego Martin 16
Mr. Michael Phillips
Sponsoring the Diego Martin "ciclovia" 16
Mr. Gerald Hadeed
On-line Discussion Forum – NCD FP Field Training Implemention Possibilites and Challenges 20

SESSION 2: Opening Ceremony

Dr. Rudy Cummings 21
Programme Manager, Health Sector Development, CARICOM Secretariat
Dr. Akenath Misir 22
County Medical Officer, MOH, TRT
Prof. Samuel Ramsewak 23
Dean, Faculty of Medical Sciences, UWI St. Augustine
Dr. Ernest Pate 25
PAHO, Caribbean Programme Coordinator, OCPC, PAHO

SESSION 3: Surveillance (POS #11, #13)

Meeting Objectives 28
Dr. James Hospedales
POS NCD Declaration Status – Surveillance / NCD Surveillance Advances and Challenges 30
Dr. Beryl Irons

HIS and Surveillance in Belize 32
Dr. Aisha Andrewin
HIS and Surveillance in Dominica 33
Dr. Paul Ricketts
Outcomes of the IADB/RPG Regional Surveillance Project 34
Dr. Rohan Maharaj
Discussion on Surveillance 36
On-line Discussion Forum - Surveillance 39

MONDAY DECEMBER 12th 2011

Workshop design, process and outcomes, Review 1st NCD meeting 40
Dr. Alafia Samuels

SESSION 4: UNHLM on NCDs: Implications of Summit Declaration for the POS NCD Declaration

Expected Outcomes 42
UN HLM on NCDs: Making the Political Declaration work for the Caribbean 42
Dr. Karen Sealey
Global NCD Challenges & New Evidence: Best Buys 45
Dr. James Hospedales
Implementation of the Port of Spain Declaration on Non-Communicable Diseases: Lessons Learnt 47
Dr. Rudolph Cummings
Discussion UNHLM ON NCDS and POS NCD Declaration 49
Online Discussion UNHLM ON NCDS and POS NCD Declaration 53

SESSION 5: Advancing the NCD Agenda in Countries: NCD Policies (POS #1, 14)

Expected Outcomes 54
POS NCD Declaration Status and Definitions 54
Dr. Alafia Samuels
WHO Framework Convention on Tobacco Control FCTC in Caribbean Countries 55
Dr. Roberta Caixeta
Review of Regional NCD Legislation in support of NCDs 57
Ms. Monica Bolis
Advancing multisectoral NCD approaches through engaging with the Parliament in Surinamne 59
Dr. Lesley Resida
Discussion NCD Agenda 59
On-line Discussion NCD Agenda 61

SESSION 6: NCD Agenda in Countries (POS #2)

Second Annual NCD Focal Meeting 62
Dr Rudolph Cummings
Expected Outcomes 62
Utilizing the model NCD plan to write the Dominica NCD plan 62
Ms. Anthelia James
Implementation challenges for the Jamaica's NCD plan 63
Dr. Eva Lewis-Fuller
Disease Plan 2006 - 2011 66
Dr. Merlene Fredericks
Implementation challenges for the BVI NCD strategy and plan 68
Ms. Ivy George

TUESDAY DECEMBER 13th 2011

Workgroup Reports

Group 1: NCD FPs from countries with existing NCD Plans 71
Dr. Kenneth George
Group 2: NCD FPs from countries without existing NCD Plan 72
Ms. Petronella Edwards
Group 3: CMO Workgroup report, Implementation of the chronic care model 73
Dr. Michael Pitts
Discussion NCD Agenda in Countries 75
On-line Discussion 76

SESSION 7: Food Security (Trans fat elimination, sodium reduction, trade) (POS #7, 8)

Panel: Food Security, Salt and NCDs / Food Nutrition Security and Obesity /
NCDs What must be done 77
Dr. Fitzroy Henry
Food marketing and NCDs – The Way Forward 80
Dr. Fitzroy Henry
PAHO/WHO initiative for Cardiovascular Disease Prevention through dietary salt reduction 83
Dr Branka Legetic
Barbados NCD Commission initiatives in Salt Reduction 87
Prof Trevor Hassell
Discussion: Food Security 92

SESSION 8: Intersectoral Partners: Engaging with the Non-Health Sector (POS #12)

Expected Outcomes 94
Panel: Partners Forum – Pan American Forum for Action on Chronice Diseases:
Application to Caribbean 94
Dr. James Hospedales
Partners Forum Initiatives in TRT 96
Ms. Yvonne Lewis
Advances in the civil society movement in the Caribbean 99
Prof Trevor Hassell
Faith-based Initiatives in Jamaica 103
Dr Tamu Davidson
Talking with whom? Enhancing Media support for the NCD Agenda in the Caribbean 107
Ms. Dorrett Campbell

SESSION 9: Conclusions, The Forward Agenda for Cooperative & Regional Actions

Expected Outcomes 108
On-line Discussion Forward Agenda 113

Participants 114
Conference Evaluation 119

Appendices

Appendix 1
Impact of the "ciclovia" on Physical Activity of Diego Martin Residents *122*
Dr. Shelly Mohan
Appendix 2
Key Participants IADB/UWI Surveillance Project *124*
Appendix 3
Documentation of the POS Summit process and outcomes in peer reviewed journals *125*
Appendix 4
Examples of Best Buys from countries *1266*
Appendix 5
FCTC MPOWER *127*
Appendix 6
English speaking Caribbean legislative review *129*
Appendix 7
Status of NCD programme in Suriname *13030*

Appendix 8
Jamaica' demographic and risk factor profile *131*
Appendix 9
CMO Workgroup worksheet with scores – Implementing the Chronic Care Model *132*
Appendix 10
Definitions and the role of food and Nutrition in the Obesity and NCD epidemic *135*
Appendix 11
Expanded discussion on nutrition labels *136*
Appendix 12
NCD Risk Factors mortality in the Americas for Middle Income Countries *137*
Appendix 13
Initiatives in salt reduction *138*
Appendix 14
The Partners Forum - A Platform to Move Forward *139*
Appendix 15
Terms of Reference of the T&T Partners Forum *141*
Appendix 16
FBCs and NCDs in Jamaica: A Background 142

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BAMP	Barbados Association of Medical Practitioners
BPH	Bureau of Public Health
BHIS	Belize Health Information System
BMI	Body Mass Index
BVI	British Virgin Islands
CAREC	Caribbean Epidemiology Centre PAHO/WHO
CARICOM	Caribbean Community
CARMEN	Conjunto de Acciones para la Reducción Multifactorial de Enfermedades No transmisibles / Collaborative Action for Risk factor Reduction and Effective Management of NCDs
CARPHA	Caribbean Public Health Agency
CCH3	Caribbean Cooperation in Health 3
CCHD	Caribbean Commission on Health and Development
CCM	Chronic Care model
CCS	Caribbean Community secretariat
CDAP	Chronic Disease Assistance Programme (Trinidad & Tobago)
CEO	Chief Executive Officer
CFNI	Caribbean Food and Nutrition Institute PAHO/WHO
CHD	Coronary heart disease
CHOGM	Commonwealth Heads of Government Meeting
CMC	Caribbean Member Countries
CMH	Commonwealth Ministers of Health
CMO	Chief Medical Officer
COHSOD	Council on Health and Social Development
COMSEC	Commonwealth Secretariat
CRDTL	Caribbean Regional Drug Testing Laboratory
CROSQ	Caribbean Regional Organization for Standards and Quality
CSME	Caribbean Single Market and Economy
CVA	Cardio Vascular Accident (stroke)
CVD	Cardio Vascular Disease
CWD	Caribbean Wellness Day
DM	Diabetes Mellitus
ECC	Eastern Caribbean Countries
ECOSOC	The United Nations Economic and Social Council

EHR	Electronic Health Record
EPI	Expanded Programme on Immunization
EU	European Union
FBO	Faith based organisations
FCTC	Framework Convention on Tobacco Control
HBP	High Blood Pressure
HCC	Healthy Caribbean Coalition
HDL	High density lipoprotein cholesterol
HSS	Health systems strengthening
HIS	Health Information Systems
HIV	Human Immuno-deficiency Virus
GIS	Geographic Information Systems
GPA	Global Programme of Action
GSK	Glaxo Smith Kline
HELIUS	Healthy Lifestyle in an Urban Setting survey
IBLF	International Business Leaders Forum
IDB	Inter-American Development Bank
IEC	Information, education and communication
IFBA	International Food and Beverage Alliance
INCAP	Institute of Nutrition of Central America and Panama
IT	Information Technology
J&J	Johnson and Johnson
JHLS	Jamaica Healthy Lifestyles Survey
LDL	Low density lipoprotein cholesterol
LMIC	Low and middle income countries
MDGs	Millennium Development Goals
MI	Myocardial Infarction (heart attack)
MOH	Ministry of Health
MOU	Memorandum of Understanding
MPH	Master of Public Health
NCD	Non Communicable Disease
NCCNCD	National Commission for Chronic Non Communicable Diseases (Barbados)
NCD FP	Non Communicable Diseases Focal Point for the country
NGO	Non-Governmental Organization
NHA	National Health Authority
NHF	National Health Fund (Jamaica)
OCPC	Office of Caribbean Programme Coordination, PAHO/WHO
ODA	Official Development Assistance
OECS	Organisation of Eastern Caribbean States
OECD	Organisation for Economic Co-operation and Development
PA	Physical Activity

PAHO	Pan American Health Organization / WHO
PAHEF	Pan American Health and Education Foundation
PHAC	Public Health Agency of Canada
PHC	Primary Health Care
PLHIV	Persons living with HIV
PM	Prime Minister
POS	Port of Spain
PwC	Price Waterhouse
RHA	Regional Health Authority
RHI	Regional Health Institutions
RPAQ	Recent Physical Activity Questionnaire
RPG	Regional Public Good
SOP	Standard operating practice
STEPS	STEPWISE Approach to NCD Surveillance
STI	Sexually Transmitted Infections
TAC	Technical Advisory Committee
TAPS	Tobacco advertising, promotion and sponsorship
TCC	Technical Cooperation among Countries
TOR	Terms of reference
TRT	Trinidad and Tobago
UKOTS	United Kingdom Overseas Territories
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UN HLM	United Nations High Level Meeting
UWI	The University of the West Indies
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The second annual NCD Focal Point and CMO meeting was held Sunday December 11th – Tuesday December 13th 2011, in Port of Spain, Trinidad & Tobago. It was funded and supported by the IDB/UWI Surveillance project and PAHO (Head Office, and OCPC/PAHO, Barbados). The meeting was convened 3 months after the UNHLM on NCDs, for which the Caribbean led the advocacy, and which declaration was taken into account in this meeting.

These recently inaugurated (2010) annual NCD meetings are modelled on the almost 30 years of highly successful annual EPI managers' meetings, while recognizing that NCD prevention and control is more complex and nuanced than vaccine preventable diseases. This meeting therefore likewise, included field training, programme review and forward planning. There were 69 participants from 17 CARICOM member countries, the Trinidad & Tobago Partners Forum, CARICOM, HCC and support and participation from UWI, IDB, PAHO, CAREC and CFNI. The objectives of the meeting were to identify the implications of the outcome of the UN High-Level Meeting (UNHLM) on the Prevention and Control of NCDs for the Caribbean, in the context of the Declaration of Port-of-Spain and to critically examine progress and challenges in key components of the POS Declaration, and to identify priority actions to be programmed and the regional support needed.

The first session was the field training, through participation in, and discussion about the Caribbean first "ciclovia", Diego Martin's *Streets for Wellness*, where 2km of the Diego Martin highway is closed to motorised traffic from 6 – 9 am every Sunday morning to give the space to walkers, joggers, cyclists and for aerobics classes. Participants were presented with research evidence and testimonials about the effectiveness of this intervention for community cohesion and for personal fitness.

The opening ceremony heard presentations from Dr. Rudy Cummings, Chair, Programme Manager, Health Sector Development, CARICOM Secretariat, Dr. Akenath Misir County Medical Officer, MOH, TRT, Representing the CMO of TRT and Prof. Samuel Ramsewak, Dean, Faculty of Medical Sciences UWI, St. Augustine. The Feature Address was delivered by Dr. Ernest Pate, Caribbean Programme Coordinator, PAHO. All speakers agreed on the urgency of the NCD epidemic and the need for increased resources to address this crisis.

There were sessions with presentations and discussions on Surveillance, the implications for the POS NCD Summit Declaration of the recently concluded UNHLM, WHO Best Buys, Advancing

the NCD agenda in the Caribbean, including from PAHO advisors on tobacco and legislation, Food Security, and Engaging with Partners.

The meeting also included the formal 2nd Annual NCD Focal Point meeting, focused on NCD plans and implementation challenges in countries, while noting advances in country plans and follow up to POS. The CMO workgroup considered the priority and feasibility of implementing recommended features of the chronic care model. Prof Trevor Hassell, Chairman of the Barbados NCD Commission, the oldest commission in the region, briefed incoming Commission chair from Jamaica, Dr, Rosemarie Wright-Pascoe. The final session discussed regional priorities for supporting countries in implementing their own NCD agenda.

A web-site was established for the meeting and will continue to be available. It is hosted by UWI Cave Hill and includes all the background documents, on-line discussion fora, evaluations, and a library. This information was also provided on CD in an attempt to make this a largely paper-less meeting. The meeting was evaluated as being well organised with high quality presentations and a relaxed atmosphere. However, the recommendations for next meeting included a bigger conference room, fewer topics to cover, and more time for work groups.

NCD Forward Agenda

The UN Declaration on NCDs is broader than POS Declaration, so there needs to be a common instrument that will satisfy both. Now that the priority problems and proposals have been identified by this meeting, a planning step is needed now to revise the regional plan taking into consideration the NCD meeting and UNHLM and the reporting requirements from UNHLM. However, it is unlikely that there will be a "POS + 5" summit of Heads this year, but NCD should be on the July agenda, with the evaluation report to Heads in 2013.

OCPC should visit the CARCICOM Secretariat, and in collaboration with the CARICOM Health Desk, participate in briefing the new Secretary General and advocating for "buy in" to the multisectoral NCD agenda from Heads of Divisions and SG on how to more effectively drive the POS declaration. The NCD meeting for 2012 will likely not have IDB support a crucial partner in the past two years, so alternative supports will need to be identified. This would be a key responsibility of the NCD secretariat, and should be included in the briefing and discussions on how CCS is to function in support of the regional NCD agenda.

Regionally, the top priorities for 2012 are:

1. Country level NCD Plan developed and operationalized.
2. Further definition of targets and strengthening surveillance at country level.
3. Multi sectoral involvement in the NCD agenda at country and regional level.
4. Mobilisation of resources in country and capacity building through regional supports.

Introduction

The Caribbean Community (CARICOM) Heads of Government issued the historic 2007 Port of Spain Chronic Non communicable Diseases (NCD) Summit Declaration and led the global advocacy that resulted in the September 2011 United Nations High Level Meeting (UNHLM) on NCDs. While there have been significant achievements in implementing some of the fifteen (15) mandates of the POS Declaration (POS #1 - #15) in the region, much more needs to be done. The challenge of tackling chronic conditions requires a systematic response, as used in the EPI (Expanded Programme on Immunization), which included among other things Caribbean wide policies and protocols, surveillance and regional procurement of pharmaceuticals, anchored by annual EPI programme managers meetings. These annual CMOs / NCD focal points meetings are modelling the successes of the EPI approach. The inaugural NCD meeting was held at the University of the West Indies, St. Augustine Campus on September 1st and 2nd 2010.

This second annual CARICOM NCD meeting was held from Sunday December 11th to Tuesday December 13th 2011 in Port of Spain. The PAHO/WHO regional office of the Americas, and its agencies – Caribbean Food and Nutrition Institute (CFNI), the Caribbean Epidemiological Centre (CAREC), and the Office for Caribbean Programme Coordination (OCPC) supported this meeting in keeping with their longstanding partnership with CARICOM, along with supports from the Inter American Development Bank (IDB) funded Regional Non-Communicable Diseases Surveillance System Project for the development of capacities in health protocols and policies for regional harmonization of public policy.

Objectives

1. To identify the implications of the outcome of the UN High-Level Meeting (UNHLM) on the Prevention and Control of NCDs for the Caribbean, in the context of the POS Declaration: Uniting to stop the epidemic of Chronic NCDS;
2. To critically examine progress and challenges in key components of the POS Declaration identifying priority actions to be programmed and the regional support needed for:
   a) Food Security;
   b) Effective inter-sectoral approaches;
   c) Review of the results of the UWI/IDB Surveillance project
   d) Review of the experiences among NCD Focal Points and Chairs of the multi-sectoral coordinating mechanisms and identified common needs, including for capacity building

Main Outputs

1. Assessment of advances in Regional and country plans, successes, gaps and needs to advance with POS commitments;
2. Confirmed mechanisms of engagement, roles and responsibilities of different actors (centres, countries, university, partners); and
3. Identification of next steps to advance country NCD agenda and the regional support needed.

SUNDAY DECEMBER 11TH 2011

SESSION 1: NCD FP Field Training (POS #10)

Expected Outcomes

- *Knowledge of the impact of the Diego Martin Family Fun Day on community knowledge, attitude and practice of physical activity*
- *Enhanced capacity of NCD FP for forming partnerships for physical activity promotion and implementation*
- *Field training of NCD FP in the logistics of implementation of sustained community based physical activity programmes, including facilitating and retarding factors*

Background

Diego Martin, in POS, TRT, has maintained CARICOMs only "ciclovia" for the past four years, beginning on the first Caribbean Wellness Day in 2008. Led by cycling enthusiast Michael Phillips, every Sunday from 6 – 9 am, 2 km of the new highway in Diego Martin is blocked to allow community residents the space to participate in physical activity. The POS NCD Summit Declaration encourages this community based mass physical activity, so Session 1 of the 2nd NCD FP meeting was field training in mass physical activity using the Diego Martin experience.

Field Training

By 7.00 am, 12 participants were at the Diego Martin "ciclovia"/Community Physical Activity event. All walked the 1 mile course and most participated in the one hour aerobics session. Following the re-opening of the road to regular vehicular traffic, was the roundtable with presentations and discussions.

Promoting population-based physical activity in Trinidad & Tobago

Ms. Yvonne Lewis, Chair

MOH, Director of Health Promotion, TRT

Ms Lewis welcomed the participants and the twelve (12) visitors and advised that since "ciclovia" was a Spanish word, reflecting the origin of this initiative, TRT called it "Streets for Wellness" or

"Keep Moving Family Fitness Sundays", which is a "ciclovia like" community physical activity initiative which takes place every Sunday morning, from 5:00 am to 9:00 am on a stretch of the Diego Martin Highway.

Four community members shared their experiences of participating in the "ciclovia". The main point they all made was the impact of the event on community cohesion, meeting neighbours on the track that they had not known before which created a greater sense of community. They also pointed to the impact of this regular physical activity on their physical and mental fitness, and they all took the opportunity to thank Michael Phillips and the sponsors for maintaining this initiative every Sunday for the past four years.

Impact of the "ciclovia" on Physical Activity of Diego Martin Residents

Dr. Shelly Mohan

Medical Officer, MOH, TRT

Dr. Mohan made the first presentation and shared the results of her MPH programme research. See Appendix 1 for full report.

Chronic Non Communicable Diseases (NCDs) account for six out of ten deaths worldwide and this impact is projected to worsen unless urgent public health action is taken to control the modifiable risk factors, namely tobacco use, alcohol abuse, poor diet and physical inactivity. Inadequate physical activity has devastating health and economic consequences, causing 6% global mortality with significant economic consequences. Physical inactivity is prevalent worldwide with the highest rates being in the Americas where 50% of women and 40% men are inactive. Similar to other countries in the region, in Trinidad and Tobago 39% of population and 74.2% students aged 13- 15 years are insufficiently active. Therefore there is urgent need to improve physical activity (PA) levels.

Community based interventions have been identified as efficacious and cost effective in improving PA levels. One such effective intervention is the "ciclovia" (bicycle way), a regular mass recreation event facilitated by temporarily closing streets to motorized traffic to allow exclusive access to individuals for leisure activities.

The English speaking Caribbean's first "ciclovia" is this one in Diego Martin, which was started on the first Caribbean Wellness Day, Sept 13th 2008. Every Sunday since then, from 6am to 9am a 2 km long (Diego Martin Highway) has been blocked for Family Fun Sunday, for walkers, joggers, cyclists, skateboarders, and includes a Physical Activity class.

There was need to assess the local applicability and effectiveness of this “ciclovia”, hence a random cross sectional study was done. A modified RPAQ (Recent Physical Activity Questionnaire) was administered during face to face interviews with 137 residents. The main findings were that 56.2% were physically active, while 43.8% were physically inactive. The majority of residents (82.5%) knew about the “ciclovia”, 19.7% had participated before and 10.2% currently participate. Most participants spend 1 - 2 hours at the “ciclovia”. Knowledge of the “ciclovia” and having ever participated were positively associated with leisure time physical activity, which is consistent with regional studies.

In conclusion the results of this study suggest that the “ciclovia” can be used as an effective mechanism to improve population physical activity levels, however recommendations were suggested to improve “ciclovia” participation, such as having more attractions, increasing media involvement and greater intersectoral collaboration.

Dr. Shelley Mohan, Medical Officer, Ministry of Health presents results of her study on the impact of the ciclovia on physical activity levels in residents of Diego Martin

Ms. Hyacinth Chow (centre) and Ms. Jacinta Mitchell (right), UWI IDB project, with fruit for the ciclovia

Mr. Michael Phillips, (Mike's Bikes), the driving force behind the four years of Weekly "ciclovia" in Diego Martin. Seated at the projector, Ms. Yvonne Lewis, Director of Health Promotion, MOH, TRT

Lessons Learned from 4 years of "ciclovia" in Diego Martin
Mr. Michael Phillips

Primary Organizer, Diego Martin "ciclovia"

Mr. Michael Phillip, the person who started the Diego Martin Ciclovia, shared that as a national cyclist, he had visited Colombia and personally witnessed the ciclovias there. He indicated that when he did a check of his community of Diego Martin, he recognised that there was no park or recreational facility in the densely populated area. He then approached several agencies from both the public and private sector to support the establishment of the 'Keep Moving Family Fitness Sunday'. He shared that the initiative had brought persons from upper middle class and lower socio-economic communities together as an unintended consequence of the program.

He thanked the community for their support, especially the local Laundromat which provides the electricity for the sound system, the Fitness Instructor, the police and ambulance services, and the Beacon Insurance Company, Mike's Bikes and the Ministry of Sports for their support. He discussed the logistical challenges of getting out each Sunday by 5.00 am to start the set-up, with cones in the road to block traffic and appropriate signage, tents and music. There is also the parallel activity of cyclists assembling at Diego Martin, and going out for a longer ride with police escort. He also thanked his brother.

Sponsoring the Diego Martin "ciclovia"
Mr. Gerald Hadeed

CEO Beacon Insurance

The major sponsor is Mr. Gerald Hadeed, CEO Beacon Insurance who at 73 years old is an active participant and cyclist at the "ciclovia". He expressed his pleasure at being associated with this community intervention and thanked the group for his own improved level of physical fitness.

The health promotion officer from the Ministry of Health described the Exercise by Prescription/Exercise is Medicine intervention which is implemented at the Petit Valley Health Centre in the North West Region. Exercise is prescribed by Health Care Provider and a trained Physical Activity instructor works with the clients in the exercise facility in the Health Centers, 3 times per week – one hour each to facilitate physical activity with the clients.

In the Eastern Region there was formal training of community members as physical activity instructors. Some were later kept on as staff, and utilised to implement Well-weight

Management programs which targeted community members who were overweight or obese. This initiative included screening and monitoring of BMI, nutrition education and aerobic exercise. The exercise component is conducted twice per week in a dedicated areas of the Health Centre call the Wellness centre, which can be made accessible to the community after the health centre is closed.

Yvonne Lewis also shared that "ciclovias" such as the Diego Martin initiative had been implemented since 2008. Port of Spain had been made a walk able city in observance of the first Caribbean Wellness Day. Several "Streets for Wellness" were implemented in San Fernando and Valencia. However Diego Martin was the only one that was sustained.

Dr. Samuels thanked the participants for coming, and the organizers for facilitating us. She challenged the representatives from other Caribbean countries to replicate this or similar type event in their own countries. Fruit and water were served.

