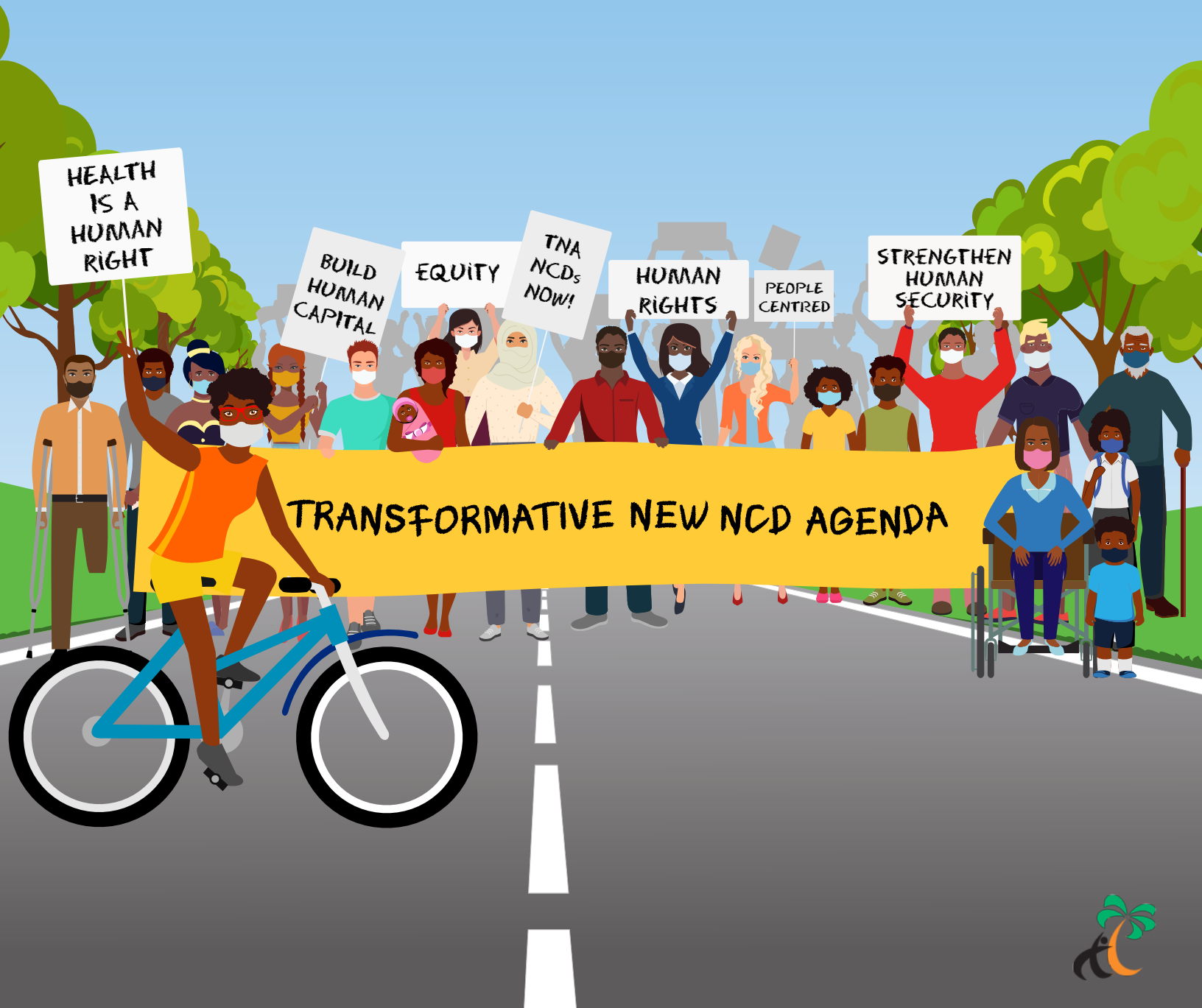


NCDs AND COVID-19 IN THE CARIBBEAN: A CALL TO ACTION

THE CASE FOR A TRANSFORMATIVE NEW NCD AGENDA



ACKNOWLEDGEMENTS

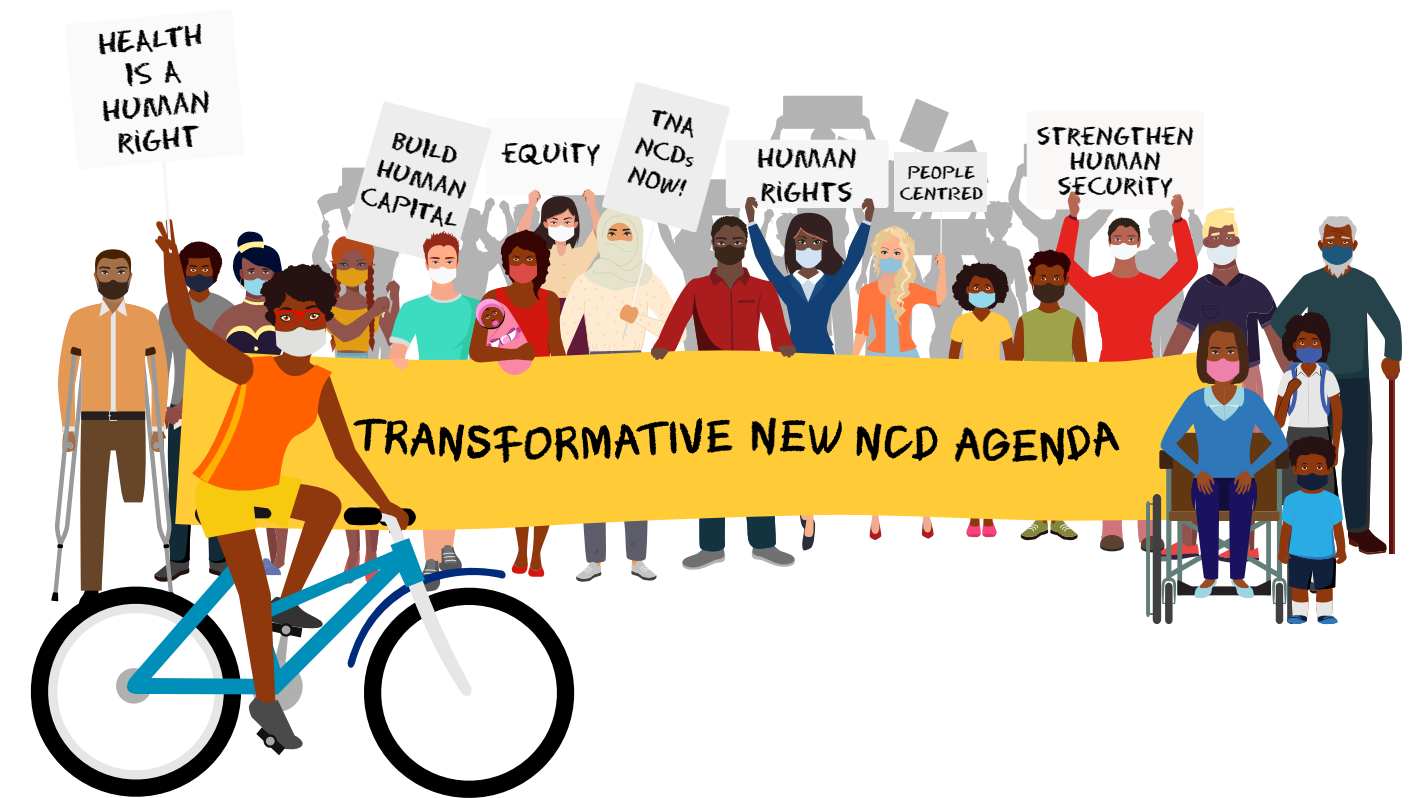
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January 2021

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ACRONYMS AND ABBREVIATIONS

BBs	best buys	NNCDC	National Noncommunicable Diseases Commission
CARICOM	Caribbean Community	OECS	Organisation of Eastern Caribbean States
CARPHA	Caribbean Public Health Agency	ORIs	other recommended interventions
CDEMA	Caribbean Disaster and Emergency Management Agency	PAHO	Pan American Health Organization
COVID-19	coronavirus disease of 2019	PEA	political economy analysis
CRC	Convention on the Rights of the Child	PHC	primary health care
CSO	civil society organisation	PLWNCDs	people living with non-communicable diseases
CVD	cardiovascular diseases	POSD	Port of Spain Declaration
ECLAC	Economic Commission for Latin America and the Caribbean	PPE	personal protective equipment
FAO	Food and Agriculture Organization of the United Nations	PPS	Pharmaceutical Procurement Service
FNS	food and nutrition security	ROI	return on investment
GDP	gross domestic product	SDGs	Sustainable Development Goals
HCC	Healthy Caribbean Coalition	SIDS	small island developing states
HiAP	health-in-all-policies	SSBs	sugar-sweetened beverages
HIV	human immunodeficiency virus	TNA-NCDs	transformative new agenda for non-communicable disease prevention and control
HCC	Healthy Caribbean Coalition	UHC	universal health coverage
HLM	high-level meeting	UN	United Nations
HoSG	Heads of State and Government	UNICEF	United Nations Children's Fund
JMD	Jamaican dollar	USD	United States dollars
LAC	Latin America and the Caribbean	UWI	University of the West Indies
MHPSS	mental health and psychosocial support	WHO	World Health Organization
MNS	mental, neurological, and substance use	WoG	whole-of-government
NCDs	noncommunicable diseases	WoS	whole-of-society
NCDA	NCD Alliance	WTO	World Trade Organization
NCDI	non-communicable diseases and injuries		
NGO	nongovernmental organisation		

KEY MESSAGES

Call to Action



The Healthy Caribbean Coalition (HCC) is calling for a Transformative New Agenda (TNA) for the prevention and control of non-communicable diseases (NCDs) in the Caribbean region, based on lessons from the coronavirus disease of 2019 (COVID-19) pandemic and in light of the significant burden of NCDs in the Caribbean—the highest in the Region of the Americas.