NCD meeting participants at Field Training in Diego Martin

Mr. Gerard Hadeed, CEO, Beacon Insurance, sponsors the ciclovia and participates weekly

The youth taking advantage of the blocked roads as "streets for wellness"

Exercising at Diego Martin "ciclovia"

Aerobics Instructor takes us through our paces

On-line Discussion Forum – NCD FP Field Training Implementation Possibilities and Challenges

- The main driver of the activity lies outside of the Ministry of Health. This seems to be a significant contributor/determinant to the sustainability of the activity. This must be kept in mind as we seek to replicate the Diego Martin experience. A sound knowledge of our communities will be necessary. The search for community leaders may be done through an examination of present collaborations between the health sector and our social partners. This must be the first step in replicating the experience

- One challenging factor will be resources, both financial and human. Trained personnel need to identified and be attracted to the programme. The present declining economic conditions in many of our countries may limit the ability of Governments to make and keep financial commitments. Social partners with a high level of commitment are difficult to find. When they are available, they must be encouraged and serve as models to motivate other members of the community. Generally, our country is weak on communication. Any replication will require significant advocacy and communication with and among all stakeholders.

- Notwithstanding the difficulties above, there are several opportunities. There is greater awareness regionally regarding NCDs, and thus greater preparedness to respond. This comes on the heels of the POS declaration and UNHLM. Furthermore, every single person knows of someone who is affected, or has died due to a NCD. If we keep the focus on high yielding low costing intervention like an exercise programme, this will encourage governments to contribute more. There are several issues affecting our communities including crime. Many are willing to take collective actions in response to this threat. It presents an opportunity to integrate into community action response to NCDs.

SESSION 2: Opening Ceremony

CARLTON SAVANNAH HOTEL

Dr. Rudy Cummings, Chair

Programme Manager, Health Sector Development, CARICOM Secretariat

Immediately following a welcome luncheon, Dr. Rudy Cummings, Program Manager, Health Sector Development, CARICOM Secretariat welcomed the participants to the meeting and introduced the speakers. He conveyed greetings from the Secretary General of CARICOM, Ambassador Irwin LaRocque and from Mrs. Myrna Bernard, Officer in Charge of the Human and Social Development Directorate.

Dr. Cummings noted that this meeting was being convened in the fifth year since the historic CARICOM Heads of Government Summit on Non Communicable Diseases which issued the 15 point Port of Spain Declaration which addressed many of the issues regarding the prevention and control of NCDs.

Since that time, the CARICOM Secretariat has played a pivotal role in international advocacy for NCD control as our Heads of Government have continued to acknowledge the importance of NCDs in the Caribbean and the world. The advocacy of our Headscontinued in 2009 with the Summit of Americas declaration on NCDs in April and the November CHOGM Declaration leading to global awareness and advocacy inThe United Nations Economic and Social Council (ECOSOC). This allowed the UN Secretary General to be mandated to do a review of NCDs and convene a global meeting which was held on September 19 and 20th 2011 at the United Nations in New York. This UNHLM on NCDs was a glorious highpoint for Caribbean advocacy, and was helped by PAHO, UWI, IDB, and the HCC chaired by Prof Trevor Hassell, as we projected the Caribbeans' view and advocacy through a number of side events.

The international community recognised the leading advocacy role of the Caribbean. Ambassador Raymond Wolfe of Jamaica was appointed co-chair with Luxembourg, of the working group that crafted the political statement representing the import of CARICOM.

CARICOM had at least 9 Heads of Government present at the UNHLM, and the Opening Statement was made by Suriname's President H.E. Dési Bouterse on behalf of CARICOM, setting the tone for the meeting. St. Kitts and Nevis' Prime Minister, the Hon. Dr. Denzil Douglas, chaired the third roundtable, and also presented his country's report in the General Assembly.

CARICOM hosted one of the most important side events on Monday, chaired by Sir George Alleyne, showcasing our regional programmes and global advocacy, which were well recognized, eliciting statements in support of our efforts from the global community present. This generated an immense sense of pride for Caribbean nationals. These were significant meetings for Caribbean, where we were able to demonstrate the political commitments which convinced many that we were serious about NCDs. The final declaration, while it did not contain everything that we wanted, it does point the way forward for global action for NCDs.

This meeting therefore is taking place against the backdrop of very important recognition of our Caribbean social agenda, and participants should work hard to meet the meeting objectives so as to sustain these efforts. Since the POS NCD Summit Declaration, the celebrations of Caribbean Wellness Day have brought an intense sense of pride. The UN has even proposed a similar global celebration of NCD efforts. In the Americas Wellness Week in September was promoted by PAHO, inspired by CWD. There has been a fair amount of work re advocacy on tobacco, though still more to be done.

A lot of what needs to be done is intense political strategy. The Commonwealth will present an NCD report to Ministers and Heads of Government regularly. The CARICOM website on-line publication, CARICOM View is on NCDs this month.

There has been great collaboration between the CARICOM Secretariat, PAHO, UWI and IDB providing resources to support both the NCD meeting this year and last.

Dr. Cummings ended his presentation by expressing appreciation for the NCD work being done at regional level by Dr. Alafia Samuels, e.g. the regional NCD plan, PHC and Chronic Care policies, representing the region at meetings in the Pacific, monitoring the implementation of the POS Declaration, publication of the regional newspaper supplement and the coordination of Caribbean Wellness Day.

Dr. Akenath Misir

County Medical Officer, MOH, TRT

Representing the CMO

The Chair then introduced Dr. Akenath Misir, who the meeting was advised, has been selected to be the next Chief Medical Officer of Trinidad and Tobago. He represented the current CMO, Dr. Anton Cumberbatch. Dr. Misir welcomed the participants to Trinidad and Tobago and asked everyone to introduce themselves.

He advised that is was very important to understand the significance of this exercise. Having advocated for, and gotten the UNHLM, we now need to work on implementation and delivery. Important outcomes of this meeting are to get plan, programme and projects deliverable.

On behalf of the Government of Trinidad and Dr. Misir welcomed the participants and wished for a productive workshop, strengthening of regional camaraderie and improved service to the people of the region.

Dr. Akenath Misir, County Medical Officer, MOH, Trinidad & Tobago and Prof. Samuel Ramsewak, Dean Faculty of Medical Sciences UWI, St. Augustine were speakers at the Opening Ceremony

Prof. Samuel Ramsewak

Dean, Faculty of Medical Sciences, UWI St. Augustine

Prof. Samuel Ramsewak recalled the first meeting of the UWI/IDB Surveillance project in 2007 with just eight people setting sail with cargo for the benefit of our islands, and expressed pleasure to be here to see where we have reached. He congratulated all associated with the project, including UWI academic, Prof. Paul Teelucksingh.

He welcomed the participants on behalf of UWI to this 2nd Annual NCD meeting. The framers of the POS NCD Summit Declaration were aware of the role of multiple partners, including the UWI, in addressing the needs. The Declarations point #13 states:

> *That we will establish, as a matter of urgency, the programmes necessary for research and surveillance of the risk factors for NCDs with the support of our Universities and the Caribbean Epidemiology Centre/Pan American Health Organisation (CAREC/PAHO);*

He was pleased that this has happened, and hopes for a long, fruitful and sustainable relationship between members and UWI. Many of the participants here are graduates of the UWI, and working with us, have a sense of ownership as part and parcel of archipelago, seeing difficulties and seeing solutions. We know each other well, so it is easy to band together in recognizing the urgency of the NCD challenge. This includes the dangers of obesity which underlies many of the NCDs. Childhood obesity has tripled in the region in the last 10 years, outstripping many of the developed countries.

As a region, we have worked towards a common cause and purpose. It is not the size of the nation, but the contribution that will commend it as a force. We should be proud of the achievements of the partnerships.

The UWI/IDB project will show international agencies that we can deliver on proposals thus increasing our credibility to a) Define the problem; b) Make the proposal; and c) Deliver on the promise. He was happy to have been part of the process which delivered and commended all the partners.

UWI is proud to be a partner and co-sponsor of this meeting, to share information and collectively advance individual nations and ultimately the region. Special thanks to IDB and PAHO/WHO, who saw value of the project.

Special recognition was paid to Sir George Alleyne, UWI Chancellor, the Vice Chancellor, Prof. Nigel Harris and Ms. Hyacinth Chow and the other UWI/IDB staff. He offered commendation to all with a wish for success.

Dr. Ernest Pate, Caribbean Programme Coordination, PAHO, Dr. Rudy Cummings, CARICOM Health Desk – speakers at the Opening Ceremony

Dr. Ernest Pate

PAHO, Caribbean Programme Coordinator, OCPC, PAHO

The Feature Address was delivered by Dr. Ernest Pate, Caribbean Programme Coordinator, OCPC, PAHO/WHO who conveyed greetings on behalf of Director of PAHO, Dr. Mirta Roses, who has a keen interest that follow-up work in the Caribbean be strengthened, demonstrated by the financial and human resource support put into this area. He also conveyed greetings on behalf of colleagues who work in country offices of PAHO.

The Caribbean has come a long way since 2007 making tremendous strides, thanks to some stalwarts who have pushed this area, but there is more work to be done.

The data confirms NCDs as the leading cause of death globally, with higher rates in low and middle income countries than in high income. There is a need to look at the economic cost and impact of the NCD epidemic on those countries, where they are impeding development, as well as the impact on individuals. NCDs are now usually detected when there are already complications and the cost of interventions then are significant, and that cost is not only that of the health care system. Out of pocket expense is significant, often ranging from 50 – 70% of expenditures which can drive individuals into poverty, and diminish other aspects of family development.

We should examine the health and economic impact on development. Globally of the 57million deaths annually, 63% are from NCDs big 4. With aging, we are going to see even more of a challenge. In LMIC, those with NCDs die at a younger age due to complications, late diagnosis and sub-optimal health care delivery services.

Challenges and Needs

We do not have accurate data on NCDs from countries, which are needed to plan and monitor death and disability from NCDs. Mortality surveillance needs strengthening, not just in the Caribbean, but globally, and the OCPC is tackling this.

How can we get governments to put the needed financing in place? This has been discussed and promises made, but the allocation of funds has not happened, and if the resources are not in place, we will not be able to tackle this epidemic. This epidemic is now beyond capacity of low income countries to reverse, and without resources, we cannot make the impact. NCD plans will need commitment and resources to implement.

WHO has data to advise which interventions are "Best Buys", e.g. increased tax on tobacco and alcohol, nicotine dependence treatment, breast feeding and complimentary foods, foods in schools, physical activity in populations, taxation. In many areas, we have data, but don't have the means to expand and scale up to national programmes. The challenge is to move from discussion to implementation. We talk prevention, but interventions are carried out for acute events in hospitals, and this is too costly, much more expensive than prevention. We need to move to prevention, but this needs a reorientation of your health services to the PHC approach, and to look at the efficiencies in the health care systems.

Priorities

We need to improve country capacity, and strengthen the health services. We can use draft policies to develop country plans and policies, including NCDs. Once plans are in place, we lack the capacity to move from a plan on paper to financing and implementation at operational level. The 2010 evaluations by the NCD group in Geneva showed the same problem globally. Some countries started funding NCDs, but with the financial crunch, the budgets decreased.

We need advocacy to policymakers to increase their awareness of the need for a comprehensive approach, since many policymakers do not have the level of awareness. They should know that NCD interventions need to start early in life, through adolescence and into adulthood. The countries that have successfully tackled and reversed their NCD epidemics have used a comprehensive approach, targeting risk factors at population level, but also utilized both treatment and prevention using multisectoral interventions. For example, Finland who was

main producer of beef and butter, exported it and imported food with lower fat content, which contributed to the dramatic decline in CVDs there. Here, it is difficult to implement some of these measures. We need to involve Ministries of Trade, Tourism, Agriculture and other intersectoral partners, since many determinants lie outside of the health sector.

We need data to show the cost of NCDs to populations, as well as cost effectiveness data, including in resource poor environments with competing need, and to get buy-in by demonstrating the impact on sustainable development.

This meeting then is very timely and builds on excellent work over the last 7 – 10 years. We must improve our collaboration with other stakeholders and other government sectors. We need a framework and tools to do that. We need to help many of the small countries with implementation, after identification of needs at country level, and PAHO can help. Congratulations on the good representation of member countries at this meeting.

In order to translate policy into practice, our priorities must be:

- Moving from Plans to Implementation and Operation
- Increasing funding to match the epidemic
- Advocacy and Awareness especially with policy makers
- Strengthening surveillance and monitoring – providing evidence for policy makers, highlighting the impact on development
- Comprehensive and Multi-sectoral approaches
- Banding together communities on legislation and activities
- Support at regional and country level for implementation

Dr. Cummings thanked the speakers and closed the Opening Ceremony.

SESSION 3: Surveillance (POS #11, #13)

Dr. Eva Lewis-Fuller, Chair

CMO, Jamaica

Expected Outcomes

- *Regional NCD surveillance immediate priorities*
- *Country Health Information systems (HIS) immediate priorities*

Dr. Lewis-Fuller said that she was honored to chair this 3rd session on surveillance. She wanted to start by specially recognizing our colleague Dr. Alafia Samuels as the catalyst for NCD prevention and control in the region and internationally. She has promoted collaboration and provided tools and technical resources for example with the POS NCD evaluation grid which everyone now uses.

She then invited Dr. James Hospedales, Senior Advisor NCDs, PAHO WDC to speak about the meeting objectives.

Meeting Objectives

Dr. James Hospedales

Senior Advisor NCDs, PAHO WDC

We were referred to the objectives of meeting on page 2 of the agenda. Dr. Hospedales then made the point that the NCD light arose in this planet in this region, then spread to the rest of Americas and then globally, 4 years after the CARICOM NCD Summit.

Food security and multi-sectoral interventions for food are mentioned 17 times in UNHLM document. Technically, we know what to do, but how do we work intersectorally within government and with all of society? This is the big challenge. We should share experiences and identify common needs. This meeting is modelled on the EPI Annual Managers meeting. The first EPI meeting was held 30 years ago. The first NCD Focal Points meeting was last year, so this is a new era.

He ended by reminding the meeting of the commitment by PAHO to support an external evaluation of the implementation of the POS Declaration before end of 2012.

Participants at the Opening Ceremony

Dr. James Hospedales
Unit Chief NCDs, PAHO

Dr. Beryl Irons
Director, CAREC

POS NCD Declaration Status – Surveillance / NCD Surveillance, Advances and Challenges

Dr. Beryl Irons
Director, CAREC

The four main NCDs responsible for the greatest burden are cardiovascular diseases, diabetes, cancer and respiratory diseases and these also contribute to 75% of all deaths in the Region of the Americas. Twenty-five percent (25%) of deaths from NCDs are premature and could be prevented by addressing modifiable risk factors such as tobacco use, unhealthy diet, insufficient physical activity and harmful use of alcohol. By eliminating modifiable risk factors, an estimated 80% of heart disease, stroke, Type 2 diabetes and 40% of cancers would be prevented.

Disease surveillance is expected to provide information for action at country, regional and global levels as well as for strategic planning, development and evaluation of policies and targeted interventions for the population and individuals.

The NCD surveillance programme includes surveillance of risk factors for prevalence and trends, morbidity incidence and prevalence, mortality surveillance through age-standardized death rates, Potential Years of Life Lost (PYLL) and premature mortality. The priority diseases/conditions for inclusion in NCD surveillance are heart disease, stroke, cancers, type 2 diabetes and chronic respiratory diseases. Available data on respiratory diseases is sparse.

NCD surveillance data should be available through routine data collection from the health systems e.g. Disease Registries (cancer, stroke) and hospital discharge data. Other data sources include periodic population-based Risk Factor Surveys and mortality data. Morbidity surveillance that can provide invaluable data is not formally organized.

Eleven (11) CAREC Member Countries (CMCs) have completed national Risk Factor surveys with 8 using the Pan Am STEPS methodology. Annual NCD Minimum Data Set reporting by countries began in 2010 and 14 countries submitted at least 1 report to CAREC - Aruba, Barbados, Bahamas, Belize, Bermuda, BVI, Dominica, Grenada, Guyana, Jamaica, St. Lucia, St. Kitts & Nevis, St. Vincent & Grenadines, Suriname CAREC and the CMCs are experiencing challenges re the surveillance of NCDs. The main challenges faced are inadequate human and financial resources. There is also inadequate involvement of the sub-regional Centres in the development of studies related to chronic diseases and their risk factors for example, Adolescent surveys, Tobacco surveys and School Health surveys. Countries also have limited capacity for research, leadership/supervision, data collection, data analysis and report writing. The health information systems of many countries remain inadequate and reports are not

prepared and available on a timely basis. The disease registers are not well maintained and most are not population-based due to resource limitations.

Countries need to be commended for the effort that is being made to address the issues. However for many countries financial commitment is still required.

Prof Trevor Hassell, Chairman, Healthy Caribbean Coalition

Dr. Alafia Samuels, Meeting Facilitator, Dr. Rudy Cummings, CARICOM Health Desk, Dr. Karen Sealey, PAHO/WHO

HIS and Surveillance in Belize

Dr. Aisha Andrewin

National Epidemiologist, Belize

Belize has a multi-ethnic population of 320,000 with 44% urban and 25% > 60 years. The public health sector is Primary Care based, administered in six districts divided into 4 administrative health regions. About 75% of the population uses the public system.

The Health Information System utilizes information mainly from the MOH but also from a number of other sources and has been developed with technical and monetary support from UWI, PAHO/WHO, CAREC, CHRC and other UN agencies. Private health providers submit reports on communicable diseases, birth and mortality. The Statistical Institute of Belize (SIB) regularly collect population, education, vital statistics, agriculture and health information as well as the national census, the family health survey and others. The Vital Statistics Unit registers births, deaths and marriages and collaborates with health officials to validate the births and deaths.

The Ministry of Health is the main the generator and user of health data and the Belize Health Information System (BHIS) is the main tool for data capture. It is a web-based system designed to be used in all types of health facility and by all sectors, clinicians, administrators, lab technicians and pharmacists. The data is captured in "real time" using electronic medical record (EMR), and includes maternal & child health; laboratory; pharmacy, financial, human resources and supply chain management (SCM). Once entered into the BHIS the information becomes immediately available to the epidemiology and surveillance unit at the MOH; and can be accessed from anywhere with an internet connection.BHIS is a powerful tool, already strategically placed for NCD information capture. It is supported by strong intersectoral collaborations and existing relationships e.g. with the NHI group with their comparative advantage in monitoring and evaluation tools and auditing and the NCD Commission. There are dedicated IT & EPI professionals with strong support from the Director of Health Services. The data collected is used to inform health intervention decisions. Risk factor surveillance was done in 2006 through the Central American Diabetes Initiative. Also Global Youth Tobacco Survey in 2008 and Global School Health Survey in 2011.NCD minimum data set has been submitted to CAREC

Priorities going forward include the need to ensure collection and collation of critical information for use in policy, planning and implementation. For example Inpatient and outpatient, hospital morbidity and mortality data including those in the private sector, National

registries for selected diseases (Cancer, Diabetes), risk factors data, monitoring and evaluation of all programs related to prevention and control of major NCDs, monitoring standards of care (audits), research and special studies on NCDs including representation and inclusion of the private sector.

There is need for Increasing the capacity for staff especially health informatics for the National Epi Unit which will be a health systems strengthening initiative. This should focus on the already known gaps in information, e.g. a comprehensive epidemiological picture of NCDs, information of the health effects and impact of alcohol use, data on the economic costs of NCDs and impact assessment of interventions.

Potential areas for regional support include technical support in data analysis, health informatics (report building and data analysis utilizing EHR), disease registries, monitoring and evaluation tools e.g. from CHRC, SOPs (standard operating practice) and financial support to conduct risk factor surveys and impact assessment studies.

HIS and Surveillance in Dominica

Dr. Paul Ricketts

National Epidemiologist, Dominica

The HIS policy framework includes at the International/Regional level, the Port of Spain NCD Summit Declaration of 2007. At the national level, there is the National NCD declaration, National Policy on NCD, Violence and Injuries and the National Strategic Plan for Health, 2010-2019.

The data sources include data from the public health sector, including institution-based data. It is a hybrid system with data capture on paper in health care facilities, paper and electronic (email) data transfer, data entry at the Health Information Unit, analysis, reporting and dissemination electronically, oral reports and limited in print. The information generated is for both internal use and for regional/international agencies.

The HIS benefits from close collaboration with key departments like the Central Statistics Office for socio-economic data, the Registry for vital statistics and the Police. The HIS system is being strengthened by the CDB Hospital Project, People's Republic of China, PAHO, CAREC, CDC/PEPFAR and volunteers

The E-Government Regional Integration (EGRIP) is funded by the World Bank, and includes St. Lucia, St. Vincent & the Grenadines, Grenada and Dominica. It includes a legal framework, policies and guidelines.

There is surveillance of NCD mortality and morbidity data and the technology can be used to enhance efficiency with surveys, reported indicators and methods of dissemination.The first national survey of NCDs and their risk factors has been completed and the results used to inform national policy and program development. A second survey is being planned for 2013.

Key Challenges include the need for dedicated resources. Human resources enhancement needs include work analyses, the need for new positions – statisticians, information officers, ICT/HIS trainers, health economists. System resources needed include hardware & software, funding for recurrent costs and special surveys. There is need for improved data quality, change management.

There is increased demand for data/information. Opportunities for strengthening the system include the ICT/HIS initiatives, Inter-sectoral and inter-disciplinary collaboration at country level, and at regional/sub-regional level e.g. CarHIS, OECS EGRIP, UWI/IDB NCD Surveillance Project.

It is proposed that virtual teams be formed at regional level to support HIS and Surveillance

Opportunities for funding and technical assistance through partnerships with regional and international partners

Outcomes of the IADB/RPG Regional Surveillance Project

Dr. Rohan Maharaj

UWI, St. Augustine

The IADB/RPG (Regional Public Goods) Regional Surveillance Project was in response to transnational challenges or opportunities for collective action among the countries in the region. The components of the project were first, strengthening the surveillance systems including a gap analysis with highlights and recommendations for the features of an appropriate IT system. The second component was the development of an IT platform for NCD surveillance and third, developing regional policies and protocols.

Project Milestones were the 2007 convergence of ideas on the need for data generation and use by the UWI, Ministries of Health, IADB and Sir George Alleyne. In 2008 the inaugural Steering

Committee was held at St. Augustine, the UWI and IADB signed the agreement and the project coordinator was hired. In 2009, the 6 participating countries and CAREC signed the agreement, the second steering committee meeting was held in St Lucia and the GAP analysis began. In 2010 the case study was completed, the IT infrastructure work began, the inaugural NCD Focal Point / CMO meeting was held in St. Augustine and the Midterm Evaluation review meeting was held in Barbados. In 2011 the model PHC and Chronic Care policies were developed, the project made a presentation to CARICOM Ministers of Health in Georgetown, the 2nd Annual NCD Focal Point / CMO meeting was held in Port of Spain, discussion were held with CAREC/PAHO for handing over of the software and IT platform and the wrapping up of the project.

The gap analysis of the six IDB countries revealed a lack of data reliability and validity, a manual paper-based data collection, processing and reporting which was not integrated. There was also a lack of standard instruments for NCD data collection and reporting. The recommendations included improvements in mortality data, registries, improved Health Information System, which should be web-based with a central data repository, secured user access, online registration and confirmation with access, user friendly data reporting, spreadsheet data upload, an intuitive and methodological query tools and administrative capabilities to create and modify reporting tools

Revised Primary Health Care and Chronic Care model regional policies were developed through an iterative process and approved by the CMOs and then by the Ministers of Health. The project also supported two annual meetings of CARICOM NCD focal points and CMO meetings.

Additionally a pilot project for point of care screening for NCDs was carried out. The aim of this was to determine the prevalence of NCDs at a walk-in clinic in Trinidad and establish the cost of identifying high, medium and low risk patients with NCDs. 514 patients participated, and the cost ranges from USD $2 902 – $20 317/ high risk patient, USD $540 - $1 069 / medium risk patient and USD $152 – $294 / low risk patient. A previous study of the mass screening of children for diabetes suggested that at USD $4 286/ patient the project was cost effective.

Other outputs included the notable achievement of using an independent regional institution (UWI) as a convener of the project, executing agency, technical advisor and intermediary between IDB and countries which formed a formal commitment to the project by each country and extended the matrix of responsibility beyond UWI. This created significant stakeholder participation. (Key participants are listed at Appendix 2).

Discussion on Surveillance

It was observed that most presentations indicated challenge in data gathering, storage, management and export, and CAREC is not getting the data. Is the problem capacity or organizational behaviour / laziness? If it involves capacity, we need funding resources, so what is to be done about that?

Data gathering will always be an issue. There is no perfect situation with totally reliable and valid data. Human resources need to be strengthened, but what is a priority for the region is not necessarily a priority at country level. There is the commitment and willingness but there is a gap to performance. CAREC will assist, but CAREC is also limited because it has only one NCD consultant.

Yes, it takes "cash to care", but we still have to proceed as we can, with or without cash. Movement is slower without the cash, but we are still moving. We hope this meeting will motivate countries to improve their reporting.

Each island is a sovereign nation, so we have to ask countries, and they decide how to go. OCPC as a regional grouping is looking at the systems and the way forward to guide countries, based on ideas from the countries. OCPC has presented a sub-regional proposal to COHSOD. We need a common backbone and transferability with common standard and a common basic data set agreed.

A technical team reviewed all studies on HIS including an analysis of why projects have failed. In the past 8 years there have been 14 serious studies with recommendations, so we have a road map – software, hardware, compatibility, unique ID and basic definitions. The technical team is taking this to donor groups to decide what to put in and how to pull in expertise. OCPC is now at the point of getting countries on board.

HIS is a Health systems strengthening (HSS) issue and much of this is being driven by HIV.

There is need for capacity building in countries for NCD surveillance. For example, training in ICD coding and data quality at all in-service levels, plus training in medical and health professional schools, during orientation etc.

There is a need for a unique identifier to facilitate data analysis and allow transferability between jurisdictions, given the CARICOM single market and economy (CSME) and the need for portability of health insurance within the region.

Belize HIS unique ID is generated by the system and this number is used throughout the health sector, but it is different from the passport number and numbers in other sectors.

CARICOM reiterated the need for a unique Identifier and others are studying it. We need to identify generic things to do and build synergies to help get this done.

How can the Belize and Dominica successes be transferred to other countries? How long did it take to get to the national coverage in Belize?

In Belize, improved data reporting has been due to both capacity building and institutional support. There is good data from the private sector on births and deaths, but some problems with reporting of communicable disease, and they are not as efficient as the public sector. There are laws on the books requiring notification, but Belize has not gone the legal and prosecution route.

It took Belize five years to get equipment and systems for the BHIS to all twenty-two (22) facilities, covering the population of around 300,000 people. We are still working on implementation.

Dominica: Yes we could consider exporting HIS, but what does it cost? There are start-up and maintenance costs, so not every country can afford the system that others have. HIS needs to be affordable and effective. Consultants often recommend the use open source systems to reduce costs.

Where someone is not performing, the process to get them up to scratch is very time consuming, and a few are unwilling to change. There are always new people with staff turn-over, so there is always the need for training and retraining.

There are concerns about data security and patient confidentiality.

We are already in an information age. We bank and buy on line with credit card. So an open system does not mean it is open to everyone. The statistical clerk

does not have access to everything. Yes, there can be breaches which can happen with paper based system also. But we have rules and consequences. We will be spending money next year to further secure the system.

Can we form virtual teams to share expertise? What type of collaboration and agreements across countries would be needed before we can utilize shared teams?

Virtual teams are very important, because open source software has no consultants, so we need a technical support team, especially in small countries. We would need a policy and MOU between countries to address the legislative issues around data management and to allow those identified to set aside time to work on that regional good. Then we would have to identify the individuals. So there are a number of steps before we could operationalize this, but the vision the first step. We should pool our resources because we have more than we realise. There is a lot of replication in countries, so we should do a regional inventory of our skills and resources and develop a master plan so we can build on what we have.

How are you connecting the information to policy makers and the media? Are we showing the correlations between NCDs, their risk factors and social determinants?

For transmitting data to policy, CAREC has dissemination workshop and for example, fact sheets shared with policy makers. We do need to do more to inform the public including analysis on social determinants. We should recognize that all countries are not at the same level. Some countries doing their second NCD risk factor survey and some have not done the first.

Countries have their own priorities, willingness and challenges. CAREC works with them where they are. Where we can push, we do, but sometimes we need to step back.

In Dominica, there have been several public sessions with Cabinet and high level administrators, as well as public broadcasts on TV, radio and in print. The challenge is to keep up with media questions, so the publicity can be a double edged sword.

The UNHLM identified NCDs as a development problem, so we need data on the social determinants to show the association to be able to say that NCDs are contributing to poverty and so to connect to other sectors. We need to link with the Geographic Information Systems (GIS) so we can pinpoint where there are issues.

We need to know more about the RPG agreement between the IDB/UWI project and CAREC. How can we engage the private sector in NCD surveillance? Can we use a web based tool? Has CAREC endorsed such a tool and how soon can we use it?

On-line Discussion Forum – Surveillance

CARICOM Secretariat: my challenge is obtaining surveillance data for reporting purposes. I now have an opportunity to network with focal points, CMOs and CAREC in obtaining such data. I also need to find creative ways to promote the importance of surveillance in preventing and treating NCDs. Support from CMC - regional media in facilitating public education initiatives developed by the CCS.

- Aisha Andrewin - National Epidemiologist, Ministry of Health, Belize: Main challenge continues to be human resource constraints and impact work from source of the data (e.g. at the facilities with high turnover of foreign staff; analysis and use of data) to the back end of data at the Epi & IT Units (report building and data analysis).
- Our main achievements in NCD surveillance include the minimum dataset reporting since 2008 and the execution of at least risk factor surveys such as the Central American Diabetes Initiative (CAMDI) and the Global Youth Tobacco and Global School Health Surveys.

Potential areas for regional support include the following:

- Technical support – data analysis, health informatics (report building and data analysis utilizing EHR), disease registries.
- M & E e.g. CHRC tools to accompany protocols; SOPs.
- Financial – conduct of risk factor surveys, impact assessment studies.
- Dr. Rickets' idea of the virtual regional teams is one that merits attempting. I think it's a great idea.

Caveat - BHIS is not a magic bullet- ideally pre-existing structural & institutional issues should be addressed prior to introducing an electronic information system as they will persist - speaks to established policy & procedures, change management.

MONDAY DECEMBER 12TH 2011

Dr. St. Clair Thomas, Chair

CMO, St Vincent & Grenadines

Dr. Kenneth George, Rapporteur

SMOH, Barbados

The chair called the meeting to order and a word of prayer was offered.

Workshop design, process and outcomes, Review 1st NCD meeting

Dr. Alafia Samuels

Meeting Facilitator

The inaugural NCD FP / CMO meeting was held on September 1st, 2nd 2010, at St. Augustine, supported by IDB and PAHO, the same sponsors as this year. 10 CMOs, 10 NCD FPs, UWI and HCC attended. Unfortunately, no UKOTS were funded to the 2010 meeting. These meetings are being modelled on CARICOM EPI Annual Programme Managers meetings and their deliberations guided the successes of the regional immunization programme against vaccine preventable diseases.

The inaugural NCD meeting had 6 objectives listed below with their current status

1. Produce the first draft of a Chronic Care Model of care for the region - CCM model policy adopted
2. Produce the first draft of an updated CARICOM Primary Health Care (PHC) policy - PHC model policy adopted
3. Convene the Inaugural Annual Meeting of CARICOM NCD Focal Points - Done
4. Review NCDs in relation to CARPHA, CCH3, UN HLM – In progress
5. Identify mechanisms for implementation of POS Item #5 (improving quality of care for persons already living with NCDs) – Little progress. On CMO agenda again this meeting.
6. Enhance awareness of the IDB NCD Regional Surveillance System project. - Done, also with report this meeting

So that four (4) of the six (6) objectives were met and one is in process and one is outstanding.

This second annual NCD meeting will be for 3 days, with 3 sessions each day. Day 1 comprising Field Training, Opening Ceremony and Surveillance. Day 2 will be Advancing NCD agenda in countries and three (3) working group. Day 3 will be Food Security, Working with partners and discussion of the Forward agenda

We are attempting to have a paper-less meeting as far as possible. All comments and reports should be typed. Workshop documents are on the website below and were also distributed on a CD. A web-site hosted by UWI, Cave Hill was developed for our on-going use. The URL is
http://myelearning.cavehill.uwi.edu/course/view.php?id=18782
Log on is firstname.lastname.ncd
Password: caricom

The meeting has a tight agenda, so presenters are asked to keep to time.

Ms. Hyacinth Chow and Ms. Jacinta Mitchell are responsible for logistics. Dr. Alafia Samuels is the Meeting Facilitator. Drs. Brennen, George and Davidson are the daily rapporteurs, Ms. Ivy George, Petronella Edwards, Anthelia James are our resource team and Prof Unwin will assist participants with the UWI on-line site.

The Organizing Committee were Rudy Cummings from CARICOM, Alafia Samuels UWI, Hyacinth Chow and Paul Teelucksingh UWI/IDB, James Hospedales, Branka Legetic, Karen Sealey, Ernest Pate, Tomo Kanda PAHO, Beryl Irons, Glennis Andall CAREC and Fitzroy Henry CFNI.

The outcomes anticipated for this meeting are the determination of the Regional Forward NCD agenda for 2012 - 2013, which should dovetail and support country NCD plans and programmes. We should determine research and evaluation priorities and establish a web-based NCD community and resources

Dr. Brennan, Day 1 rapporteur, gave a brief overview of Day 1.

SESSION 4: UNHLM on NCDs: Implications of Summit Declaration for the POS NCD Declaration

Expected Outcomes

- *Identification of the areas of the POS NCD Summit Declaration impacted by the UNHLM NCD Declaration*
- *Review of WHO Best Buys for NCDs*
- *Prioritization of NCD Best Buys for the Caribbean*
- *Review of progress and challenges of implementation of POS NCD Summit Declaration*

UN HLM on NCDs: Making the Political Declaration work for the Caribbean

Dr. Karen Sealey,

PAHO/WHO Special Adviser, External Relations and Partnerships

The meeting was reminded that the Caribbean has led on NCDs at the UN: CARICOM led the adoption of Res.64/265 which authorized the convening of the UNHLM on NCDs; Jamaica was one of two co-facilitators; Guyana represented the G77+China in negotiations, CARICOM cosponsored four side events at UN before HLM and there was significant participation in UNHLM.

Dr Sealey noted that most of the expectations of the first UN NCD HLM had been met:

1. Increased awareness of development implications of NCDs; changed perception that there are no cost effective interventions. **These were achieved**
2. Political Declaration of Commitment for coordinated, multi-sectoral, national, regional, and global programs. **This was achieved**
3. International solidarity for policies in support of national plans including for universal access to services, medicines & technologies. **This was partially achieved.**
4. Increased engagement by international partners and commitment to significant increase in ODA and technical cooperation. **We need to wait and see**
5. Establishment on UN agenda through request for status reports from SG every 2 years and regular reviews of situation by high level review meetings. **This was achieved**

It was emphasized that the Political Declaration is a critical reference document for guiding advocacy and action: the pre-ambular paragraphs *(PP1-42)outline* key background development and diplomatic issues; and the Operative Paras *(OP 43-65) can be used as a b*eacon for rallying action locally and internationally; it offers high-level support for technical principles and approaches e.g. determinants of health, whole of government and whole of society strategies and it outlines elements of an accountability framework.

Heads of States have made key commitments in NCD Political Declaration

NCDs are recognized as a development issue; there is need for national leadership and ownership of the process at all levels; Countries should have national plans with indicators and targets, with prevention as the cornerstone of the response, facilitated by a strengthened health system based on PHC and integrated care; Additional national resources should be allocated to NCDs and collaborative partnerships formed at all levels including for research. Countries should report on the status of the writing and implementation of their NCD plans, progress towards global targets and risk factors and disease trends and this is to be collectively followed up at a review meeting

In response, there needs to be national leadership and ownership to drive progress.

- By 2012, NCD should be in all national development plans
- By 2013, countries should have developed multi-sectoral plans and policies with measureable objectives
- NCD must be given priority in budget and innovative, dedicated financing is required.
- There needs to be effective leadership of response and support for coordinating mechanisms
- The country should be kept informed of progress towards global and national goals

The Declaration calls on countries to:

- Reduce risk factors and create health-promoting environments
  - Accelerate the implementation of the FCTC
  - Advance the implementation of WHO global strategies for prevention of other risk factors
- Directly call on to private sector to participate
- Promote health through information, education, and communication (IEC) strategies
- Optimize known effective fiscal measures
- Implement healthy public policy, introducing as relevant, health in all policies

It is necessary to strengthen health systems to scale up of effective, evidence-based, cost-effective interventions. In the Declaration, PHC is reaffirmed as the model for care, with priority to surveillance, early detection, treatment and care, through accessibility to affordable drugs and technologies and strengthening of physical infrastructure and systems

Partnerships, reports and reviews should drive and monitor follow-up action

In 2012, there is to be a review of the Secretary Generals' options for global partnerships (*Para 65*). In 2013/14 there will be the 68th Session of UN General Assembly where the SG will report of progress and in 2014 a comprehensive review and assessment is scheduled, perhaps including another meeting.

Dr Sealey stressed that it is what goes on before 2014 that is critical. It is important to continue advocacy at all levels. Opportunities identified include: the Executive Board meeting of WHO in January; the World Health Assembly in May; the Summit of the Americas in April 2012; other UN Meetings and Commissions in New York; and the Commonwealth Heads of Government Meeting in 2013.

She recommended the following actions for NCD Focal Points

- Learn about the development cooperation agenda and process.
- Help other sectors at all levels understand what is needed to address NCDs & risk factors - persuade them sectors that NCDs is their agenda.
- Support meaningful civil society participation locally.
- Use "health days" for advocacy e.g. TB, Diabetes, Hypertension, World Health Day, etc.
- Develop or strengthen national policies/plans by 2013 with a focus on 2 or 3 short term priorities for action.
- Promote Three Ones:
  - One NCD plan
  - One M&E framework
  - One coordinating body
- Use Caribbean Wellness Day to inform of progress in plans; celebrate actions of partners.

Global NCD Challenges & New Evidence: Best Buys

Dr. James Hospedales

Senior Advisor, NCD Prevention and Control, PAHO

The Burden

We were reminded that NCDs are the #1 killer in the region of the Americas, with 36% deaths occurring prematurely, below age 70 years. In CARICOM adult smoking prevalence is relatively low, but is higher among youth 13 – 15 years in some countries. Whereas alcohol is the number six (6) cause of death, it is the number 1 cause of morbidity. Obesity is increasing and assuming epidemic proportions in the world and the Caribbean. In the 1990's almost 60% of our women were overweight or obese.

The relationship between fitness to health risk in Trinidad and Tobago was demonstrated by the St. James Cardiovascular Study of 1309 men who had their blood sugar, cholesterol and fitness measured at baseline and then followed up carefully for seven (7) years. Unfit men compared with fit men were 3.6 times more likely to die and 2.5 times more likely to have a heart attack.

The Economics

The economic burden from hypertension and diabetes ranges from 1 – 8% of GDP in four Caribbean countries[i]. NCD will cost the world economy $30 trillion in next 20 years with mental health costing an additional $16 trillion[ii].A partnership has been formed to develop the economic framework and build country capacity for economic evaluation of NCDs in the AMERICAS. This involves PAHO/WHO, PHAC, UN-ECLAC, Washington Univ. and OECD and countries Canada, Mexico, Costa Rica, Colombia, Brazil, Argentina, Chile, Uruguay and UWI Trinidad and Tobago and Jamaica

Global NCD Challenges

The size and complexity of the problem, the relationship between health and development is still not well appreciated. Part of this is a communications challenge. What is/are "NCD"?

Civil society mobilization and involvement are insufficient, with fragmented constituencies. There is insufficient investment in prevention and promotion, including surveillance, and there is need for an inter-sectoral accountability architecture with goals, indicators and a monitoring framework.

We know what works technically, but we do not know how to scale up and how to work all together (within health, within government, all of society). We also need to llinkage to other major issues: MCH, Climate change, Fiscal Consolidation, etc.

This process has been well documented in the region, with publications listed at **Appendix 3.**

WHO "Best buys": Many more successful practices in countries taking place
Mostly outside the health sector; need political commitment, and all of society approach
Examples of Best Buys from countries listed in Appendix 4

NCD 'best buys': Population Measures
(Source: NCD Global Status Report; WHO, 2011)

Population- or individual-based measures that are very cost-effective, feasible and low-cost for all low- and middle-income countries, based on analysis of 42 countries that account for 90% of the NCD burden in low- and middle-income countries, with the scale up period is 2011-2025.

Condition	Interventions
Tobacco use	Tax increases; smoke-free indoor workplaces & public places; health information / warnings; advertising/promotion bans
Alcohol use	Tax increases; restrict retail access; advertising bans
Unhealthy diet & physical inactivity	Reduced salt intake; replacement of trans fat; public awareness about diet & physical activity
CVD & diabetes	Counselling & multi-drug therapy (including glycaemic control for diabetes) for people with >30% CVD risk (including those with CVD); treatment of heart attacks with aspirin
Cancer	Hepatitis B immunization to prevent liver cancer; screening & treatment of pre-cancerous lesions to prevent cervical cancer

How much will it cost to scale-up these NCD 'best buys'? For all LMIC, US$ 11.4 billion per year on average.

Population-based measures: close to US$ 2 billion per year:

Low- and lower-middle-income countries:	*< US$ 0.20 per head*
Upper-middle income countries:	*< US$ 0.50 per head*

Individual-based measures: nearly US$ 10 billion per year:

Low-income countries:	*< US$ 1.00 per head*
Lower middle-income countries:	*< US$ 1.50 per head*
Upper-middle income countries:	*~ US$ 2.50 per head*

Implementation of the Port of Spain Declaration on Non-Communicable Diseases: Lessons learnt

Dr. Rudolph Cummings

Programme Manager, Health, CARICOM Secretariat

CARICOM has long displayed leadership and taken advantage of political opportunity to advance health. Several studies and political declarations have identified health priorities for the region. The Report of the Commission on Macroeconomics and Health 2001, Nassau Declaration on Health 2001: *"the Health of the Region is the Wealth of the Region"* which identified three super priorities in Health according to CCH II: HIV/AIDS, NCDS and Mental Health and Injuries, The Report of the Caribbean Commission on Health and Development 2005

Champions and Opportunity: Sir George Alleyne, Chancellor, The University of the West Indies is the regional NCD Champion. He sat on the Commission on Macroeconomics and Health, championed the Nassau Declaration and encouraged the CARICOM Secretariat and COHSOD to identify CARICOM Health Priorities, chaired the CCHD and brought its findings to the 2005 Conference of Heads. Former Prime Minister of Trinidad & Tobago, Patrick Manning, at the February 2007 Inter-sessional meeting of the Conference of Heads, proposed the September Summit after a successful 2006 Trinidad consultation. PAHO with PHAC worked tirelessly with CCS to promote and organise this Summit which is now world famous

Quick Wins: Following the POS NCD Summit Declaration, there was immediate follow-up with OECS Ministers of Health and the full Caucus of Ministers of Health in Sept 2007 who identified the need for an intersectoral program, led by Health Sector. The Declaration of St. Ann's by the Ministers of Agriculture in support of POS followed, also in 2007 and advocacy continued with a presentation to CHOGM in Kampala, Uganda in 2007.

There are mandatory reports on the implementation of the POS NCD Summit Declaration to the Conference of Heads twice yearly. The NCD agenda has been supported through engagement of the Regional Health Institutions: CAREC in PAN AM Steps, CFNI in food and nutrition advocacy and engagement of the agricultural and food manufacturing sector, CHRC in streamlining treatment protocols for secondary prevention, CRDTL in conjunction with PAHO the development of a pharmaceutical policy for access to cost effective medication for secondary prevention

Other Sector Engagement: Early in 2008 the UWI's involvement was assured through this IDB project in the area of surveillance. A 2008 Physical Activity workshop in POS raised the regional private sector participation in workplace wellness programmes. Regional civil society engagement was strengthened in 2008 with the formation of the Healthy Caribbean Coalition.

The media has and is willing to continue its support of Caribbean Wellness, in particular the print media. The new media has been employed including a text messaging campaign to promote the UNHLM by HCC as well as at local level support thru phone companies in particular to reach youth and younger generations

Partnerships: PAHO has been our principal partner at the POS NCD Summit, at the Summit of the Americas, at the Commonwealth Ministers of Health meetings, with the CARMEN Collaboration, at the UNHLM and its side events and more. There has also been great support from the Caribbean UN representatives.

External Collaboration: CARMEN collaboration and annual meetings through PAHO, supported by PHAC is an opportunity for exposure of Caribbean progress in NCD prevention. The COMSEC Commonwealth Ministers of Health Meeting (CMH) provides an annual forum for sharing Caribbean experiences. Special meetings such as the Lancet collaboration allowed presentations from Caribbean

Financial Support: IDB has interest in supporting national surveillance systems (UWI project). The World Bank has interest in Health Systems strengthening in the Caribbean (OECS). There has been bilateral support from the Government of Spain and there is the potential for Australian support

International Leadership and Advocacy: CARICOM advocacy for a UN summit stimulated resolutions in support from the Summit of the Americas in POS in 2009, from the Commonwealth Heads of Government Meeting also in POS in 2009. At the UN High Level Meeting 2011, CARICOM leadership was acknowledged and again demonstrated in negotiating

the Political Statement, in Side Meetings and in the Plenary Sessions. CARICOM is also advocating for an international day in support of NCD Prevention

Regional Achievements: All of CARICOM celebrates Caribbean Wellness Day, this year expanded to include Dutch, French, Spanish and American participation. The Caribbean diaspora participated as of 2011 with PAHO strong support and leadership. A Regional Strategic Plan for NCD Prevention and Control with a Gap Analysis has been completed, 50% of Member States have National Commissions, Regional Tobacco labeling policy drafted, tobacco warning images tested and Primary and Chronic Care policies drafted;

Challenges: It will be necessary to ensure that the Political Leadership has an acute understanding of their Global responsibility and its national responsibilities, despite democratic traditions which may result in a change of political leadership being a hiccup to policy continuity. We need strategies to make National Commissions more effective. We need to create the fiscal space and regulatory frameworks necessary for policy implementation

Urgent Needs: We need a sustainable forum for crafting and reviewing the requirements for the development of effective intersectoral NCD policies and plans and their implementation, such as this annual NCD meeting. Though EPI model is attractive the intersectoral nature of NCD control will require some creativity and adaptation of this approach.

Discussion UNHLM ON NCDs and POS NCD Declaration

Linkages between NCD and national development

NCD development linkage raises this to a higher level than health. It should become a policy of state. We will fail if other sectors feel that this is a health issue. Health has to be the midwife of this development issue, and then make it the child of the country. Even while most of the responsibility will lie in the health sector, there need to be a wider sector approach. Countries need to find ways to bring others to the table and put them in the leadership positions. This broader sector approach can be achieved by learning from the HIV/AIDS with partnerships etc. Information and surveillance data was presented from the HIV/AIDS programme but this may have been skewed to the public sector.

National Commissions on NCDs do not need to be outside of health, but the Prime Minister, perhaps even as the coordinator, needs to put NCDs on the

developmental agenda for the Cabinet to recognise how important it is in their respective sectors, and take ownership. There needs to be a state policy on NCDs.

The Chair of the Commission must have the respect of the entire Cabinet to get action in all sectors, and to be seen putting it on the national development agenda. They should have the independence to make national and impactful decisions.

If we are not at the table for the discussions on development planning we won't get project resources, so we need to expand our understanding of the development cycle and get to know the players, what is coming up for discussion and decision, and how to get your counterparts to work with you. This means expansion of the knowledge base within countries including the planning and finance sector.

NGOs should lead the advocacy because the country needs the whole of government, whole of society approach. They also can help with grass roots advocacy. For example, HIV and gender became central to the Ministry of Community Development agenda.

CARICOM needs to link with other sectors and evaluate whether the policies are meeting the needs of the poor.

NCD does not have a global fund. In the long haul, is our aim for a global NCD fund?

There is the proposal of Global fund for NCDs, but this is a difficult time to advocate for a global fund especially in light of the global economic situation, and support from international agencies requires accountability, measurement, monitoring and evaluation. Because most countries of CARICOM are middle and high income countries they may not qualify for international development aid. Therefore, most resources will have to come from within national and regional sources, which need to be earmarked for NCDs.

POS NCD Summit Declaration #3 states:

> *That public revenue derived from tobacco, alcohol or other such products should be employed, inter alia for preventing chronic NCDs, promoting health and supporting the work of the Commissions.*

Tobacco Taxes

It is difficult for countries to be asking for external support for NCD work when they have the option of sustainable indigenous funding from tobacco taxes. Sustainability is key. External funds will not continue. Countries need to commit to the POS by using tobacco revenues for sustainable resources and prevention programmes.

There should be a target of 1% of GDP for HIV and NCD prevention and control programmes. Eastern Caribbean Central Bank, Caribbean Development Bank and other regional banking and investment institutions need to be involved in the process of NCD prevention and control strategies. The IADB project is a good example.

Grass roots advocacy efforts within the communities needed.

The non-health sector must feel as NCD is their issue too e.g. within Community Development.

NGOs, civil society and the private sector need to use their influence to tap into international resources particularly for prevention and advocacy (e.g. NCD Alliance), with emphasis on the return on investment and a challenge to the private sector to match funds. Innovative and creative ways need to be found, and technical resources and expertise from different countries can facilitate strengthening of capacity in other countries.

Is the health sector and MOH in the Caribbean in the best position to guide process?

The health sector may have the technical resources to lead NCD policies and programmes, but influence and leadership is required to mobilize the other sectors. The health sector must use the opportunity to brief cabinet, parliament and other senior government officials. There should be emphasis on the economic benefit using regional data.

Advocacy

We need to have a special session for Permanent Secretaries and senior technical staff in the Ministries of Health on how to lead and coordinate this process at country level and what are the specifics about what other government agencies should do. We need to be more clear about specific targets for specific agencies.

A national intersectoral forum was mandated by the Heads of Government NCD Declaration, and we need to develop skills to engage and sustain other sectors - government, private and civil society.

How, when and where are NCD resources being utilized?

Surveillance should involve the monitoring and surveillance of how funds are being spent. Are we catering to those who can afford it? What about low income sections of the population? For example, when Jamaica did an analysis of NCD funding through the NHF, it was found that it was the middle and upper classes, not the lower income persons, who were accessing the benefits. Such inequities need to be addressed.

Funding inter-sectoral collaboration

We need to develop skills to harness non health sectors to look at their spheres of influence. Policy formulation, enactment and analysis need to be revisited with leadership being given from Planning and Research Units MOH. All sectors need support in costing NCD prevention and control programmes.

Implementation

POS NCD Summit Declaration lacks specificity of implementation by each sector. We need to develop an implementation matrix with concrete actions and targets for specific sectors. The 5 year review in 2012 should examine this area.

Online Discussion UNHLM ON NCDs and POS NCD Declaration

Guyana has already started the development of the NCD National Plan (preliminary draft), it needs to continue to work on with the new authorities (new government is in place). In addition, the NCDs component has been included into the Guyana-UNDAF 2012-2016. We are on track, however more needs to be done. I appreciate Dr. Karen's presentation through which she encouraged us to include NCDs in the Caribbean's Development Agenda (high level agenda).

Guyana should be applauded for its concerted efforts in promoting healthy lifestyles through public education. Perhaps it is one of the few countries which do this all year-round.

Update the Guyana NCDs Strategic Plan, eventually it will be negotiated and reviewed by new national authorities. It will be shared with Regional and HQ colleagues; your comments will be appreciated.

A regional meeting with CARICOM has been proposed, then your collaboration will be appreciated.

Some activities have been implemented such as a) Media campaign on Diabetes; draft the Tobacco control Law; IEC materials on NCDs prevention. b) Former Minister of Health was so committed to NCDs and it is expected the new authorities to continue to be committed. d) UNDAF 2012-2016 states: UN system to support the development and implementation of the NCDs Plan. The Caribbean countries are on track, however more effort is necessary to elevate the NCDs to the Development process Agenda at country level.

Capacity building – nutritionist, health care providers, health informatics

- Legislation – model legal frameworks and laws from the region
- Political support for the NCD Secretariat mechanism
- Tools – M&E; quality of care, protocols
- Sharing of best practices
- Sharing of communication materials

SESSION 5: Advancing the NCD Agenda in Countries: NCD Policies (POS #1, 14)

Prof. Trevor Hassel, Chair

NCD Commission, Barbados

Expected Outcomes

- *Identification of advances, opportunities and challenges around the multi-sectoral approach*
- *Identification of priority legislation to advance the NCD agenda in countries*
- *Outlining of priorities for regional supports*

POS NCD Declaration Status and Definitions

Dr. Alafia Samuels

Consultant, UWI Cave Hill

CARICOM Heads of Government Port of Spain NCD Summit Declaration of September 2007, "Uniting to Stop the Epidemic of Chronic NCDs identified WHAT TO DO: Tobacco control (#3, 4), Healthy Eating (#6, 7, 8, 9), Physical Activity (#10, 15), Scaling up Treatment (#5). It identified WHERE TO DO IT: Workplace (#10), Schools (#6), Faith based organizations and in Communities, It identified HOW TO DO IT: NCD Secretariat, Plan, M&E (#1, 14), NCD Commissions (#2), Surveillance, Gender (#11, 13), Partners – private sector, civil society, Media & Communications (#12) and Sustainable financing (#4). The regional NCD agenda is in the context of, and guided by CCH3 and the PAHO and WHO NCD strategies and action plans.

It is acknowledged that NCDs need multi-sectoral interventions. For example, to address tobacco we need to partner with the Attorney General, Ministries of Legal Affairs, Finance, Trade and civil society. To promote healthy eating, we need the participation of Ministries of Trade, Finance, and Agriculture, the Private sector, civil society, Consumer Affairs, Media, Food manufacturers, importers, providers, workplaces, schools, communities, Fast food sector and Restaurants

Country Compliance vs. Regional/Global Supports

Our evaluation of country compliance with NCD Declaration mandates indicates that larger countries are most compliant, likely due to having more human resources. However, when there is regional support, all countries perform well, for example, CWD, FCTC ratification, NCD risk factor surveys and Food and Nutrition plans. The exceptions being that despite regional supports, there has been little progress on elimination of trans fats or graphic tobacco labeling.

WHO Framework Convention on Tobacco Control – WHO FCTC in Caribbean Countries

Dr. Roberta Caixeta

Tobacco Team, PAHO

In the region of the Americas, 29 countries have ratified the FCTC and 6 have not, including the USA, El Salvador, Haiti, Dominican Republic, Argentina and Cuba. In CARICOM, all states have ratified with the exception of Haiti. MPOWER is a technical evidenced-based package of tobacco control measures that provides a foundation and assists country-level implementation of effective measures to implement and manage tobacco control so as to reduce demand for tobacco. It is an entry point of WHO FCTC implementation.

MPOWER stands for Monitor, Protect, Offer, Warn, Enforce and Raise taxes (See Appendix 5)

Monitor Tobacco Use and Prevention Polices

Research, surveillance and exchange of information

In CARICOM nine (9) countries have completed STEPS NCD Risk Factor surveillance or equivalent survey which included prevalence of tobacco smoking. The Global Youth Tobacco Survey has been completed in 14 countries.

Protect People from Exposure to Tobacco Smoke:

Article 8 – Protection from exposure to tobacco smoke

In CARICOM, only Barbados and Trinidad & Tobago have enacted laws prohibiting smoking in public spaces.

Offer Help to Quit

In CARICOM, no country has this in place for its population.

Warn about the Dangers of Tobacco

Article 11 – Package and Labeling of Tobacco Products

Despite the efforts of CROSQ, the region has been unable to collectively implement rotating tobacco warnings because 2 countries do not agree. The other countries have decided to proceed at national level to implement the rotating graphic tobacco warnings.

Enforce bans on tobacco advertising, promotion and sponsorship (TAPS)

Article 13 – Advertising, Promotion and Sponsorship bans

In CARICOM, no country has this in place for its population.

Raise Taxes

Article 6 – Increase the Prices and Taxes on Tobacco Products

In CARICOM, no country has achieved the 75% goal. Jamaica, Suriname, Grenada and Barbados have taxes at around 50% of sale price, while Trinidad & Tobago, St. Lucia and Bahamas have taxes of around 30% of sale price.

Protection from Tobacco Industry Interference

Article 5.3 of the FCTC addresses Protection from Tobacco Industry Interference in setting and implementing their public health policies with respect to tobacco control.

Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law. These principles refer to the fundamental and irreconcilable conflict that exists between the tobacco industry's interests and public health policy interests and advises that. Parties should establish measures to do not allow interactions with Tobacco Industry and once it's necessary the interaction ensure transparency during these process as promoting public hearings for example.

The tobacco industry has a "new dirty trick" and is taking countries to court to demand the right to advertise their products as being in defence of "free speech". There is still a lot of work to be done even though tobacco smoking prevalence in the CARICOM is relatively low and shows that countries could be at the beginning of a tobacco epidemic. it is important to implement WHO FCTC so as not to allow tobacco consumption in any of its forms to increase.

Review of Regional NCD Legislation in support of NCDs

Ms. Monica Bolis

Advisor, PAHO

Legislation is a main tool for implementing health policies. It establishes responsibilities for the National Health Authority, service providers, and the service sector at large, in the prevention and control of NCDs. Legislation also allows individuals to assert their rights.

We have produced two health legislation studies aimed at reviewing and analyzing existing legislation and exchange best practices among countries: *Compilation of legislation for the English-speaking Caribbean countries and territories on prevention and control of obesity, diabetes and cardiovascular diseases* (Sylvia Moss) and *Recopilación de normas sobre prevención y control de enfermedades crónicas en América Latina: obesidad, diabetes y enfermedades cardiovasculares* (Susana Castiglione). Both studies were prepared as a cooperative project between two Areas of PAHO, Health Surveillance, Disease Prevention and Control and Health Systems based on Primary Health Care, and was financed by the Public Health Agency of Canada.

English speaking Caribbean review. (Methodology and Typology in Appendix 6)

Main Findings Latin America

- Legislation developed at the same pace as the diseases became epidemic
- Diabetes prevention, control and treatment is the most regulated
- Three (3) countries with specific legislation on obesity (obesity prevention and control issue of national interest)
- Less regulation on cardiovascular diseases

Main Findings in the Caribbean

- There is not yet comprehensive legislation on the prevention and control of NCDs
  - Some legislation specifically refer to the issue e.g. Coverage by National Insurance schemes of prescription drugs for NDCs (three countries)
  - The rest is broad in nature: Recreation and sports, Responsibilities of NHA for health promotion, Consumer protection, Vendors in school premises, Caribbean Food and Nutrition Corporation, Preparation and promotion of food standards, National Agricultural Health and Food Control Agency

In Latin America there is need for legislation on strengthening preventive aspects (physical activity and insurance coverage services). In the English-speaking Caribbean there is need to review General Health Acts or enact legislation to deal with prevention and control.

There is not yet comprehensive act or regulation on NCD prevention and Control. Few speak to specific NCDs but many of the legislations are broad involving other sectors. There is a broad spectrum of issues to be addressed by legislation. Food availability and importation, Codes of responsible conduct for food and beverage industry (including commitments to develop healthy products), Improved food labeling to include specific caloric, nutrient and fat/cholesterol content, Conditions to facilitate healthy lifestyles (sports and recreational areas) and guarantee consumption choices in marketing products, Review of Regional NCD Legislation in support of NCDs.

Areas for legislation intervention in support of NCD prevention and control:

- Audit, compilation and analysis of legislation and regulations including consumer rights and protection, food labelling etc.;
- Audit and review of public health legislation; Access to essential medicines; Prevention and treatment;
- Discrimination children and disability rights;
- Physical activity and insurance coverage esp. in Latin American and the Caribbean;
- Food availability, content and importation, codes and labelling.

Chronic disease has only got on the legislative agenda for many countries in Latin America and the Caribbean within the last 10 years with diabetes and obesity control prevention and treatment being the most common issue. There is not yet comprehensive act or regulation on NCD prevention and control. Few acts concern specific NCDs; most of the legislation however is broad in content involving other sectors e.g. sport and physical activity, and quality of food.

Advancing multisectoral NCD approaches through engaging with the Parliament in Suriname

Dr. Lesley Resida

Director, Bureau of Public Health, Suriname

Status of NCD programme in Suriname (Appendix 7)

Advocacy

A briefing session was held with the Parliament on 18 Nov. 2011 to raise awareness and stimulate support from other sectors to include NCDs and risk factors in their agendas. There were presentations by UNDP, PAHO, NGOs, the Ministry of Health and the Bureau of Public Health. Information was presented on the national, regional and global impact of NCDs, the economic burden of these diseases, the most cost effective interventions, human rights aspects of the epidemic and the need for inter-sectoral collaboration e.g. with City planning, housing etc. these programmes should take into consideration the sex, age and race importance in education and activities. This advocacy to Members of Parliament used the economic burden to stress low cost measures, human rights etc.

Results of the briefing session with Parliament

There is now established contact between the political and technical institutions, and there has been the introduction of the NCD issue at the highest decision making level, with increased awareness about and advocacy for NCDs. There is now a better appreciation and insight into the health budget which should facilitate approval and support for funding of NCDs

Discussion NCD Agenda

Jamaica has developed tobacco labelling which went to CROSQ but was not sanctioned because Dominica and Trinidad & Tobago did not approve. There is a regional standard approved by Ministers two caucuses ago, and last caucus (September 2011), countries agreed to proceed at national level, but there is no clear consensus on how to proceed at national level. Even though it was agreed to accept the regional standard, each country will have to proceed on their own, without a regional standard as reference, and this will make it more difficult.

Should notification of chronic diseases be mandated?

The question is, how effective would this be in the real world? What are the alternatives, e.g. registries? The issue is finding ways to engage and incentivize the private sector in notification of chronic diseases. Caribbean Health Insurance with appropriate information systems is still a credible option. In Jamaica, reporting through the electronic notification systems that will facilitate notification from the private sector. We need to work to get Buy in from the medical fraternity.

Is the ban on tobacco sponsorship absolute?

Yes. However, in some countries, the fight against e.g. breast cancer, sponsorship of carnival etc. is still being supported by the tobacco industry. FCTC Article 5.3 calls for government and NGOs not to promote relations with the tobacco industry or to accept sponsorship. We should build a lobby with NGOs and civil society to act as a watch dog for monitoring the tobacco industry.

We also need to consider alternatives after removal of the tobacco support for particular projects.

Role of Legislation in NCD prevention and control

There is a lack of enforcement of legislation, and a need for more transparency and accountability.

We can use legislation as a tool, but advocacy and health promotion are important also. All these approaches need to be driven by evidence, changing the message as appropriate, with successes also being touted. We should recognize the possibility of interference by the political directorate thus creating bottle necks as is currently being seen with tobacco labelling legislation.

On-line Discussion NCD Agenda

Tobacco

I am uncertain if the CROSQ standards have be declared nationally in St. Vincent. I do believe that we could priorities the ban on smoking in public places beginning with government buildings. More and more, smoking is becoming less socially acceptable. The meeting has not addressed the issue of marijuana smoking and what are the approaches to be adopted. This remains a sensitive issue for our country. Model regional legislation will assist in advancing the cause of a smoking ban in public places. Regional experiences regarding social communication and advocacy will be a great asset.

Guyana has drafted the national law to banned tobacco. Some areas have been declared as "tobacco zone free" such as at the University of Guyana, Schools among others.

Regional supports: finalization of the tobacco control law/policy.

Legislation

Presently there is an urgent need to review practically all public health legislation in St. Vincent and the Grenadines. This includes legislation meeting our national obligations under the IHRs, MEAs etc. Traditionally there are limited legal drafters and a demanding national legislative agenda. One approach is to have draft model legislations (as per the example outlined by Dr. Pate) and have them reworked to meet national needs. The fear of having several different pieces of legislation which will present difficulties implementing, is a real one. One way to overcome this is to add regulations to already existing laws, instead of making new laws. The need for cross training of health professional will be very important in the enforcement. The multi-sectoral agencies (like those used during cricket world cup) will be instrumental in meeting the legislative agenda. The point made on day one by James regarding using the POS declaration as a guide to our national response remains very important. So all legislative must, at a minimum, reflect the commitments of the POS declaration.

SESSION 6: NCD Agenda in Countries (POS #2)

Second Annual NCD Focal Meeting
Dr. Rudolph Cummings, Chair

Expected Outcomes

- *Identification of regional support for country plans and policies*
- *Identification of stimulating or hindering factors for development of NCD plans in counties with and without national plan. What supports would be needed to write NCD plans in those countries without plans*
- *Discussion of gaps and priorities to advance the NCD agenda in countries*

Panel: Country Reports: Status of NCD Plans, Resource Implementation Challenges

Utilizing the model NCD plan to write the Dominica NCD plan
Ms. Anthelia James
Coordinator, MOH, Dominica

Dominica utilized the model draft country NCD plan in writing their plan. Supporting documents were the STEPS NCD risk factor survey, the NCD policy and the National strategic plan for health 2010- 2019.

The benefits of using the draft were that is was a well-informed document which was easy to use. It already had all the headings and sections identified the global and regional NCD status and trends already done. The country situation analysis was easily completed by plugging in country data and editing the suggested country actions. The model draft country plan is a valuable tool and guide and was very helpful in the preparation of the Dominica NCD plans.

The Dominica plan was worked on initially by a committee made up of representatives of: PAHO, the Ministry of health, The CNCD advisory committee and the National CNCD commission. The format as proposed in the regional plan was adjusted to correspond with that of the National Strategic Plan for Health. Goals and objectives were formulated to correspond reflect to priority areas identified in the national plan.

The five priority areas from the model plan was accepted and the draft document was finalized by a broader stake holder group comprising also of NGOs, CBOs and other civil society partners who not only gave their input but allowed for consensus to be realized.

Challenges included the following:

1. The size of the document is increased by the number of appendices attached.

Lessons learned were:

1. It is important that stakeholders be involved in the process but the lead agency must be the Ministry of health.
2. Having the draft plan makes it easier for the preparation of the country's NCD plan. However the Ministries of Health must be committed to put in the additional work needed as the draft plan must be informed by country statistics and strategic health plans.
3. The plan is evidence driven, so countries must have some form of baseline data available.
4. National health priorities must guide the document.
5. Technical support is necessary.

Recommendations

- Technical support should be provided for its implementation of this document.
- All stakeholders should play their part of the process.
- The Draft Regional Plan for CNCDs should be used as a standard plan for all CARICOM countries.

Implementation challenges for the Jamaica's NCD plan

Dr. Eva Lewis-Fuller

CMO, Jamaica

Jamaica' demographic and risk factor profile at Appendix 8.

Implementing the NCD POS Summit Declaration has been tracked and reported using the regional grid.

POS # 1,14 NCD Plan by 2012: There is now a draft National Strategic NCD Plan 2013 – 2017 developed with support from PAHO and the IDB/UWI Project, which covers the following conditions - Cardiovascular Diseases, Diabetes, Cancer, Chronic Lower Respiratory Diseases (Asthma & COPD), with special programmes for Violence & Injuries and Sickle Cell Anaemia. The challenges have been funding and the availability of an appropriate consultant to assist in writing the plan.

POS #4 NCD Budget and staff: There are dedicated NCD staff, 3 at the national Level and 1 at a Regional Health Authority. The challenges are that there is no specific programme budgetary allocation with ad hoc funding sought for specific events from PAHO and National Health Fund etc.

POS #3 Implementation of FCTC: Jamaica ratified in July 2005. Tobacco taxes are approximately 60% of retail price. Tobacco legislation has been drafted and plans are being made to implement graphic health warnings. The challenges are that it was thought that the tobacco legislation could be expedited as a Regulation of the Public Health Act. However, licensing fees, taxation and trade issues could not be entertained under the Public Health Act. The recommendation now is for it to be an independent law, which is now in draft. There is still no consensus at sub-regional level regarding acceptance of graphic health warnings for cigarette packages.

POS #7 Multi-sector Food & Nutrition Plan, trans fat free food supply, policy & standards promoting healthy eating in schools: A draft Food & Nutrition Security Policy has been completed. The lead agency was the Ministry of Agriculture, with contributions from the Ministry of Health. There has been no progress on the implementation of a trans-fat free food supply. A policy and standards promoting health eating in schools has been implemented through the Health and Family Life education curriculum. There are also National nutritional standards for schools. The challenges are that there is no laboratory capacity to test for trans fats in foods, there is inadequate funds for schools to implement healthy foods in schools. School canteens are outsourced so it is a challenge to implement changes, and there is need for assistance with policies on regulating salt content, fats, and sugar.

POS #8 & #9 Trade agreements utilized to meet national food security & health goals. There has been no progress. The challenge is that this is not perceived by the main actors in trade as a significant issue.

POS #6 & #10 Mandatory physical activity in all grades in schools and provision for PA in new housing developments, ongoing, mass PA: A policy directive has been issued by Ministry of Education on mandatory physical activity in all grades in schools. There are significant opportunities for ongoing mass PA, with many marathons/walkathons and Emancipation park being a favorite for walkers. However, there is no mandatory provision for PA in new housing developments. The challenges include getting buy-in by schools to make physical activity mandatory throughout, since the policy is not enforced widely in schools for upper level classes. In some schools, the physical infrastructure is not in place to support PA. Health issues are not mandated in housing policies.

POS #15 & #10 Caribbean Wellness Day (CWD): Caribbean wellness day has been commemorated annually since 2008 and CWD has been utilized to support ongoing activities and to launch new initiatives. The challenges are the need for more involvement of other sectors and inadequate financial resources to support activities at parish and community levels.

POS #11, #13, #14 Surveillance: Jamaica has been reporting on the Minimum Dataset for NCDs. There have been two risk factors surveys (2000 and 2008) similar to STEPs, three Global Youth Tobacco Surveys (2001, 2006, 2010) and one Global School Health Surveys (2010). The national minimum dataset is now included in the National Surveillance manual. A situational analysis of Health Information System was completed under the IADB/UWI Project. The challenges include the need to standardize indicators that are used in surveys in keeping with regional and national standards, inadequate data on morbidity, inadequate financial resources to effectively implement the National Health Information System. There are only two persons on staff dedicated at national level to support NCD surveillance and at regional level, there are competing priorities with communicable disease surveillance.

POS #5 Chronic Care Model/NCD Treatment protocols in ≥ 50% of Primary Health Care (PHC) facilities; cardiovascular (CVD) or diabetes demonstration project: Protocols/guidelines for diabetes, hypertension and asthma, nicotine use are in place. The diabetes collaborative quality of care project has been implemented at seven (7) health centre sites. The challenges include low compliance with protocol/guidelines by health care providers, high attrition of doctors especially in Primary Care Setting, inadequate access to laboratory and diagnostic services and sustaining the NCD demonstration programmes.

Other challenges include: Competing priorities with other programmes and communicable diseases. Especially at implementation level there is competition for the same manpower, materials and money resources. Programmes are still often operating in silos and there is the

need for more integration to maximize efforts where synergies occur. NCDs are still seen as a health problem and not cross-cutting to other sectors.

There will be elections held in Jamaica in two weeks and there is the ongoing economic crisis.

Opportunities include: There is a restructuring process ongoing at the Ministry of Health including the head office technical services. There is now a mandate supported at highest level for the re-establishment of a National Epidemiology Unit and to establish a Health Information system.

There are well-established annual/periodic national surveys that minimum indicators for NCDs can be integrated into i.e. Survey of Living Conditions.

Priorities 2012:

- Completion of the National Strategic NCD Plan 2012 – 2016
- Developing a Strategic Plan for Health Information System
- Establishing a Multisectoral National Committee on NCDs
- Strengthening of surveillance of morbidity of NCDs using disease registries
- Strengthening the health promotion/social marketing strategy

Implementation challenges: St. Lucia Non Communicable Disease Plan 2006 - 2011

Dr. Merlene Fredericks

CMO, St Lucia

NCD Focal Point: Anne Margaret Henry

The NCD plan was developed in 2006 as an annex to the National Strategic Plan for Health 2006-2011. Multiple agencies were involved in the process, and it was funded by EU. The NCD plan addressed diabetes, hypertension, cancer, arthritis and lupus.

NCDs are the leading causes of death and disability. The top five (5) causes of death (2008) were heart disease, cancers, stroke, diabetes and accidents. In 2009, the leading causes of admission to hospital were hypertensive diseases, other cardiovascular diseases, diabetes, malignant neoplasms, asthma, renal failure and sickle cell disorders.

NCD Achievements

There is increased population awareness of NCDs and their risk factors, and there is an increase in Government, NGO and Private Sector initiation of wellness activities, including initiation of Physical Activity programmes. There has been a formal establishment of workplace wellness programme in one health region. Medications for diabetics/hypertension are more accessible via the piloted Universal Health Care System, and there has been the initiation of foot care programmes, throughout the Primary Care Service.

Implementation Challenges

There is need for a dedicated NCD coordinator to drive the multi-sectoral response necessary for implementation. The NCD commission had been very active initially, but is now dormant. We will be reviving it to assist with guiding policy decisions regarding the multi-sectoral approach needed for advancement of the NCD agenda.

There are insufficient financial resources allocated for addressing NCDs. There has been little movement toward enacting further anti-tobacco legislation. The consumption tax on tobacco however was increased from 100% to 150% of the imported value in 2011. There is currently no national NCD Policy which contributes to the inadequate allocation of resources at the highest levels and compromises the ability to implement activities at a national level since there is no obligation to do so.

Current NCD mortality and NCD risk factor information is absent, influencing the capacity for an evidenced-based, effective and timely response.

There is an absence of a formal monitoring and evaluation mechanism to assure that NCD treatment protocols are adhered to within the public and private sectors. There is no functioning cancer registry.

There is no Government Pathologist and other key pathological support staff in place, increasing the time taken to diagnose and treat cancer.

The Way Forward

- Revise and update NCD Plan
- Advocate for dedicated NCD coordinator
- Re activate NCD commission
- Meet and sensitize new Cabinet
- Increase availability and access to updated health statistics

- Engage the media more successfully
- Develop a NCD policy and fully implement the chronic care model
- Review the school feeding programme and develop policy for food available on school compounds
- Increase Workplace wellness programmes

Implementation challenges for the BVI NCD strategy and plan

Ms. Ivy George

NCD Coordinator, British Virgin Islands

Towards a Healthier Virgin Islands - A Strategy for the Prevention of NCDs August 2011

Vision: A healthy British Virgin Islands.

Mission: To improve the health of all residents of the British Virgin Islands through leadership and collaboration.

Guiding Principles:

- Utilizing a population health approach
- Employing a whole of society and whole of government approach
- Reducing inequities in health status
- Fostering cooperation between all sectors in the approaches to healthy living and prevention of chronic disease, and where feasible and appropriate, integrating these approaches
- Decision and actions based on the best available evidence.

Strategic Areas

- Reduce the prevalence of risk factors for NCD: increase by 20% the proportion of residents of BVI who are physically active, eat healthily and are at healthy body weights by 2020
- Reduce the health inequities that contribute to NCD
- Ensure appropriate surveillance and monitoring
- Assessing all policies for health and health inequity risk

Strategies

- Health promotion
- Institution based interventions

- Community based interventions
- Improving the built environment
- Work based programmes
- Legislative, regulatory and enforcement measures
- Partnership building

Challenges

- Buy in from new government
- Inadequate finance
- Inadequate intersectoral infrastructure to support an integrated approach
- No formal institutional policy and framework for active community participation
- Chronic disease is still seen as a health issue and not as developmental issue
- We need to devise new ways of working in the public sector

Opportunities

- Former alliances with members of new government
- By in from top management team of Government
- High cost of care and treatment NCDs and the economic impact on territory should encourage attention to prevention
- Strong grass root support with high population interest and health and wellness.

Briefing for New NCD Commission Chair

While the three formal work groups were in session, Prof. Trevor Hassell discussed his experience as the Chairman of the National NCD Commission in Barbados, the longest standing in the region. He briefed Dr. Rosemarie Wright-Pascoe, incoming Chair of the Jamaica NCD Commission.

His briefing included two (2) main areas:

1. Membership of the Commission
   This should not include exclusively government employees, since they may be hindered by the policies of the Government and may be inhibited in their ability to speak out. It should include very influential people from private sector, such as manufactures, food distributors, the Unions, media etc. so that any activities of the Commission can be more easily implemented as the relevant sector to be approached will already be members of the Commission.

2. Relationship with the Minister of Health
   There may be uneasiness between the Minister of Health and the activities of the Commission. To overcome this he suggested that the Minister of Health should buy into the policies of the Commission by making whatever activities suggested by the commission be his or her own and pointing out how it may affect his or her constituents and thus how it may affect abilities to be re-elected.

Prof Hassell committed to offering further guidance and advice to Dr. Wright-Pascoe as needed.

Workshops

The other members of the meeting separated into three (3) workshops below, and the results of their discussions were presented in the first plenary of Day 3.

Group 1: NCD FPs from countries with existing NCD Plans

Challenges in implementing the plans and programmes

Identify additional support to overcome the challenges especially collectively at regional level

Group 2: NCDFPs from countries without existing NCD Plan

Country NCD plans – Current status and supports needed identification of common areas of weaknesses and requests for support and capacity building

Group 3: CMOS

POS #5 / Implementation of the chronic care model

Propose expected outcomes for the five-year external evaluation of POS implementation

TUESDAY DECEMBER 13TH 2011

Dr. George Mitchell, Chair

NCD FP, Grenada

Dr. Tamu Davidson, Rapporteur

NCD Coordinator, Jamaica

Workgroup Reports

Group 1: NCD FPs from countries with existing NCD Plans

Dr. Kenneth George

NCD FP, Barbados

Challenges, strengths and weaknesses in implementing NCD plans and programmes

Identify additional support to overcome the challenges especially collectively at regional level

St Lucia, St Kitts/Nevis, Barbados and Jamaica and Trinidad and Tobago

Focal points exist within countries but frequently they performed other functions far removed from the day to day work of NCD prevention and control. Focal points provide leadership with respect to realizing the outputs of their respective national NCD commissions. In addition the NCD focal points frequently work with their respective health ministries' Health Promotion Units. Specifically the focal points requested assistance with policy formulation and implementation with respect to NCDs and the development of strategic plans for NCD programmes. Continuous efforts are needed to engage the political directorate so as to keep NCD as high priority on the health agenda, particularly with reduced spending on healthcare and challenges of a global economic downturn.

The focal points suggested the need for greater commitment from the Ministries of Health within the Region to having a specific tobacco focal point (separate from the NCD Focal Point) in order to meet in a timely manner the requirements for the Framework Convention on Tobacco Control (FCTC); given the FCTC's stipulated timelines for reporting and specific

commitment targets for countries. Governmental and civil society partners that focal points need to engage for FCTC implementation.

NCD strategic plans were frequently outdated and needed review. There was the expressed view that more inter-country collaboration should be initiated to assist countries with updating their plans. There was much variability in the structure and content of country plans with some countries being more advanced than others. Monitoring and evaluation was identified as a weak area within country plans with limited feedback mechanisms to initiate positive change.

The following were identified as areas that countries requested specific assistance, particularly with respect from CARICOM

- Establishment of national food and nutrition policies - More technical cooperation with CFNI to develop regional goals for trans-fat and salt will be required
- Updating national and sub-national NCD plans
- Chronic disease and risk factor surveillance particularly with technical corporation and assistance in repeating the STEPS surveys

a) What should be the focus and function of the NCD focal points?
b) Is there a need for both NCD focal point and a Tobacco focal point?
c) For NCD focal points the job description is not clear and some have other responsibilities other than NCD.
d) There has been no review of NCD plan or M & E built into Plan.

Group 2: NCD FPs from countries without existing NCD Plan
Ms. Petronella Edwards

NCD FP, St Kitts & Nevis

Country NCD plans – Current status and supports needed identification of common areas of weaknesses and requests for support and capacity building and requests for support and capacity building.

Countries without plans were seven in all: 2 UKOTS – Cayman, Anguilla, 4 ECC - St. Vincent & Grenadines, Grenada, Antigua & Barbuda, St. Kitts & Nevis; and mainland Suriname. It was noted that all countries in this group, with the exception of Suriname, were ECC or UKOTS, thus reinforcing the point made earlier of the need to provide supports to the smaller countries.

Countries discussed using the draft model NCD plan as outlined in the presentation by Dominica. The recommendation is to:

a) Establish guidelines for the steps required in developing national plans.
b) Use available country data (morbidity, mortality, assessments & studies related to social determinants etc.) to start the NCD development in absence of national chronic diseases survey (STEP survey).
c) Integrate the health programmes and activities that are already being implemented into the NCD plan and build on that over time.
d) Conduct a boot camp for developing plan and for costing the plan for those that have drafts.
e) Continue dialogue virtually to support Focal points in advancing the NCD agenda in country.

PAHO ECC office will help them develop plans over the next 6 months.

Questions raised for further discussion:

i. How do we influence and get the input of the population <25 years of age in the process of developing and implementing the NCD plan?
ii. How can we dovetail "NCD planning" and "primary health care renewal"?

Group 3: CMO Workgroup report, Implementation of the chronic care model
Dr. Michael Pitts
CMO, Belize

Propose expected outcomes for the 5 year external evaluation of POS implementation

What works in improving quality of care?

The CMO group assigned a priority and feasibility score to items from "Priorities for cardiovascular health in the Americas" (Appendix 9) to determine priorities for implementation in the short to medium term.

The five implementation priorities identified based on feasibility were:

- Develop comprehensive, sustainable continuing education strategies geared especially to primary caseworkers, reinforce the CVD prevention and control component, and, where necessary, modify academic programs to meet this objective.

- Apply criteria for patient referral from the first level of care to other care environments in the health system that address coordination problems between levels of care and are based on the effectiveness of the services provided at each level and the system's overall efficiency.
- Promote individual total cardiovascular risk assessment in preventive clinical services, with emphasis on the treatment of patients at high risk of cardiovascular disease.
- Strengthen early detection and treatment of chronic kidney disease in people with hypertension and diabetes.
- Monitor hypertension control in the population on the national and local levels, especially among vulnerable groups.

A major issue is competency of Health personnel, thus the emphasis on training. We need to make sure that the technological tools are high quality and effective. Post vendor surveillance lacking and we need this, possibly in collaboration with PAHO.

Pocket guidelines

Guidelines for care are a pivotal concept, but guidelines are not a panacea. Guidelines set a pathway for practitioners, but we also need to ensure robust Health Information Systems to be used as a tool to evaluate quality of care. CRHC guidelines exist, but it needs ownership. There is no one professionally responsible for the guidelines. There needs to be financial incentives for use of guidelines.

Pocket guidelines for diabetes have been published, but there has been no progress re CVD pocket guidelines, the draft of which was presented to the meeting last year. The skill is there, but there needs to be a push effort to get them. We need to make sure people use them so we need incentives around them.

Identify areas for Regional Support

- Training in quality assurance
- Region-wide assessment of technology
- Assist with difficulties in terms of procurement
- Technical cooperation between countries to assist member states.

Discussion NCD Agenda in Countries

Was HIV/AIDS discussed with NCDs? Should NCD Commissions expand to other chronic diseases e.g. HIV?

The CMO group did not mention HIV/AIDS because HIV already has programme. Dr. Hospedales stated that there was a special session on integrating HIV and Chronic Diseases at the PANCAP meeting. It was agreed that we need to integrate HIV into the chronic disease. We need to put Human Resource in place to make this possible.

The Suriname experience with integrating HIV and Chronic Diseases: Global Funds were used to build capacity, so that systems are in place to integrate HIV and NCDs, including HIV prevention. The HIV centre that was established was not only used for HIV but also for NCDs. When NCD screening was added to HIV testing sessions, the uptake of testing increased.

Barbados has started the process of integration. The World Bank has done a mid-term review. HIV will be joining the NCD unit and team. There is room for marrying the two and Barbados has started the process.

We are talking about reorienting health services from a curative to a preventative type of approach.

Selected countries have started to look at how the reorientation can take place.

On-line Discussion

There does not seem to be extensive knowledge of the CCM in the region. Neither in theory or evidence. Just one question I will like answered. Most the evidence on the CCM seems to relate to the management of diabetes. Does this mean that the model is applicable (with the same level of success) to other NCDs? The application of the model is hinged on obtaining the required skill mix at the primary care level, where it must be applied. I think more evidence is needed regarding the application and success of the model beyond the management of diabetes. This could be done as a regional initiative as well as the re-orientation of our primary care services.

St. Kitts & Nevis has no NCD Intersectoral Body as yet. Perception is that civil society organizations are deficient and weak in terms of organizational capacity. We have been working with CBOs to assess / build on their capacity so that they can function independently and effectively collaborate with government and other CSOs. We would like regional support for the civil society groups in relation to organizational development and some technical skills such as strategic planning, resource management, proposal writing etc.

SESSION 7: Food Security (Trans fat elimination, sodium reduction, trade) (POS #7, 8)

Dr. Emma Herry-Thompson, Chair

CMO, Grenada

Expected Outcomes

- *Identification of approaches for strengthening the inter-sectoral alliance for healthier foods*
- *Identification of solutions to Food Labelling and Trans Fat in the Caribbean marketplace.*
- *Review of approaches to move the agenda for sodium reduction in the Caribbean*

Panel: Food Security, Salt and NCDs / Food Nutrition Security and Obesity / NCDs – What must be done

Dr. Fitzroy Henry

Director, CFNI Jamaica

1. The Role of Food and Nutrition in the Obesity and NCD epidemic

Food security policy needs to be developed with health considerations being a key factor. Obesity is a major risk factor for the main causes of death: - cardiovascular disease, cerebrovascular disease, diabetes and some cancers.

Food security, when defined adequately, has a major influence on Obesity. The definitions from the World Food Summit, 1996: Food Security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. This implies stability of availability, accessibility and consumption/utilization. **The overarching objectives are:**

Food Availability: Promote the sustainable production, processing, preparation, commercialization and consumption of safe, affordable, nutritious, high quality Caribbean food commodities/products.

Food Access: Ensure regular access of Caribbean households, especially the poor and vulnerable, to sufficient quantities of safe, affordable, quality food at all times, particularly in response to diverse socioeconomic and natural shocks.

Food Utilization / Nutritional Adequacy: Improve the nutritional status of the Caribbean population, particularly with respect to NCDs including diabetes, hypertension, overweight and obesity.

2. Trends in Prevalence of Overweight / Obesity

In the Caribbean in > 30 years old: Barbados, Trinidad &Tobago and Dominica have >50% prevalence of female overweight / obesity, while Barbados, Dominica and Bahamas have >20% prevalence of male overweight / obesity. These are among the highest rates in the world. Recommended daily requirements are 2300 calories per day. We have exceeded this since 1971, and have even increased this excess consistently since then, with an average consumption of >2700 calories in 2001. These excess calories are coming from fats and sugars, while only 5% of our populations eat the recommended 5 servings of fruits and vegetables / day.

3. Political commitment

The region is not short of mandates to achieve the link of food – nutrition- health. Since 1996, the Caribbean Ministers Responsible for Agriculture in the Food Security Declaration #5 stated "…Food Security in the Caribbean is also related to obesity, stroke and heart attacks…" Then in October 2007, the month following the POS NCD Summit, CARICOM Ministers of Agriculture issued the St Ann's Declaration in support of the POS Declaration. Recently, CARICOM Heads of Government Liliendal Declaration, July 2009 "The food & nutrition security strategy must… bridge the disconnect between food availability, health & nutrition, education, trade & investment policies and use a nutritional approach in estimating regional food needs."

4. Formulating policies towards food security

If problem is insufficient supplies of nutritious food, then the food security policy measures need to be promotion of domestic production and facilitate imports of nutritious food.

If problem is insufficient access to nutritious food, then the food security policy measures need to be enabling households to obtain nutritious food.

If problem is insufficient consumption / utilization, then the food security policy measures need to be - ensure households consume diets that reduce risk of major health problems

Public policy impacts obesity rates through national and community policies and programs related to both food intake / nutrient density and energy expenditure, including food, import, health, workplace, school, transport and other policies. It does not matter how many policies you have but it is important they should be integrated.

What Can Be Done?

a) Changes that are needed for transitioning towards obesity / NCD control

The new approach to food and nutrition policy is a bottom up approach producing food for a purpose.

Increase the consumption of stapes, legumes, and vegetables, and reduce consumption of food from animals, fats/oils, sugar and salt. We therefore must impact availability, accessibility and consumption i.e. food security

b) The Food Security Policy Goals

For the Caribbean the goals are to reduce fats and sugars and increase fruit and vegetables. The Caribbean Food security policy and plan has just been completed. It emphasizes that we should use a nutritional approach in estimating regional food needs and the guidelines developed should be culturally acceptable to the population. CROSQ is an important part in the setting of dietary standards, in establishing the standards and guidelines for food labelling health claims. We also need to examine and correct our vending policies.

c) Food & Nutrition must be important part of the NCD plan.

NCD plans must include Food Policies (Domestic and Import) to ensure healthy foods are available and affordable for adequate consumption.

The challenge is to utilize the limited resources – human and financial- to involve multiple partners and various levels in all sectors. The goal is to implement public policies in food and nutrition that can impact obesity and NCDs. (Definitions and the role of food and Nutrition in the Obesity and NCD epidemic are at Appendix 10.)

Food marketing and NCDs – The Way Forward
Dr. Fitzroy Henry

Food Marketing and Obesity

Food Marketing influences preferences, requests and consumption, and ultimately the health of the population. When challenged to refocus with emphasis on public health, marketers claim "free speech" and that their approach is "good for business". They are now using toys, games, educational materials, songs, movies, cartoon characters, celebrity endorsements via social networks and internet to market their unhealthy products. The result is that 30% of child's calories from sweets, soft drinks, salty snacks, fast foods, and childhood obesity in the Caribbean has almost tripled over the past 10 years. Among girls and boys 11-13 years old (2008), 33% and 27% respectively are now overweight or obese.

Facing threats of lawsuits over promotion of obesogenic foods, these companies are now scrambling to support health and exercise programs and are now trying to make products appear more healthful with:

- Whole grain chocolate cereal
- Vitamin enriched candy
- Trans fat free salty snacks

And, these are the most heavily promoted.

Countries are taking action

- At least 50 countries regulate TV advertising aimed at children
- Australia bans food ads to children < 14 yrs. old
- Netherlands bans ads for sweets to children <12 yrs old.
- Sweden bans cartoon characters to promote foods to children < 12 yrs old
- USA: Only controls duration of ads: Food ads may take up to 12 min per / hr. during weekdays but "only" 10.5 min / hr. during weekends

What are we doing in the Caribbean?

Banning ads is desirable but not sufficient. We Need:

- Dietary Guidelines - Suited To Country
- Standards &Education
- Regulation &Monitoring

1. **Food-Based Dietary Guidelines:**

We need to develop public policy across relevant sectors: food industry as it relates to production, manufacturing, processing, and preparing in institutions e.g. schools, hospitals, workplaces, etc. and for the general public.

Eight countries have already implemented their guidelines, two more are in development and four countries in the preparatory phase. A representative diagram, typical of the country is a feature of each country's guidelines. There are some common themes throughout the guidelines across the region.

- Eating a variety of foods;
- Eating more vegetables and fruits
- Reducing sugar, fat and salt intake;
- Drinking more water;
- Using alcohol sparingly or not at all,
- Increasing physical activity.

These **guidelines** have been used by health providers, teachers, journalists, extension officers and other persons working directly with the public.

Action needed

National NCD plans must include a strategy to guide public policy makers, food industry and the general public on healthy dietary practices

2. **Food Labeling**

Does use of nutritional information lead to dietary change? Results from studies vary, but there is evidence that using the nutrition label results in improved quality of diet, reduced consumption of unhealthy foods, lower cholesterol intake and higher intakes of fibre, iron, vitamin c and protein.

Supermarket survey of food labels in Jamaica in 2008 showed an average of 85% of packaged foods with nutrition labels. However, understanding the "nutrition facts panel" can be quite a challenge.

Nutrition labeling also include nutrition claims e.g. "fat free", "low salt", "high in …", "good source of …", "extra", "enriched", "fortified", "light", "healthy", "reduced", "lean", "more", "less" etc. These nutrition claims suggest or imply a relationship between a food or a constituent of that food and health, either expressly or by

implication, including "third party" references, written statements (e.g., a brand name including a term such as "heart"), symbols (e.g., a heart symbol), or vignettes.

Health claims can legitimately be based on the relationships between:

- Calcium and osteoporosis
- Sodium and hypertension
- Dietary fat and cancer
- Dietary saturated fat and cholesterol and risk of coronary heart disease
- Fibre-containing grain products, fruits, and vegetables and cancer
- Fruits, vegetables and grain products that contain fiber, particularly soluble fiber, and risk of coronary heart disease
- Fruits and vegetables and cancer
- Folate and neural tube defects
- Dietary non-carcinogenic carbohydrate sweeteners and dental caries
- Soluble fiber from certain foods and risk of coronary heart disease
- Soy protein and risk of coronary heart disease
- Plant sterol/stanol esters and risk of coronary heart disease
- Whole grain foods and risk of heart disease and certain cancers
- Potassium and the risk of high blood pressure and stroke
- Fluoridated water and reduced risk of dental carries
- Saturated fat, cholesterol, and trans fat, and reduced risk of heart disease

Action needed

National NCD plans must include a strategy to protect consumers against unscrupulous food marketing – media, labeling etc.

3. Trans Fat

Coronary heart disease risk increases with increased consumption of trans-fats with no threshold. 160 calories a day from trans-fats increases the risk of CHD by 250% and trans-fats both raises LDL cholesterol and lowers HDL cholesterol. Trans-fat decrease good cholesterol and increase LDL, thus being a significant risk factor for CVD. Trans-fats are everywhere, including in baked goods and fried foods

There is currently a program to undertake trans-fat studies in Dominica, Trinidad, Jamaica, Guyana and Barbados though funding has not yet been identified for Barbados. Analysis has actually started in Dominica. Trinidad is partly funded, and should be next.

What is the process to reduce trans-fat?

Analysis: standards & education; legislation & monitoring

Action needed

National NCD plans must include a strategy to go beyond reducing animal fats and target trans-fat elimination from the food supply

Food Marketing: The way forward

Focus on:

- Product characteristics and messages
- Marketing techniques and incentives
- Guidance for schools
- Guidance for retail stores (grocery, toy, and convenience video stores)
- Marketing approaches **not** to be used

PAHO/WHO initiative for Cardiovascular Disease Prevention through dietary salt reduction

Dr Branka Legetic

NCD Advisor, PAHO

When the POS NCD declaration was released, the understanding of the role of salt had not yet been established. Since then, global rates for hypertension have increased and we recognize that globalization impacting on nutrition and salt consumption.NCD Risk Factors mortality in the Americas for Middle Income Countries is at Appendix 12. There is a direct relationship between salt and high blood pressure, so salt is also a leading risk factor for death worldwide. The life-time risk of hypertension in our settings is >90% by age 85 years in both males and females. However, meta-analysis of reductions in dietary salt shows a resultant reduction in blood pressure of 2 to 10 mmHg.

Is the association between sodium and hypertension and the need for reduced dietary salt controversial?

The evidence has been reviewed by many national and international scientific and health organizations (WHO, IOM, AHA, APHA, national and international guideline processes and UK and most EU governments) and the conclusion is that excess dietary salt intake increases blood pressure and is a health risk (e.g.)

Mean levels of BP in populations are on the rise, and increased blood pressure causes cardiovascular morbidity and mortality. Excessive salt consumption causes increases in blood pressure, which then increases cardiovascular events. High salt intake has also been linked to other important health issues including direct (non BP related) vascular and cardiac damage, obesity and related diseases (e.g. diabetes), asthma, kidney stones, osteoporosis and gastric cancer

WHO & FAO recommended target for salt intake in the population (2003)
Less than 5 g of salt (< 2300 mg of sodium) per day, ensuring that it is fortified.

Data from 3 Caribbean countries from early 1990s show that even at that time, our salt intake was already 60% higher than the target. There is no current salt intake data from the region, although Barbados will have data from the Health of the Nation study in the coming year

Where is the salt in our diets coming from?

- **77% from processing of food -manufacturing process and restaurants**
- 12% natural content of foods
- 11% added at the table (5%) and in cooking (6%)

The data do not account for regional or cultural variation in salt added at the table

The Evidence: Lancet 2007 studies show that

- Lowering blood pressure through population-wide salt intake reduction is cost effective.
- A strategy that combines mass-media awareness campaigns with regulation of the salt content of food products has been estimated to cost between $0.04 and $0.32 US per person per year.
- Over 10 years, the strategy is predicted to avert 8.5 million deaths world-wide, mostly from CVD.

PAHO Initiative: Expert Group on Cardiovascular Disease Prevention through Dietary Salt Reduction with the goal of a gradual and sustained drop in dietary salt intake to reach national targets or the internationally recommended target of less than 5g/day/person by 2020. Professor Rainford Wilks is the Caribbean group expert.

Recommendations

To National governments

- Seek a multi-sectoral endorsement of the Policy Statement.
- Develop sustainable, funded, scientifically based salt reduction programs that are integrated into existing food, nutrition, health, and education programs.
- Initiate collaboration with domestic food industries.
- Regulate food industry to match the lowest salt content in the specific food category.
- Development of surveillance system that monitors population salt intake.
- Review national salt fortification policies and recommendations.

To non-governmental organizations

- Endorse this policy statement.
- Educate memberships on the health risks of high dietary salt and how to reduce salt intake.
- Promote and advocate media releases on dietary salt reduction
- Broadly disseminate relevant literature.
- Educate policy and decision makers on the health benefits of lowering blood pressure among normotensive and hypertensive people, regardless of age.
- Promote coalition building, increase organizational capacity for advocacy and develop advocacy tools to promote civil society actions.

To the food industry

- Endorse this policy statement.
- Make current best in class and best in world low salt products and practices. Provide salt substitutes readily available at affordable prices.
- Commit to gradual and sustained reduction in the salt content of all existing salt-containing food products, restaurant and ready-made meals.
- Use standardized, clear and easy-to-understand food labels that include information on salt content.
- Promote the health benefits of low salt diets to all peoples of the Americas.

Consumers International takes part in dietary salt intake reduction expert group of PAHO and produce Fact sheets for professionals and consumers/patients and a survey on consumer knowledge and behaviour with respect to salt/sodium. Working with industry is better than attacking industry. They have worked with industry through CODEX.

Surveillance

There is a need for:

i. A critical evaluation of the literature regarding protocols and methods for determining salt in the urine.
ii. Development of a protocol and statement on assessment of dietary iodine intake (visa vi 24 hour urinary excretion of iodine)
iii. Systematic review of the literature on utility of 'spot' or timed urines vs. 24 hour urines to assess iodine intake in surveys

Advocacy

The Healthy Latin American Coalition (40 civil society organizations) launched a specific initiative 'Asociacion Latino Americana Sal y Salud (ALASS)'

Monthly reports of the expert group activities

Engagement in WHO platform 1: Creating an enabling environment. June 30-July 2 2010

Food Industry Engagement

Codex Alimentarius is collaborating with the Salt Commission on labeling nutrients of special importance for prevention of NCDs. There was dialogue with industry members at the PAHO partners forum and an 'Industry questionnaire' was developed and piloted for multinational and national food manufacturers and industry leaders, to identify progress and intentions to reduce salt additives. There was also some discussion with individual companies regarding global responsibilities to reduce salt additives throughout the America's

In April 2011 there was a Joint PAHO and World Economic Forum on Latin America meeting and the "2011 Statement of Rio de Janeiro" created jointly by governments, the food industry and civil society. It encourages stakeholders to act now to improve the health of the people of the Americas using a comprehensive multisectoral approach to specifically reduce dietary salt.

Synchronizing salt iodization and salt reduction programs

Joint meetings of salt reduction and iodine fortification committees and leaders

Grant proposal to pilot programs to synchronizing salt iodization and salt reduction programs

Economic studies on the cost effectiveness and cost savings from population level dietary salt reduction

A 5% reduction in dietary salt per year in 10 years was estimated to prevent 400,000 premature CVD events and 20,000 deaths in countries in the Americas.

Countries in PAHO region that have Sodium Reduction Activities

Argentina, Barbados, Brazil, Canada, Chile, Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama) and the Dominican Republic, Cuba, Mexico, Suriname, United States and Uruguay

Further resources

CVD Health /salt

http://www.paho.org/cncd_cvd/salt

Policy statement

http://www.paho.org/cncd_cvd/salt/policystatement

Barbados NCD Commission initiatives in Salt Reduction

Prof Trevor Hassell

Barbados Special Envoy for NCDs and Chairman of NCD Commission

Professor Hassell acknowledged the significant role played by Dr Kenneth George, Senior Medical Officer of Health (NCDs), and the staff of the Ministry of Health, Barbados, in this initiative.

Prevalence of NCD risk factor, hypertension in Barbados

It is estimated that approximately one fifth, that is, 54,000 of the entire population, is hypertensive. An optimistic estimate suggests that only 30% of Barbadians have their blood pressure controlled to target, despite the fact that more than 40 different medications are listed in the Barbados National Drug Formulary and available free of cost at point of delivery to treat hypertension. This is a particular source of concern since hypertension contributes to 45% of all ill health and death from heart disease

Response

Against this background, the National NCD Commission launched a National Nutrition Improvement program that gives priority to salt reduction with the objective of controlling hypertension and reducing heart disease, stroke and diabetes

CARICOM Heads of Government NCD Summit Declaration of 2007 speaks to enhanced food labeling, the promotion of physical activity, the need to take account of gender, public education

programmes, research and surveillance, and support for CARICOM/PAHO. There is no specific mention in the Declaration of Port of Spain of 2007 of the need for salt reduction, but this item is included as a priority in the outcome statement of the Heads of Government of CARICOM meeting of 2009.

Heads of Government of CARICOM NCD Summit Declaration of 2007 states

> *"Burdens of CNCDs can be reduced by comprehensive and integrated preventive and control programs… ...collaborative programs, partnerships and policies supported by governments, private sectors…"*

Heads of Government of CARICOM – 4th July 2009

> *Committed to support activities related to the identified super priorities of Healthy eating – use of legislation, regulation and taxation to reduce trans fats, reduce salt intake, increase fruits and vegetables, facilitate healthy food choices.*

In 2009, the Barbados NCD Commission put together a plan to reduce salt consumption. Many of the target organizations are represented on the NCD commission thus contributing to much of the success thus far, and providing environment for many opportunistic initiatives. The approach of the commission was very action orientated.

The Approach

In the production of the earlier referenced nutrition improvement and salt reduction program consideration was given to many of the fundamental elements of a successful NCD prevention program, namely, creation of an enabling environment through policy enactment, community and civil society action, encouragement and fostering of individual responsibility and action, enhanced care and monitoring and evaluation. The following approaches were specifically promoted in the program:

Creation of enabling environment through enacting policy

- Policies to ban soft drinks in schools, such as the removal of vending machines and the sale of healthy items in school canteens
- Fiscal measures to make foods and drinks high in salt and sugar less available and affordable and those low in salt and sugar more available and affordable

Community and civil society action

- Advocacy
- Reformulation of food and drink products by producers and manufacturers
- Make salt the difficult choice in restaurants, hotels, eating places

- Support for the Physical Activity Task Force which has been tasked to promote and encourage physical activity, nationally.

Encouragement/fostering of individual responsibility and action

- Dissemination of information, pamphlets, health fairs, workshops and small group sessions, including a Best practice nutrition booklet for schools.
- Educational messages about salt, sugar and improved nutrition broadcast on radio and TV

Enhanced screening and care

- Improved access to blood pressure, height and weight measurement using innovative approaches.
- Workshops for health care workers on salt, sugar, fibre, fruit, vegetables, physical fitness and NCDs

Monitoring and evaluation

- Surveys of salt intake undertaken, including monitoring of adherence to the phases of the programme and monitoring of change in salt intake.

When the National Nutrition improvement and population salt reduction program was conceived it was envisaged that it would be led by a committee of the Ministry of health and the NCD Commission, that would include the National Nutrition Centre, representatives of the food industry (producers and distributors), Ministry of Education, the CDRC, Civil society, media Barbados Association of medical practitioners, Price Waterhouse Coopers and Nestle. These stakeholders were expected to have roles as follows:

Roles of stakeholders – members of the Committee

Ministry of Health	Announce policy, and lead initiate and coordinate policies
Food producers/distributors	Encouraged to take initiatives to reduce salt content in food products and/or meals
Ministry of Education	Ensuring that healthy food options and food snacks are available, affordable and easily identified
National Nutrition centre	Monitor, educate, provide guidelines,
Media and press	Send simple coherent messages
Civil society and NGOs	Advocate, organise campaigns, support dissemination of information
BAMP	Provide professional support

PwC	Provide the overall technical project management
Nestle	Source funds to conduct the monitoring aspect of the project
CDRC	Oversight the setting up of a mechanism to determine salt intake

The following is an over-view of some of the specific achievements and outputs of the Nutrition Improvement and population salt reduction program with emphasis on salt reduction.

Initiatives in salt reduction

Publications

- Produced booklet – "Battling salt the hidden enemy"
- Supported and endorsed recipe booklets of Nutrition Officers in the Ministry of Health
- Health and nutrition guide for schools
- Articles posted on the Healthy Caribbean Coalition (HCC) website,in Barbados Association of Retired Persons and the Better Health magazine of the Nation Newspaper, and in other daily newspapers

Media

- Produced and distributed PSAs for local television, distributed regionally; PSAs on local TV station
- "Get Healthy Barbados" TV Series
- Culturally appropriate salt jingle by local calypsonian
- Featured low salt issue, using Facebook, and cell phones in the Get the Message mobile phone advocacy and educational text campaign of the HCC leading up to the UNHLM

Events

- Promotion at Labour Day Rally
- Patron of and support for Agrofest 2011, "Healthy Living through Agriculture"

Training

- Workshops for school canteen operators and another for Agrofest food vendors
- "Salt seminar" for food and drink producers and manufacturers
- Discussion with bakery and food producer around product reformulation

Monitoring and evaluation

Health of the Nation Study, a population based survey of levels and sources of salt intake and other NCD risk factors administered by the CDRC has begun. The NCCNCD is in discussion with Prof. Nigel Unwin, UWI, Cave Hill, to support the "Development of a public health research programme to monitor, evaluate and guide policy measures aimed at the prevention of NCDs in Barbados and the wider Caribbean"

International initiatives

- Endorsed PAHO/WHO Policy Statement "Preventing CVD in the Americas by reducing dietary salt intake population-wide" A member of World Action on Salt and Health (WASH) with distribution of material to members.
- Presentations at PAHO/WHO meetings on salt reduction.

Lessons learned

There is no substitute for action and enthusiasm. It is important in the initial phases of national program implementation to spend time to obtain "buy-in" of all parties. NCD Commissions are well placed to lead and secure official agreement and support for national NCD initiatives.

Plans

- Further broaden strategic partnerships between government, private sector, academia and civil society (National Standards Institute and Manufacturers Association).
- Monitor and evaluate the nutrition improvement and salt reduction program, while at the same time strengthening and expanding it and possibly extending its reach into the OECS.
- Use of mobile phones, new media and traditional media to promote specific NCD programs.
- Continue to create an enabling and facilitating environment that allows for implementation of major policy changes and enactment of legislation.

Support needed

- Continuing technical support from PAHO, especially around salt controversy.
- Assistance in securing the participation of the medical community and health care professions in the NCD effort. Support fora Caribbean multi-sectoral salt reduction conference/workshop.

Discussion: Food Security

What is impeding the local agricultural productions?

As it relates to agriculture policies, a lot has to do with the awareness of the Ministers. The Ministers at the St. Ann's summit were pleased to hear how nutrition affects health. Minister Tufton was the chair, and the Declaration was a readily accepted. He is calling on COTED and COSHOD to meet. It cannnote be realized without a clear concept of their role. These are Caribbbean people and once presented in the right way persons will come on board.

Nutrious high quality food means that food should be made available in the raw state, and then it needs to be kept nutritious during the cooking process. Work needs to be done in this regard at both the policy and community level.

What is the evidence and feasibility of using fiscal polies and intiatitives for modifiying dietary behavor?

We have to ddo the analysis and look at alternatives. Is taxation politically feasible? Whe have to look at the evidence, practicallity, cost and political feasibility. Much more needs to be done.

What about gender, cultureand family on nutrition and food choices?

Triggers for people to change diet are first taste, convenience, cost (time) and then health. If we are going to target health it is not high on the agenda. It boils down to food economics. We are putting too much emphasis on the individual. There is need for infrastructure to be put in place to facilitate societal responses to making healthy foods available.

An example of an intiative in the Latin America was ann agreement with supermarkets to change the place were fruits and vegetables were in the supermarket. These items were moved to the front of the supermarket and their sales increased. Dr. Cummings recommend a study on how we can educate our children about good nutrition and its impact on the obesity epidemic.

Can we have user friendly labels i.e. the stoplight (red. yellow, green) as is used in the UK?

We would need to get CROSQ involved in those discussions, but it would be helpful, since regular nutrition labels are so difficult to figure out.

Also re: labeling, transfat free does not mean that the product has zero transfats. So the small amouts can accumulate and have the effects of transfat.

What is the role of media?

Is it a reommendation to have media houses included in the commission. Prof. Hasell stated that the composition influences the role and function of the commission, so if media is included that is a better position.

Dr. Legitic added that it is extremely important to have the right mesage going out. PAHO is trying to develop a social marketing guide.

SESSION 8: Intersectoral Partners: Engaging with The Non-Health Sector (POS #12)

Dr. George Mitchell, Chair

NCD FP, Grenada

Expected Outcomes

- *Showcase of advances in engaging with the private sector and civil society*
- *Discussion of lessons learned and how to improve media and civil society engagement*
- *Review of advances in the Pan American forum for action on NCDs and Partners Forum in the Caribbean*

The invited guests for this session from the TRT Partners Forum were introduced and welcomed.

Panel: Partners Forum – Pan American Forum for Action on Chronic Diseases: Application to Caribbean

Dr. James Hospedales

Senior Advisor NCDs, Pan American/World Health Organization

Why should there be a Pan American Forum for Action on NCDs?

The reason is that NCDs are the number one killer in the world, and confer a heavy human and economic burden. They are a threat to development, yet are largely preventable, but we need an all of society solution.

"It took us, all of us, governments, people and companies, decades to get into this mess (NCD epidemic), and it will take all of us working together for many years to get out of it" *Mirta Roses-Periago, D/PAHO.*

In December 2009, PAHO launched the *Partners Forum for Action on Chronic Disease in the Americas* in collaboration with the CARMEN country network and many interested partners. Special thanks to PHAC which has supported us strongly and to WEF which facilitated the engagement with the private sector. The Forum was welcomed by all stakeholders as a needed

platform. A review of the roles of different sectors shows the **synergy** that can be obtained by combining their different roles/ capacities.

Implementation and evaluation in 2010 showed a need to revise our modus operandi, so a consultant engaged in late 2010 to review progress of the Forum to date and make recommendations

The Partners Forum - A Platform to Move Forward at Appendix 13

Provisional Timeline Aligned with the Regional Strategy: Foreseen Products 2012-13

- A functioning Forum with annual meetings
- 100 members from a balanced background have joined
- 50 PAHO & MOH officials trained in multi-sector collaboration
- Compilation of successful practices in region
- IT platform developed and successful practices showcased
- At least two (2) national/sub-regional multi-stakeholder forums started,
- Project pipeline mechanism established
- At least four (4) regional projects underway - Wellness Week, Salt Reduction, Healthy Workplaces, Public awareness, Treatment adherence, Cervical Cancer and others

Managing conflict of interest in the Forum

Passion is one thing; nitty gritty is another.

Members will be invited to sign a document outlining shared values and commitment, rights and responsibilities and rules of participation. There is the need to differentiate policy ("WHAT" is to be done) decided by public health authorities from implementation ("HOW" we achieve these goals) were members work together.

The Forum will engage a diverse range of government, civil society, academic and business entities to ensure no one has undue influence and hold each other accountable. There will be applications and due diligence process in vetting membership and Tobacco, Alcohol, Firearms will not be allowed to participate or contribute. The process of Forum dialogue will be separate from action and funding. **Early Supporters (see Appendix 14)**

Next Steps

The project teams are on the move. They are developing a detailed 2-year Plan of Action, including a strategy to diversify membership. The infrastructure is being put in place i.e. IT

Platform, hiring the management team, communications. The next Advisory committee will be Feb 29, 2012 and the next Forum meeting with the CARMEN Network meeting in March 2012. The Forum will be looking to leverage other events in 2012.

Application to Caribbean

The regional Pan Am Forum, regional strategy goals and UNHLM declaration are applicable. Potential partners include PAHO/WHO, CDC, PHAC, CLAS, HCC, GHC, WEF, IBLF, Media, IFPMA, IFBA, WFSGI, SDA, and McGill. This initiative should align with WHO NCDnet.

Areas for interventions include communications and advocacy, Workplace Wellness programmes, salt, tobacco text2quit, clinical management of CVD, diabetes and cervical cancer.

Caribbean: Regional/national

The CARICOM NCD plan, CCH3, POS NCD Summit Declaration and the UNHLM Declaration are referenced.

Partners should include CARPHA, CARICOM, HCC, CAIC, CCC, CDB, CHA/CTO, UWI, Caribbean Air, LIAT, Media, national NCD commissions with a PAHO supportive role. It should be aligned with the Pan Am Forum, but should determine its own funding and structure.

Partners Forum Initiatives in TRT

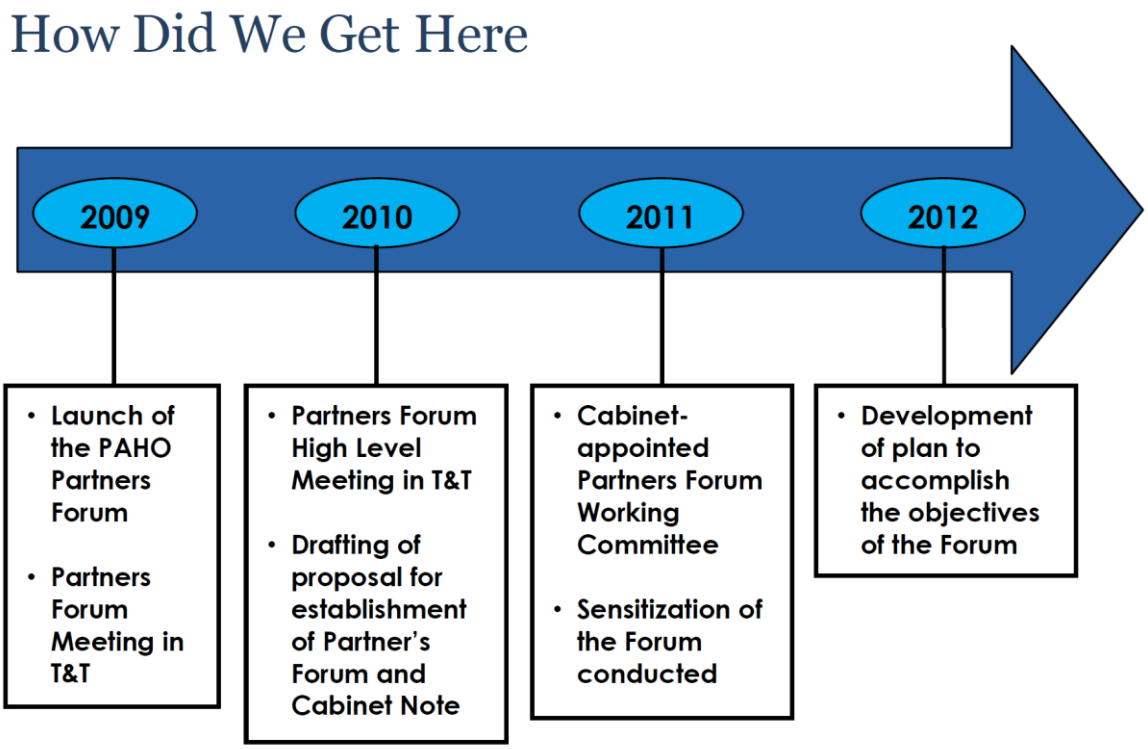
Ms. Yvonne Lewis

Director Health Promotion, TRT

The Partners' Forum for Chronic Disease Prevention and Control is a new approach established by PAHO/WHO, under its Chronic Disease Program. The Forum was established to create partnerships between the various sectors, create synergies and catalyze environmental, social and policy changes that promote health and prevent chronic diseases.

How Did We Get Here

In 2009, PAHO launched the Pan American Forum for Action on NCDs. Trinidad and Tobago was one of the countries invited to attend the launch and to pilot the development of a national Partners' Forum. In 2009 a first Partners Forum meeting was held in Trinidad &Tobago to share the new strategy for engaging manufacturers, the private sector and civil society in the response to NCDs.



From the Office of Yvonne Lewis
Director, Health Education Division

In 2010, there was a second Partners Forum High Level Meeting in T&T and the drafting of the proposal for establishment of Partner's Forum. Subsequently, the Minister of Health took a note to Cabinet for the establishment of a national forum, and in 2011, the Cabinet appointed a Partners Forum Working Committee for action on NCDs. For 2012, there will be the development of an action plan to accomplish the objectives of the Forum.

Basis for establishment of Priorities: Declaration of POS

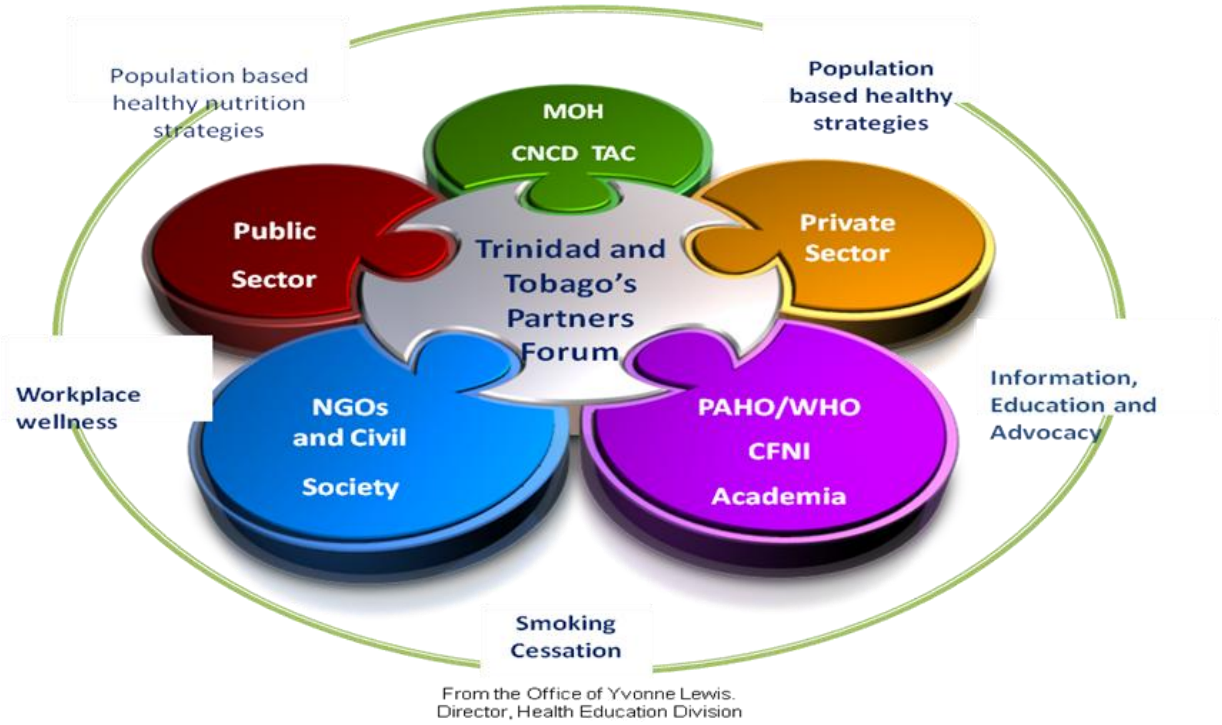
Resolution #2: Establishment of National Commissions on NCDs or analogous bodies to plan and co-ordinate the comprehensive prevention and control of chronic diseases

Resolution #5: That our Ministries of Health in collaboration with other sectors establish comprehensive plans for screening and management of chronic diseases …

Resolution #7: Endorsement of the efforts of the Caribbean Food and Nutrition Institute (CFNI) Caribbean Agricultural Research and Development Institute (CARDI) and regional inter-

governmental agencies to enhance food security and our strong support for the elimination of trans fats from the diet of our citizens, using CFNI as focal point for guidance and public education.

Structure of the Trinidad and Tobago Partners' Forum



The goal of the Trinidad and Tobago Partners Forum

To act as both a catalyst and a mechanism for multi-sectoral action to promote health and reduce the burden of chronic diseases on the population.

Participants are MOH NCD TAC, Public Sector, NGOs and civil society, PAHO/WHO / CFNI, Academia, Private sector.

Terms of Reference

The Terms of Reference of the T&T Partners Forum and Global strategies for the prevention and control on NCDs are at Appendix 15. Actions will focus on addressing the modifiable biological, environmental and social determinants of NCDs including population based healthy nutrition strategies regarding elimination of trans fats, reduction of salt and sugar in locally produced

foods, provision of product information and health education to support healthy lifestyle choices. The TORs also include development of supportive environments for population based physical activity, smoking cessation and workplace wellness programmes.

A key mechanism to achieve these goals:

To achieve this national objective, the Minister of Health has mandated the Forum to:

1. Develop a mechanism for and broker industry led agreement(s) to:
   a. Reduced salt and sugar content in locally produced foods
   b. Produce healthy food options to the high fat, high sugar, high salt foods
   c. Eliminate trans fats from locally produced foods
2. Work with private sector and manufacturing sector to increase access to healthy food choices in schools and in the workplace
3. Support and promote education on healthy eating through consumer education and advocacy for access to healthier products
4. Introduce product labeling on locally produced foods
5. Support joint action to develop mechanisms for and facilitate physical activity :
   a. Through Workplace physical activity initiatives
   b. Through the network of village and community recreational grounds and playing fields
   c. For special groups, the elderly, differently able persons etc.
   d. Culturally relevant physical activity (identify good/best practices/scale up)

Advances in the civil society movement in the Caribbean

Prof Trevor Hassell

Chairman of the Healthy Caribbean Coalition.

An audit of Caribbean health NGOs show that some are very effective and engaged in major initiatives. A limited number provide contractual services to Government, but most are underfunded, lack capacity and have weak governance structures. Many are not well established or do not exist in several of the smaller countries.

Health NGOs will need much assistance if they are to make a meaningful contribution to the "whole of society approach" to NCDs.

CARICOM Heads of Government NCD Summit Declaration of 2007 states in part

> *"the burdens of NCDs can be reduced by comprehensive and integrated and control strategies at the individual, family, community, national and regional levels through collaborative programmes, partnerships and policies supported by governments, private sectors, NGOs and our other social , regional and international partners".*

As a direct response to the call for a collaborative and supportive role of civil society in responding to the chronic diseases, a civil society Caribbean Chronic Disease conference was held titled *"Healthy Caribbean 2008: A Wellness Revolution Event".*

Action Plan

Out of that meeting was established a Caribbean Civil society NCD Coalition/Network to contribute and participate in all aspects of advocacy as a tool for influencing positive change around NCDs, develop an effective method of communication for and among members of the coalition and to contribute to chronic disease public education campaigns and programmes.

Priorities include monitoring, evaluating and holding policy makers and stakeholders accountable, support for Annual Caribbean Wellness Day celebrations, advocacy and support for chronic disease risk factor reduction, support of initiatives, plans and programmes at country and organization level.

Implementation by an Organising Task Force, Healthy Caribbean Coalition

The Healthy Caribbean Coalition (HCC) was formed in 2008. It is a live network of health non-governmental and civil society organisations from across the CARICOM region with a specific remit to address non-communicable diseases (NCDs).

Achievements

A website and effective communications system has been established. HCC has endorsed the PAHO policy statement on preventing cardiovascular disease through population salt reduction and has initiated a public education salt reduction campaign which is considered as a model for development of advocacy initiative.

External relations have been established with PAHO, Agita Mundo, International Union for Health Promotion and Education, Global Advocacy for Physical Activity, Common Interest Group of the NCD Alliance, Health Action Partnership International, UK and the National Heart Forum, UK.

In 2010 the HCC held a Workshop, the objectives of which were to report on progress of the HCC and develop a vision for the future. Guidance came from learning from international and regional networks to assist in improving the functionality of the network and to develop the best mechanism to achieve the vision. It built on relationships with other networks and initiated the development of a wider communication and stakeholder engagement strategy.

The workshop also identified international and Caribbean specific issues, policies and drivers for action in relation to NCDs. It sought to strengthen the coalition by engaging members and new partners in working towards a common goal, so that it could articulate added value to countries, build a consensus on ways of working, identify short and long term funding streams and strategise on the role of the HCC leading up to the UNHLM.

Outputs of HCC workshop 2010

Specific plan of action for strengthening HCC and making it "fit for purpose", including enhanced governance, coordinated approach to NCDs that is relevant to, and takes into consideration, priorities of HCC, strengthening civil society (around NCDs) within countries, identifying funding for HCC and identifying a role for the Healthy Caribbean Coalition leading up to, and at UNHLM on NCD in 2011.

Civil society in the Caribbean in addition to specific NCD related NGOs now has with the establishment of the HCC a civil society umbrella body or alliance to support the work of specific health NGOs and other civil society organizations in responding to the challenges posed by NCDs.

There now follows an outline of a project undertaken by the HCC which provides an example of how the HCC can add to the advocacy and educational efforts of health NGOs in the Caribbean in responding to NCDs.

HCC Text Messaging Campaign in support of UNHLM

Objectives

- Obtain regional support for Caribbean leaders attending the UNHLM
- Familiarize public with the NCDs
- Empower people to agitate for change that leads to a decline in common risk factors for NCDs

Challenges

- Limited funding
- Manage an NCDs campaign in 17 territories with different cultures, languages and varying literacy
- Introduce the concept of using mobile phones for advocacy and of the importance of the UN Summit to the region.

The Brand

Get the Message

Text the Message

Be the Message

The Partners were PAHO/WHO, Health NGOs, two regional mobile phone carriers, regional media network radio / TV, newspaper, large regional health insurance company.

Call to action

Simplest statement of advocacy: SMS/text the word **"Yes"**

Social Media

www.healthycaribbean.org, Blackberry BBM groups and email lists.

Results

The greatest number of texts came from Haiti 95,000, Barbados 99,000, Suriname 48,000, Jamaica 48,000, Guyana 39,000, Antigua 37,000, Grenada 29,000 with lesser numbers from other countries, for a total of 480,000 texts.

Lessons learned

There has been limited experience in the region of civil society coming together around health issues to advocate for change and hold policymakers accountable. In developing the HCC there has been a need to educate and inform ourselves about the tools available to civil society to effect change, even as attempts are made to bring organizations together in an effective network.

Expressions of intent by regional policy makers often surpasses implementation of legislation, policies and programmes necessary for combating this group of diseases so they need to be held accountable.

Plans

Use mobile phones and social media to build capacity and possibly provide revenue, to Health NGO members of the HCC and to the HCC, thus enhancing capability of civil society to contribute to "whole of society response to NCDs". We also need to initiate and lead on specific projects in NCD prevention and treatment. A strategic planning meeting of HCC will be held in May 2012.

Further support for the HCC is needed that includes an increased "voice" at CARPHA, CARICOM and PAHO/WHO, and long-term sustainability related to core funding.

Faith-based Initiatives in Jamaica

Dr Tamu Davidson

NCD FP, Jamaica

> *The problems we face today, violent conflicts, destruction of nature, poverty, hunger and so on, are human-created problems which can be resolved through human effort, understanding and the development of a sense of brotherhood and sisterhood. We need to cultivate a universal responsibility for one another and the planet we share.* -- ***The Dalai Lama***

Background at Appendix 16.

National FBO meeting

On August 27, 2009 a National Faith-based consultation workshop was convened in collaboration with the PAHO Jamaica and Washington. The purpose of this consultation was to strengthen the national response to prevent and control non-communicable chronic diseases and promote healthy lifestyles through engaging the Churches and Faith-Based Organizations (FBOs) as partners.

The consultation objectives were as follows:

1. To provide information on NCDs, risk factors and determinants and what works in prevention.
2. To examine the role of churches in prevention and control of NCDs
3. To provide a forum for churches and faith based organizations to share information on what they are doing e.g. education, community programmes, screening etc.
4. To develop an action plan for the next 12 months including support to Caribbean Wellness Day
5. To develop a guide for Churches and FBOs in responding to the NCD epidemic and promoting healthy lifestyles

Workshop content

Section I: The Regional and National perspective on the NCD epidemic and the response.

Section II: Promising practices within the Caribbean region focusing on CNCDs prevention and control

Section III: Group work that examined the NCD response and role of churches and FBOs

Results of Participant evaluation at Appendix 16

Key actions identified for forward agenda:

1. Host annual or quarterly workshop.
2. Churches could partner with Health Centre within close proximity to host support groups sessions e.g. diabetes. Churches have available spaces for clinics, youth groups etc.
3. Establish a liaison desk with MOH to facilitate information sharing.
4. Strong advocacy among FBOs.
5. FBOs should select specific item for implementation.
6. Develop small working groups for continuation.
7. Develop a MOU with MOH & FBOs to show commitment to the process.

8. Training of Lay Wellness Promoters.
9. Develop a guide for FBOs to carry out activities.

Post forum Activities

1. FBO working group developed a "Guideline for Churches and Faith-based in responding to the Chronic Disease Epidemic & promoting healthy lifestyles." – November 2009.
2. Technical support for Health Events by Ministry of Health network on ongoing basis.
3. Implementation of a Manchester FBO project
4. Hosting of a 3-day training of FBO Wellness Promoters in July 2010.
5. Hosting of an Annual meeting for Churches and FBOs in August 2010.

Post-forum evaluation

In August 2010, one year after the original forum, an evaluation of the consultation forum was conducted. Both quantitative and qualitative research methods were used to undertake the evaluation including the administration of a questionnaire, focus group discussion and group work. The assessment was is to ascertain how the churches and FBOs are addressing NCDs and how they have responded to the invitation to partner with the MOH and PAHO as well as how they can be helped in their response.

Survey findings and Findings from focus group at Appendix 16

Major challenges identified by the FBOs

1. Influencing behaviour change.
2. Members and community members are often exposed to the necessary information but that knowledge does not effect change.
3. Members and community members have a difficulty in knowing how to put the acquired knowledge into practice and translate that message to everyday life. They sometimes begin a regime and fail to follow through.
4. There are challenges as it relates to addressing youth and their eating habits. This group needs to become a target population.
5. There is a lack of resources – technical, financial and human; as well as a need for equipment.
6. There is need for an Operating guide or manual.
7. Getting the message across to the congregation and other member churches/FBOs is challenged by continuity and lack of institutional memory as persons who are trained and/or participate in the national consultation move on.

Proposed improvements include:

- Inform leaders in the different places of worship of the importance of promoting health and a healthy lifestyle.
- Concerted efforts made to inform the church board or health ministry director so that there is institutional memory that transcends the individual and promote continuity.
- Collaboration with other faiths and organizations in responding to NCDs.
- Creation of a structured networking system that will serve to share information and promote collaboration and partnership among FBOs.
- Capacity building.
- Greater visibility of what churches/FBOs in collaboration with the Ministry of Health are doing in addressing NCDs.
- Provision of technical and financial resources by the MOH/PAHO.
- Establishment of monitoring and evaluation systems to assess work being done by FBOs and to assist in securing funds.

Current Status

- There is now a Faith-based wellness promoter's programme. The pilot project, Leadership training in health for FBO leaders was held in September 2011.
- We need a "FBO" champion for health.

A Call to Action!

Religiosity in Jamaica continues to be a critical contributor to how individuals' faith and beliefs are formed and shaped. There is an undeniable influence of church and Faith based leaders on the lives of their congregants.

FBOs are well-positioned to promote healthy lifestyles.

> *Never before probably has the need for interfaith commitment been nearly as great as it is at this very moment.* -- **Walter Cronkite**

> *Religious people must do more than offer prayers if the world is to become a better place to live.* -- **The Dalai Lama**

Acknowledgement at Appendix 16

Talking with whom? Enhancing Media support for the NCD agenda in the Caribbean

Ms. Dorrett Campbell
Media & Communications CARICOM

Ms Campbell established that the ultimate goal of communication on NCDs is behavior change. She outlined the challenges of eliciting behavior change through mass media campaigns noting that employing social marketing and theory-based behavior change communication strategies which involved development support communication in an enabling environment was the better alternative. However she highlighted three stages in a process that could lead to behavior change:

1. Public information which involves making NCDs a household name in the Caribbean.
2. Public education which involves helping the target audience to understand the severity , of NCDs - the threat to lives and livelihood as a motivation to consider changing lifestyles.
3. Participatory approach which involves participation from target audience in activities that will empower them to change behavior.

Ms Campbell pointed to the imperative of creating appropriate platforms for mass participation. Participation she stated leads to habit; habit leads to behavior change. She noted that the primary participatory mechanism that the Community now has was Caribbean Wellness Day which has been institutionalized and acknowledged other vehicles used by some Member States such as *Ciclovia* in Trinidad and Tobago.

The media culture

Ms Campbell explained that any effort to maximize the support of mass media in promoting healthy lifestyles and making NCDs sexy in the region must involve a thorough understanding of how Mass Media works. She outlined the following as critical micro-cultural factors that one should consider in engaging Mass Media: 1) Ownership, 2) business policy 3) reporting culture 4) role of Media, 5) competing priorities and 6) media relationships.

With regard to ownership she noted that approximately seventy percent (70 %) of traditional print and broadcast media was privately owned. The remaining 30% was government owned. However, she hastened to point out that there were contemporary internet-based technologies referred to as New Media which could be accessed and used by anyone with access to internet and smart phones and underscored the importance of plowing into this fertile soil to reach mass

audiences. A number of websites and social networks now facilitate user generated content thus allowing for health communicators to tailor, package and promulgate their own messages.

With regard to the reporting culture, Ms Campbell explained that Mass Media invariably practiced what was called low cost differentiation strategy. This had implications for organizing NCDs events and packaging messages for Media. In illustrating this she noted that many reporters assigned for coverage lacked relevant training in journalism and mass communication and ostensibly had basic writing skills. This very often limits their capacity to interpret and report on complex issues, hence the adoption of what she called sound-byte reproduction of speeches approach to coverage. She suggested that health communicators and health specialists provide training in their content area and break down complex issues and concepts into intelligible manageable reporting portions for media workers in order to win coverage.

The micro-cultural factors, she explained had implications for how the health community should perceive media in order to maximize their use: the following summarizes the points she made:

- Build a partnerships and not a reporting relationship with media workers
- Talk with them and not at them
- Share information with them and not disseminate information to them
- Make them owners and not conveyors of NCDs issues

The mindset of the health community she added needed a radical shift from

- Disseminating to sharing
- Informing to educating
- Reporting to partnering
- Briefings to dialoguing
- Facilitating to training
- Resisting / avoiding to accepting / accommodating
- Partnering to ownership

How do we do that? We get to know media workers better; we engage them bring them around the table with us; we train them to understand issues and we talk with them; listen to them instead of at them.

SESSION 9: Conclusions, The Forward Agenda for Cooperative & Regional Actions

Dr. Fitzroy Henry / Dr. James Hospedales, Chairs

Dr. Alafia Samuels, Wrap-Up Rapporteur

Expected Outcomes

- *Determination of Regional NCD priorities and opportunities for next 2 years / Revision of the Gap Analysis and the Way Forward*
- *Identification of common areas of weaknesses or requests for capacity building*
- *Determination of matrix with timelines, actors, resources and accountability indicators*

This exercise is looking at regional supports and interventions that countries would want to help them strengthen the implementation of the NCD agenda in their countries. Countries already have country plans, so this discussion is about what collective actions can support those plans. This exercise is not to determine country priorities. Each country does that for themselves. This is to determine what countries want the regional effort to focus on and how they can support each other.

The regional plan was tabled and approved by the Ministers of Health at their COHSOD in April 2011. The monitoring and evaluation framework is specified in the country plan and in the regional plan. There is also the specific POS NCD Summit evaluation grid which countries update at least annually.

The regional supports to be determined in this discussion can be funded by a variety of sources, as they have been over the past years, but we need to have a clear regional agenda to set regional priorities so this meeting should agree what we want to do at the regional level. We also need to identify areas for country to country support and collaboration, to facilitate learning from each other.

We will look at the individual country reports to determine their stated needs for regional supports, but that questionnaire was generic, and here we need to go through each Line of Action.

Regionally, the top priorities for 2012 are:

i. Country level NCD Plan developed and operationalized.
ii. Further definition of targets and strengthening surveillance at country level.
iii. Multi sectoral involvement in the NCD agenda at country and regional level.

CARICOM NCD FORWARD AGENDA

TOPIC	PROBLEM	PROPOSAL	TIME
NCD Plans	Suriname and several ECC and UKOs do not have a plan	Countries can use the model country plan as a start. PAHO ECC office will help them develop plans over the next 6 months.	2012 priority
Surveil-lance, HIS and Integrated reporting	CAREC has revised the surveillance system to include both CD s & NCDs Need commitment to morbidity reporting Limited human capacity compromises timely reporting and quality data	Strengthened HIS i. Further definition of targets ii. Strength surveillance at country level iii. Policy for unique identifiers for citizens	2012 Priority
Multi-sectoral partnerships	Inadequate engagement with the private sector, civil society and other government agencies	Appointment of multi-sectoral NCD Commissions Support for development of NCD partnerships Convene a Caribbean Region Partners Forum	2012 priority
Tobacco labelling	What Regional Support is needed to get the tobacco warning on the labels in individual countries, since we have failed to agree on a regional standard?	Dr. Lewis-Fuller to provide information on the process at country level going through the national Bureaus of Standards. Countries should examine the process in their country.	June 2012
Tobacco status to Heads	Briefing on Tobacco by CARICOM could be done to the Heads of State	Dr. Cummings or CARICOM Secretary General.	Next Heads meeting
Tobacco legislation	Model legislation is needed	Trinidad & Tobago model tobacco legislation is on NCD website	Done

TOPIC	PROBLEM	PROPOSAL	TIME
Alcohol	Alcohol is at an early stage of development and has to be addressed differently from cigarettes. We need to educate ourselves on the issue of alcohol. CARICOM not in support of a pure health approach to alcohol but wanted some balance as we are alcohol producers. CARICOM report on development and health is looking at alcohol in relation to injuries.	PAHO can help with guide on Alcohol, and will share strategy CNFI will send information on Alcohol compiled for the Region in two Volumes ? Regional consultation on alcohol	2013 Jan 2012 2013
Healthy Eating	Model legislative on Healthy eating and active living brief Within the MOH we need to develop internal network e.g. nutrition	Countries want this information from PAHO Encourage internal communication within MOH	June 2012 on-going
More leadership on trans fat	Trans fat study will look at food supply. In Jamaica and Barbados plan to look at trans fats in the human body as well. It is not an expensive process and can be done rapidly.	CFNI seeking further resources to complete this in the Caribbean	Jan – June 2012
Healthier foods	Role everything together salt, Trans fat - issues on food. It makes sense to bring all of this together into one place.	CARICOM to try to engage IFBA with our private food manufacturing and preparation industries to promote product reformulation	2012
Active Living	Improve collaboration with town planning, urban planning - use the Road Safety as an advocacy tool	We should be catalyst, not leader. Involve the Caribbean Association of Engineers, Architects, and town planners, Caribbean Association of Roads PAHO to get ad circulate New York Urban Design guideline CARICOM to engage Mayors, perhaps with Mayor Bloomberg as guest.	2013

TOPIC	PROBLEM	PROPOSAL	TIME
Community based PA	In T & T they have seen it work after 10 years with walking paths, light parks in urban green spaces	T & T to share process	June 2012
Food labelling	Food labelling seems to have fallen off the agenda	CARICOM support putting food labeling on the agenda with CROSQ	2013
Vending		CFNI to share the BVI policy and guidelines on vending	Feb 2012
Workplace Wellness		Jamaica can share guidelines on workplace wellness, community manual – will share T & T developed workplace, and healthy eating policy in the workplace policy in draft – will share.	Feb 2012
NCD prevention in schools	Regional revision of the curriculum for NCD prevention Problems of school time, infrastructure, trained PE teachers, safety on school grounds	Regional support for curriculum revision Regional working group should be created	2013
Public policy	We need a skeletal outline	Dr, Bolis, PAHO will help by preparing a legislative brief	2013
Media & Social communi-cations	Media have to educate civil society and provide a platform for civil society. We need strong civil society groups. It is necessary for NCDs to include the application of the stages of change theory or health promotion theories to be applied to NCDs	Regional strategy needs to be developed in collaboration with the media houses	
NCD Focal Points	Need Terms of Reference for Focal Point	Draft TOR NCD FP to be revised coordinated by Petronella Edwards St Kitts/Nevis	May 2012
Capacity Building / Training	Prevention and behavioural change	CHART & ITECH as a good partner for training	2013
Integration with HIV	Tool kit for programme management borrow from HIV/AIDS Explore the development of Health Information System as an area HIV support	Suggest James Hospedales working with PAHO Focal point for HIV to look at integration and sharing	Dec 2012
TOPIC	PROBLEM	PROPOSAL	TIME

NCD funding	Propose 1% GDP to focus on HIV and NCDs Need for skills in Costing and developing of plans The Economic Commission need to include NCDs or their projections will be wrong. Finance Ministers need to invest in prevention funding the most cost-effective intervention. Make an economic argument for a multisectoral approach	Look at resource mobilization for NCDs as a social good Regional should put it forward as a development issues Invitation to speak to the finance Minister of ECC, we need a dialogue as to the investment and policy options.	2012
Integrated Disease Manage-ment	We need to add diagnostics to the list for Strategic Plan Essential list of drugs should be included on resource site.	Dialogue with CRDTL To be put on NCD site by A. Samuels	2012 Feb 2012

On-line Discussion Forward Agenda

- Reorientation of services – toward a wellness approach
- Acceptance, distribution and implementation of protocols
- Addressing risk factors
- Increasing advocacy
- Early detection & treatment
- Improved surveillance & data: known gaps include a comprehensive epidemiological picture of NCDs; information of the health effects and impact of alcohol use; data on the economic costs of NCDs; impact assessments of interventions; risk factor surveys

WRAP-UP AND ADJOURN:

Dr. Samuels, Meeting Facilitator, thanked all for their participation, especially the supports from IDB/UWI and PAHO. Dr. Henry thanked Dr. Samuels for her NCD work on behalf of the meeting.

Participants

There were 69 participants, plus the community members at the field training site.

- 17/20 CMC:6/7 IDB member states (Guyana in post election mode), all 6 ECC and 5/6 UKOTS (TCI did not attend) Haiti did not attend
- 10 CMOs, 16 NCD FPs
- PAHO - WDC, UN, OCPC, Suriname, Jamaica, Guyana, Barbados/ECC
- PAHO RHI - CFNI, CAREC, CHRC
- UWI - St. Augustine, Cave Hill
- CARICOM
- Healthy Caribbean Coalition

- NCD Commission Chair - Barbados, Jamaica
- TRT civil society Partners Forum

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Conference Evaluation

Twenty six (26) participants completed the anonymous evaluation either on paper, or online (Surveymonke):

- 25 / 26 (96%) were extremely or moderately satisfied with the conference.
- 19/25 (76%) said the conference was slightly, somewhat or much better than expected, while 6/25 (24%) said the conference was about what was expected.
- All 26 respondents though the conference was moderately, very or extremely organized.
- 19/26 (73%) said the information presented at the conference was very or extremely organized, while 7/26 (27%) said moderately or slightly organized.
- 10/26 (38%) said there was the right amount of time for discussions, and 8 (30%) felt there was too much time given and the same 8 (30%) saying there was too little time for discussion.
- All 26 said they were moderately, very or extremely comfortable asking questions.
- 17/23 (74%) rated the conference facilities as average or good, with 4 (17%) saying very good, and 2 (9%) saying it was poor.

What did you like least about this conference?

The main concern was that the conference was too short for the amount of material being covered and presenters did not respect the time allocated. Participants were unhappy with the conference facilities, the small room and cramped seating. There was insufficient information about the physical exercise field trip. The final day's sessions was a little disorganized and too prescriptive (especially with the achievable targets). Although it was paper free, little attention was paid to submissions during the meeting. More group work should have been included. Perhaps more input from participant as to the outputs so as to have a consensus document.

What did you like most about this conference?

Meeting colleagues and sharing experiences and information. The level of participation, energy and contribution by both the presenters and participants.

The presentations were high quality and informative and contributed to more insight about NCDs. There was a high level of discussion and sharing of strategies that worked. Two persons particularly liked the Field Trip to the ""ciclovia"" and other specific sessions mentioned were the Global NCD challenges and the New Evidence, UNHLM new knowledge presentation and Session 8 – Engaging with partners.

The organizers were complimented on the use of technology and attempting a paperless meeting, the scheduling, the relaxed atmosphere and the multisectoral approach.

How can we improve?

Most comments were around timing. The Opening should be simple and short. We should cover fewer topics in more depth, with less time for presentations and more time for discussion and work groups. They advised us to start planning early to avoid the last minute rush and to make sure this meeting continues every year. All CARICOM countries should be allowed to present some aspect of their programme so that the overall group may benefit. We should change the venue and have better tech support for logging on, with presentations loaded before the meeting. More media exposure and promotion of the event would stimulate public interest and by extension bring about more awareness of NCD'S.

APPENDICES

Appendix 1 Impact of the "ciclovia" on Physical Activity of Diego Martin Residents - Dr. Shelly Mohan

Appendix 2 Key Participants IADB/UWI Surveillance Project

Appendix 3 Documentation of the POS Summit process and outcomes in peer reviewed journals

Appendix 4 Examples of Best Buys from countries

Appendix 5 FCTC MPOWER

Appendix 6 English speaking Caribbean legislative review: Methodology and typology

Appendix 7 Status of NCD programme in Suriname

Appendix 8 Jamaica' demographic and risk factor profile

Appendix 9 CMO Workgroup worksheet with scores – Implementing the Chronic Care Model

Appendix 10 Definitions and the role of food and Nutrition in the Obesity and NCD epidemic

Appendix 11 Expanded discussion on nutrition labels

Appendix 12 NCD Risk Factors mortality in the Americas for Middle Income Countries

Appendix 13 Barbados NCCNCD Initiatives in salt reduction

Appendix 14 The Partners Forum - A Platform to Move Forward

Appendix 15 Terms of Reference of the T&T Partners Forum

Appendix 16 FBOs and NCDs in Jamaica, the Background

Appendix 1:

Impact of the "ciclovia" on Physical Activity of Diego Martin Residents

Dr. Shelly Mohan
Medical Officer, MOH, TRT,

Dr. Mohan made the first presentation and shared the results of her MPH programme research.

Chronic Non communicable diseases, heart disease, stroke, diabetes & cancer account for 6 out 10 deaths worldwide, as is the case in CARICOM and in Trinidad and Tobago. This will get worse unless urgent public health action taken to control the risk factors.

The non-modifiable risk factors are age and genetics, while the modifiable risks are tobacco use, alcohol abuse, poor diet and physical Inactivity. The prevalence of physical inactivity globally is 31% among adults> 15 years. In the region of the Americas is the highest prevalence in the world with 50% women and 40% men being physically inactive. In Trinidad and Tobago 39% of population and 74.2% students aged 13- 15 years are insufficiently active.

The effects of Physical Inactivity include health and economic consequences. Physical inactivity causes 6% global mortality (3.2 million deaths), 25% breast and colon cancer, 27% diabetes and 30% ischaemic heart disease. The economic consequences are significant, accounting for 2.4- 5% US health care expenditure, and in TRT, 8% GDP spent on hypertension and diabetes, whose risk factors include physical inactivity. There is therefore urgent need to improve population levels of physical activity. Community based interventions have been identified as efficacious and cost effective in improving PA levels. One such effective intervention is the "ciclovia" (bicycle way). This is a regular mass recreation event facilitated by temporarily closing streets to motorized traffic to allow exclusive access to individuals for leisure activities.

The English speaking Caribbean's first "ciclovia" is this one in Diego Martin, which was started on the first Caribbean Wellness Day, Sept 13th 2008. Every Sunday since then, from 6am to 9am a 2 km long (Diego Martin Highway) has been blocked for Family Fun Sunday, for walkers, joggers, cyclists, skateboarders, and includes a Physical Activity class.

The evidence on the effectiveness of "ciclovia" exist mainly in the context of Latin America where this concept originated. There is therefore the need to assess the local applicability and effectiveness of the "ciclovia", so this study was done to describe participation in and knowledge of the "ciclovia" in Diego Martin and to determine the association between knowledge of or participation (ever or current) in the "ciclovia" and levels of leisure time physical activity

This was a cross sectional study of randomly selected residents from electoral lists in the 8 polling divisions immediately surrounding the "ciclovia" in Diego Martin. A modified RPAQ (Recent Physical

Activity Questionnaire) was administered during face to face interviews with 137 residents. 82.5% knew about the“ciclovia”, 19.7% had participated in “ciclovia” at some time, and 10.2% were current participants. Most participants spend 1 - 2 hours at the “ciclovia”. 56.2% were physically active, while 43.8% were physically inactive. Knowledge of the “ciclovia” and having ever participated were positively associated with achieving the recommended amount of physical activity per week using Chi Square tests and logistic regression.

These findings are consistent with regional studies, which also found that current participation in “ciclovias” to be positively associated with physical activity levels. The limitations of this study are that since it is a cross sectional study, one cannot determine cause and effect. These results were based on self-reports, so there is the risk of recall, interviewer and self-report bias, the small sample size is associated with lack of statistical power and the use of electoral lists excludes those who are not registered to vote.

The strengths of the study include the measurement of PA in real life situations, participants did not have to alter their activities, the sample population was well defined, and so had good internal validity and the use of the RPAQ with its specific lists of physical activities.

Recommendations from this study include incorporating monitoring and evaluation into all public health interventions to facilitate assessment, reviewing strategies to improve “ciclovia” participation, having more attractions, improving media involvement and Intersectoral collaboration. The results of this study suggest that the “ciclovia” can be used in a Caribbean context as an effective mechanism to improve population PA levels.

Appendix 2

Key Participants IADB/UWI Surveillance Project

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Appendix 3

Documentation of the POS Summit process and outcomes in peer reviewed journals

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Appendix 4

Examples of Best Buys from countries

- Mass communication and public education (USA)
- "Get the message" campaign (Caribbean/Healthy Caribbean Coalition)
- "Act Now BC" (Canada)
- Risk factor Reduction and Healthy Settings
- Tobacco taxes and smoke free spaces (Uruguay)
- Trans Fat Free Americas initiative
- Reduction of sodium in bread, Argentina; restaurants (New York)
- *"ciclovias"* reclaim the streets (Costa Rica, Guatemala)
- Scale up basic health care for diabetes/hypertension (Brazil)
- School meals reformulation as part of obesity law (Colombia)
- Workplace wellness programs (Argentina, Brazil)
- Health service interventions
- Scale up health care and access to medicines (Jamaica, T&T, Brazil, Chile, and Costa Rica)
- Reduce amputations through foot care (T&T)
- Quality of care improved using "promotoras" (Mexico)
- Let's Move! (USA)
- One million hearts (USA)
- Jamaica Nat'l Health Fund
- Cervical Cancer Prevention in Latin America
- The WHO Framework Convention on Tobacco Control in the Americas
- Caribbean Wellness Day
- The CARMEN Network Improving Integrated Chronic Care
- Argentina's Strategy for Prevention & Control on NCDs
- Chile's AUGE Program
- CONACRO: The national council for Chronic Disease Prevention in Mexico
- Free Drugs for Hypertension and Diabetes: Brazil's Experience
- Building Healthy Cities
- New York City Takes on NCDs
- Active Cities Healthy Cities
- Educating Healthy Kids
- School Meal Reformulation
- Salt Reduction in Latin America and the United States
- Chile 5 A day
- Cinco Pasos por Tu Salud
- Private Sector: Doing well by doing good
- La Alianza por una Vida Saludable

Appendix 5

MPOWER entry point of WHO FCTC demand reductions measures

Monitor Tobacco Use and Prevention Polices

Article 20.2 – Research, surveillance and exchange of information states:

> *The Parties shall establish, as appropriate, programmes for* ***national, regional and global surveillance*** *of the* ***magnitude, patterns, determinants and consequences of tobacco consumption and exposure to tobacco smoke****. Towards this end, the Parties should integrate tobacco surveillance programmes into national, regional and global health surveillance so* ***that data are comparable and can be analyzed at the regional and international levels****, as appropriate.*

Protect People from Exposure to Tobacco Smoke

Article 8 – Protection from exposure to tobacco smoke

> Scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability.

Principles

1. Total ban of smoking in enclosed areas
2. All workplaces and all public places smoke free
3. This must be legislated, since voluntary agreement does not work
4. Plans and resource allocation for the implementation
5. Important role of Civil Society to help implementation and enforcement
6. Enforcement control
7. Strengthen or update legislation according to new evidence

In CARICOM, only Barbados and Trinidad & Tobago have enacted these laws.

Offer Help to Quit

Article 14 requires

- National Quit Line available
- Brief Advice/ Counseling
- Nicotine Replacement Therapy

In CARICOM, no country has this in place for its population.

Warn about the Dangers of Tobacco

Article 11 – Package and Labeling of Tobacco Products requires

- Ban on misleading descriptors
- Health warnings, ideally with pictures, no less than 50% of principal surfaces

- Rotating, approved by the national health authorities, emotionally strong
- Qualitative description of contents and emissions
- This should be accomplished 3 years from the entrance into force of the WHO FCTC for each Party

Despite the efforts of CROSQ, the region has been unable to collectively agree to implement rotating tobacco warnings because 2 countries have not agreed. The other countries have decided to proceed at national level to implement the rotating graphic tobacco warnings.

Enforce bans on tobacco advertising, promotion and sponsorship (TAPS)

Article 13 – Advertising, Promotion and Sponsorship

Each Party shall:

- Implement it five years after entry into force
- Comprehensive ban of all TAPS, Including all media, all time, all population and cross-border activities
- Taking into account other means of TAPS:
  - Product display at point of sales
  - Packaging and labeling
  - Internet sales
  - Social corporative responsibility activities.

In CARICOM, no country has this in place for its population.

Raise Taxes

Article 6 – Increase the Prices and Taxes on Tobacco Products

Price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons. Legislation should be enacted and enforced to prohibit or restrict sales to and/or importations by international travelers of tax- and duty-free tobacco products.

Taxes should be at least 75% of the final price through a combination of specific and ad-valorem taxes which should be the same level for all tobacco products

Few countries had achieved this goal.

In CARICOM, no country has achieved the 75% goal. Jamaica, Suriname, Grenada and Barbados have taxes at around 50% of sale price, while Trinidad & Tobago, St. Lucia and Bahamas have taxes of around 30% of sale price.

Appendix 6

English speaking Caribbean legislative review

Methodology and Typology

Methodology

Legislation enacted up to 1st November 2009

Sources: Statute Books, bound annual volumes of Law, unbound annual collections of recent Law

Compilation and analysis included the national regulatory framework, taking into consideration supranational level instruments, e.g. the Declaration of Port of Spain, the Declaration of St. Ann, and PAHO's Regional Strategic Plan of Action on NCDs

Typology

Chronic diseases in general, Obesity (prevention; treatment, consumer and nutritional rights; discrimination; sports and physical activity prevention), Diabetes (prevention and control, access to essential medicines and devices, consumer and nutritional rights), Cardiovascular diseases (prevention and treatment; physical and nutritional aspects)

Appendix 7

Status of NCD programme in Suriname

- NCD plan, first draft already discussed, 2nd draft prepared
- NCD budget, not yet in place as a separate document
- NCD summit convened 17 August 2011
- Multi-sectoral NCD committee appointed and functional - Discussions already started for appointment
- NCD communication plan is in discussion
- FCTC ratified in 2008
- Tobacco taxes recently increased to 50% sale price
- Smoke free indoor public places is to be included in the national anti-tobacco legislation
- Advertising, promotion & sponsorship bans is to be included in the national anti-tobacco legislation
- Mandatory labeling of packaged food for nutrition content, discussions on improvements is ongoing
- On-going mass PA or new public PA spaces is in preparatory phase. There is no legislation making the provisions mandatory yet in place
- CWD, multi-sectoral, multi-focal celebrations
- STEPS or equivalent survey – Preparations are underway to implement Healthy Lifestyle in an Urban Setting HELIUS survey for next year (2012) in collaboration with the Medical Faculty Suriname.
- QOC CVD or diabetes demonstration project has several NGOs involved on a regular basis

Appendix 8

Jamaica' demographic and risk factor profile

Jamaica's 2010 population was approximately2,705,800, 49% males, and 51% females. Life expectancy is 73 years, 72 years for males and 75 years for females, while the population >60 years is 8.5%.

A review of the leading Causes of Death in Jamaica. Over the Past 50 Years shows that Jamaica has undergone the epidemiological transition, with the leading causes of death now being NCDs. From the Jamaica Healthy Lifestyles Survey 2008, among 15 – 74 years, the prevalence of pre-hypertension was 35%, hypertension 25%, high cholesterol 12%, diabetes 8% depression 20% and self-reported asthma 7%.

Risk Factors

Changes in Physical Activity levels of Jamaicans 15-74 years from the JHLS 2000 and 2008 there was an almost doubling of levels of physical inactivity from 17% - 30%, while those who were highly active declined from 47% to 32%. The nutritional status has shown a decline in normal weight persons from 50 to 45% and an increase in obese persons from 20 – 25% of the population.

Adult tobacco use was 15% (22% male, 7% female) in 2008, showing a decline from the 2000 rates of 18% (28% male, 7% female). Average age Jamaicans 25-65 started smoking was 13 years. Youth (13-15 years) current smoking rates from the Global Youth Tobacco Survey have increased over the past 10 years from 15% (19% male, 12% female) in 2001, to 17% (22% male, 12% female) in 2006 and 25% (32% male 17% female) in 2010.

Appendix 9:

CMO Workgroup worksheet with scores – Implementing the Chronic Care Model

WORKSHEET FOR CMO WORKGROUP

Extracts from "Priorities for cardiovascular health in the Americas)
Indicate level of priority: 4 = highest priority, 1 = lowest priority;
Indicate feasibility (resources, health systems etc.):
4 = greatest feasibility, needs few additional resources, 1 = lowest)

	Priority	Feasibility
Universal coverage and equitable access to health services		
Competencies of health personnel		
45. Ensure that the health system, and particularly the first level of care, has a sufficient number of competent, motivated, and stable human resources in place; operates through multidisciplinary teams; clearly defines the roles of physicians and nursing staff at all levels of care; and evaluates its performance.	4	2
46. Develop comprehensive, sustainable continuing education strategies geared especially to primary care workers, reinforce the CVD prevention and control component, and, where necessary, modify academic programs to meet this objective.	4	3
50. Ensure that the primary care level has the necessary technology, tools, and services it requires for efficient assessment and control of cardiovascular risk.	4	2
51. Apply criteria for patient referral from the first level of care to other care environments in the health system that address coordination problems between levels of care and are based on the effectiveness of the services provided at each level and the system's overall efficiency.	4	3

Chronic care model		
52. Accelerate implementation of the integrated chronic care model in health services. In this regard, it is critical to promote self-care and redefine the roles and responsibilities of physicians, nursing staff, and community workers.	3	3
53. Strengthen the active role, accountability, and autonomy of people with risk factors or CVDs, and especially those with diabetes and hypertension, by developing the skills and resources they need to maximize their self-care capabilities.	4	2
Hypertension and individual total cardiovascular disease risk		
54. Strengthen activities to improve proficiency levels, treatment, and control of hypertension (HT), with emphasis on early detection, the appropriate selection and use of medicines, and therapeutic compliance.	3	3
55. Promote individual total cardiovascular risk assessment in preventive clinical services, with emphasis on the treatment of patients at high risk of cardiovascular disease.	4	3
56. Strengthen early detection and treatment of chronic kidney disease in people with hypertension and diabetes.	4	3
57. Monitor hypertension control in the population on the national and local levels, especially among vulnerable groups.	4	3
Quality and efficiency of clinical services		
58. Implement policies conducive to a health care system that operates with high standards of clinical efficiency and safety. In this context, implement certification systems and clinical audits.	4	2
59. Establish comprehensive continuous quality improvement programs in order to assess services related to the care of CVDs in health services units.	3	2

60. Apply clinical practice guidelines tailored to the requirements, resources, and local culture, and define and harmonize the roles and responsibilities of all levels of the service network.	4	2
61. Implement policies that regulate medicines and other technologies based on their high quality, relative effectiveness, diagnostic and therapeutic value added, social value, and safety. Ensure that service coverage is consistent with these principles and that the prescription of generic medicines is promoted.	3.5	3 (1)

Appendix 10

Definitions and the role of food and Nutrition in the Obesity and NCD epidemic

The definitions from the World Food Summit, 1996: Food Security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. This implies stability of availability, accessibility andconsumption /utilization.

The Role of Food and Nutrition in the Obesity and NCD epidemic
We need to look at Food security in the context of health.

Obesity is a major risk factor for cardiovascular disease, cerebrovascular disease, diabetes and mortality
Trends in Prevalence of Overwt / Obesity in the Caribbean in > 30 years old: Barbados, Trinidad& Tobago and Dominica have >50% prevalence of female overweight / obesity, while Barbados, Dominica and Bahamas have >20% prevalence of male overweight / obesity. These are among the highest rates in the world. Recommended daily requirements are 2300 calories per day. We have exceeded this since 1971, and have increased our over-nutrition consistently since then, with an average consumption of >2700 calories in 2001. These excess calories are coming from fats and sugars, while only 5% of our populations eat the recommended 5 servings of fruits and vegetables / day.

Appendix 11

Expanded discussion on nutrition labels

Nutrition labeling also include nutrition claims e.g. “fat free”, “low salt”, “high in …”, “good source of …”, “extra”, “enriched”, “fortified”, “light”, “healthy”, “reduced”, “lean”, “more”, “less” etc. These nutrition claims suggests or implies a relationship between a food or a constituent of that food and health, either expressly or by implication, including "third party" references, written statements (e.g., a brand name including a term such as "heart"), symbols (e.g., a heart symbol), or vignettes.

Health claims can legitimately be based on the relationships between:

- Calcium and osteoporosis
- Sodium and hypertension
- Dietary fat and cancer
- Dietary saturated fat and cholesterol and risk of coronary heart disease
- Fibre-containing grain products, fruits, and vegetables and cancer
- Fruits, vegetables and grain products that contain fiber, particularly soluble fiber, and risk of coronary heart disease
- Fruits and vegetables and cancer
- Folate and neural tube defects
- Dietary noncariogenic carbohydrate sweeteners and dental caries
- Soluble fiber from certain foods and risk of coronary heart disease
- Soy protein and risk of coronary heart disease
- Plant sterol/stanol esters and risk of coronary heart disease
- Whole grain foods and risk of heart disease and certain cancers
- Potassium and the risk of high blood pressure and stroke
- Fluoridated water and reduced risk of dental carries
- Saturated fat, cholesterol, and trans fat, and reduced risk of heart disease

Appendix 12

NCD Risk Factors mortality in the Americas for Middle Income Countries

	Risk Factor	% Total Deaths
1.	High blood pressure	17.2
2.	Tobacco use	10.8
3.	Overweight and obesity	6.7
4.	Physical inactivity	6.6
5.	Alcohol use	6.4
6.	High blood glucose	6.3
7.	High cholesterol	5.2
8.	Low fruity and vegetable intake	3.9

Appendix 13

Initiatives in salt reduction

Publications

- Produced booklet – "Battling salt the hidden enemy"
- Articles on HCC website
- Supported and endorsed recipe booklets of Nutrition Officers in MOH
- Health and nutrition guide for schools
- Articles in BARP and Better Health magazine, and daily newspapers

Media

- Produced and distributed PSAs for local television, distributed regionally
- PSAs on local TV station
- "Get Healthy Barbados" TV Series
- Culturally appropriate salt jingle by local calypsonian
- Featured low salt issue, using Facebook, and cell phones in the Get the Message mobile phone advocacy and educational text campaign leading up to the UNHLM

Events

- Promotion at Labour Day Rally
- Patron of and support for Agrofest 2011, "Healthy Living through Agriculture"

Training

- Workshops for school canteen operators
- Workshop for Agrofest food vendors
- "Salt seminar" for food and drink producers and manufacturers
- Discussion with bakery and food producer around product reformulation

Appendix 14

The Partners Forum - A Platform to Move Forward

The Pan American Forum brings together government, private sector and civil society to raise awareness of and help scale-up successful practices for the prevention and control of NCDs/chronic diseases and promotion of health at all levels. This approach is relevant to all countries which will be needed to intensify action after the UN High Level Meeting on NCDs. It builds on CARMEN Network efforts and supports the Regional Strategy for NCD prevention and control approved by member states. The Forum will be an integral part of PAHO's deepened engagement strategy for Prevention and Control of NCDs and promotion of health.

The Forum will be complementary to existing national and regional mechanisms /initiatives that exist. It will help also to bring good things to light and help scale them up.

The mandates come from our Regional Strategy for the Prevention and Control of Chronic Diseases, from the WHO Global Action plan, and from the just concluded UN HLM

Aim

Support attainment of the regional strategy goal of improving well-being and productivity in the Americas, avoid billions in economic losses, and prevent 3 million deaths in the next 10 years, through multi-sector collaborative approaches

Functions

- A multi-stakeholder platform for dialogue, advocacy, sharing of information and identification of successful practices in prevention and control of NCDs and promotion of health.
- Catalyze the scale up of successful practices and joint action between government, civil society and private sector at all levels.
- Support Member States in the Americas to implement the outcomes of the UN HLM on NCDs

We have been consulting with member states, civil society organizations and companies. All welcomed the Forum as a platform for dialogue and for ACTION: harmonized actions within and between countries and stimulation of South-South and Triangular Cooperation. We look forward to collaboration with the South-South Cooperation Unit of UNDP, and their Platform for S-S exchange. This will help address the increasing global burden of non-communicable diseases, with an approach of multi-sectional stakeholder's collaboration.

Process

The Partners Forum is designed for information exchange and advocacy and to catalyze partnerships and action. It is open and inclusive and membership includes governments, CARMEN network, multilateral agencies, academia, private sector, traditional donors, civil society organisations and, faith based groups.

Criteria for action/projects are the strength of science/evidence, feasibility, interest of partners and capacity.

The projects can be led by PAHO, Ministries of Health or others, e.g., CARPHA, HCC.

PAHO & PAHEF form the Technical and Support Secretariat to Pan American Forum, as the catalyst in the creation of synergies between parties and sectors. Project teams and resource mechanisms for projects need to be put in place, including supporting materials, e.g.., guidelines, plans etc.

The FORUM is conceived as a vehicle that would be open to all partners (excluding some like tobacco companies) who are interested in supporting PAHO's regional strategy. PAHO will provide technical leadership and act as honest broker taking into account the needs of its members, and with guidance from a representative multi-stakeholder Advisory Group.

Early Supporters

- Countries (Canada/PHAC, US CDC, Mexico, Panama, Argentina, Trinidad & Tobago and Guatemala/INCAP)
- Civil Society (Inter Am Heart, 5-A-Day, Consumers Int'l, HCC, WEF, PAHEF, McGill Univ., etc)
- Business groups (IBLF, Kraft, Pepsi, Coke, Nestle, Grupo Bimbo, Arcos Dorados, Unilever, Pfizer, GSK, Sanofi, Merck, J&J, Medtronic, Nike)
- International Agencies (IADB, W Bank)

Appendix 15

Terms of Reference of the T&T Partners Forum

1. Establish a framework/alliance for joint planning and implementation of actions and policies guided by the Ministry of Health and supported by public sector, private sector, NGOs, civil society and other regional and international partners to reduce the burden of NCDs in Trinidad and Tobago.
2. Identify local, regional and international best practices on public, private, civil society partnerships in support of health.
3. Mobilise resources from all sectors to support joint actions to reduce the modifiable risk factors of NCDs, with an emphasis on population based strategies
4. Develop and implement joint, integrated, coordinated actions in support of promoting health, reducing risk factors and improving management of CNCDs
5. Review relevant health research, standards documents, policies and best practices for CNCD prevention and control and recommend industry, civil society led actions for:
6. Eliminate of trans-fats from the diet of our citizens
7. Reduce of salt and sugar in locally produced food
8. Enhance food security and promoting greater use of indigenous agricultural products and foods by our populations, reducing the negative effects of globalisation on our food supply
9. Promotion of policies and actions aimed at increasing physical activity in the entire population

Global strategies for the prevention and control on NCDs

1. Promote implementation of the WHO recommendations on the marketing of foods and beverages to children, including: foods that are high in saturated fats, trans-fatty acids, sugars, or salt.
2. Promote the development and initiate the implementation of cost-effective interventions to reduce salt, sugar and saturated fats, and eliminate industrially produced trans-fats in foods, including through discouraging production and marketing of foods that contribute to unhealthy diet.
3. Call upon the private sector to:
   a) Take measures to implement the WHO recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children
   b) Consider producing and promoting more food products consistent with a healthy diet, including by
      i. Working towards reducing the use of salt in the food industry in order to lower sodium consumption

ii. Providing relevant nutrition facts and labelling standards, including information on sugars, salt and fats and, where appropriate, trans-fat content.

4. Promote/create enabling environments for healthy behaviours among workers, including by establishing tobacco-free workplaces and safe and healthy working environments through occupational safety and health measures, including, where appropriate, through good corporate practices, workplace wellness programmes and health insurance plans

Appendix 16

FBOs and NCDs in Jamaica: the Background

Research findings proliferate which demonstrate a direct relationship between health and spirituality, health and religious practice and being a member of a church or religious community. Seventy percent (70%) of Jamaicans are practicing Christians and members of Faith Based Organizations (FBOs). Religiosity in Jamaica continues to be a critical contributor to how individuals' faith and beliefs are formed and shaped.

A review of more than 1,200 studies of religion and health reported that at least two thirds of the studies evaluated had shown significant associations between religious activity and better mental health, better physical health or lower use of health services. The church and Faith Based Organizations in Jamaica have traditionally been integral in the provision of health services and disease screening. In Kingston and St. Andrew metropolis alone there are at least twenty-nine church related clinics.

Christian, Hindu and Moslem faiths and other denominations have access to and influence over their congregations, their families and the wider society. As part of civil society, they can be potent allies along with the private sector and government.

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Workshop Evaluation

Over 60 persons from 25 Religious Affiliations participated in the workshop.

80% of the participants reported that workshop content was consistent with stated objectives
73% indicated that the meeting met their expectations
90% felt that the meeting will make a difference
90% indicated that the workshop was useful
80% felt confident that they can engage in the response to chronic diseases
67% felt confident that they can implement the commitments made at this workshop

Survey findings

- Fifty-eight percent (58%) of FBOs participated in the survey
- Of the total respondents seventy-nine percent (79%) indicated that they offered health programmes prior to August 27, 2009.
- Fifty-four percent (54%) of the FBOs that participated in the forum made changes to their programme.
- Prior to consultation forum, FBOs were offering a mixture of services, which targeted both congregants and community members. When this was compared to types of programmes and activities that are being offered by FBOs after the consultation there were slight increases in all areas with the exception of health events, which remained the same.
- The health education topics offered prior to and since the consultation increased and included: NCDs, promotion of a smoke free environment, promotion of physical activities, prevention of alcohol abuse, mental health and conflict resolution.
- Where direct health services are concerned there was an increase in key areas following the consultation, mostly seen in the areas of exercise and mental health
- FBOs found the consultation to be very useful. Forty three percent (43%) of FBOs implemented health programmes targeting NCDs after the consultation.
- All FBOs (100%) believed it to be good to collaborate with MOH in the fight against CNCDs
- 86 % felt FBOs play an important role in this fight

Findings from focus group

- From the focus group discussion it was observed that Churches and FBOs have clearly been influenced by the MOH/PAHO initiative to respond to NCDs. Some have been influenced to initiate programmes and activities while others have taken steps to improve and increase their programmes and activities. Participants agreed that the church and FBOs are poised to play a critical role in the prevention of NCDs and in providing health and wellness services to its members and community.
- Their mandate is to care for the body and soul/spirit/mind of those within their care; hence there is a natural fit for programmes focused on the prevention of chronic diseases

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End Notes

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[ii] World Economic Forum & Harvard University, 2011.