The TNA-NCDs proposes a new approach to NCD reduction by government, civil society, and private sector for at least the next five years, underpinned by principles of equity and human rights; aimed at enhancing human security and human capital; based on social activism by persons living with NCDs (PLWNCDs) and other key stakeholders; and focusing on a life course preventive approach.

The TNA-NCDs incorporates inputs from civil society organisations and key stakeholders/thought leaders in the region, including PLWNCDs and youth; is validated by representatives of influential entities at national, regional, and international levels; and presents a framework that all interested and invested persons and entities can use to guide their actions in taking a new approach to NCD reduction in the Caribbean.

Rationale



The Caribbean region has the greatest burden of NCDs in the Region of the Americas; a significant and increasing proportion of older people, contributing to increasing NCD prevalence; and growing levels of obesity, including among children—all factors that increase the risk and severity of COVID-19.

The COVID-19 pandemic has heightened awareness of the social, economic, political, commercial, and other determinants of health, and exposed for-profit industry tactics that are at odds with the achievement of public health objectives. It has also revealed inequities and serious shortcomings in countries' implementation of the multisectoral, health-in-all-policies, whole-of-government, whole-of-society approaches needed for effective NCD prevention and control in the Caribbean and elsewhere.

The pandemic has had serious health, social, and economic impacts, with heightened risk for, and negative health outcomes affecting, PLWNCDs and other persons in conditions of vulnerability. COVID-19 has slowed progress to achievement of Sustainable Development Goal (SDG) 3, the goal that most directly addresses health, and other SDGs, and has put at risk gains made in reducing premature mortality from NCDs, including mental, neurological, and substance use disorders.

The widespread effects of the pandemic and efforts to contain it have disrupted lives, livelihoods, supply chains, including for food and nutrition security, which has emerged as a major concern in the Caribbean. Health services have been affected, resulting in

delays in interventions for the promotion of health, prevention of disease, and care and treatment, particularly for PLWNCDs.

Even before the pandemic, United Nations (UN) and World Health Organization (WHO) assessments of advances toward internationally-agreed NCD reduction targets documented a slowing of progress and an implementation deficit in evidence-based global recommendations such as the WHO Best Buys and Other Recommended Interventions. At Caribbean regional level, a 2016 evaluation of the ground-breaking 2007 Port of Spain Declaration for NCD Prevention and Control made by the Caribbean Community (CARICOM) Heads of State and Government also demonstrated delays in fulfilment of the commitments made.

COVID-19 has demonstrated the imperative of an inclusive, multisectoral, multidisciplinary, integrated response for its containment, an approach that is also critical for NCD reduction, climate crisis adaptation and mitigation, disaster preparedness and mitigation, food and nutrition security, and poverty reduction, among other issues.

The Lancet Non-communicable Diseases and Injuries (NCDI) Poverty Commission reported in September 2020 that progressive implementation of affordable, cost-effective, and equitable NCDI interventions between 2020 and 2030 could save the lives of more than 4.6 million of the world's poorest people, including 1.3 million who would otherwise die before the age of 40 years.

There is urgent need for transformative action to ensure that NCDs receive attention compatible with the substantial danger that they pose to health, well-being, and sustainable development in the Caribbean. Concurrent action to fight NCDs, COVID-19, and other existential threats to sustainable development is imperative, through policy coherence and pooling of resources across sectors and disciplines to address the social and other determinants of health, regain lost ground in NCD reduction, and enable co-benefits, cost-efficiency, and more effective use of limited resources.

Snapshot of the TNA-NCDs



Approaches

The TNA-NCDs includes **transformative approaches** that:

- Promote and emphasise equity and human rights as overarching principles for NCD prevention and control, and the critical importance of NCD reduction in developing and strengthening human security and human capital;
- Enable appreciation of mental, neurological, and substance use disorders as integral components of NCD prevention and control policies and programmes;
- Encourage and empower PLWNCDs, children, adolescents, youth, and other persons in conditions of vulnerability to participate in NCD policy and programme development, implementation, and assessment;
- Promote strategies to improve health and digital literacy, and communication for health, for an informed public that can make healthier choices;
- Promote research and information systems for health that provide disaggregated data on the impact of the COVID-19 and NCDs syndemic, and enable evidence-based policies and interventions that advance equity and human rights;
- Promote analysis of political economy and behavioural economics in the Caribbean context, with a view to, respectively, catalysing investment and multisectoral collaboration, and influencing behaviour change; and
- Promote a shared value and social impact business model tailored to the Caribbean that enables and enhances investment by, and partnerships with, healthy commodity industries.

The TNA-NCDs builds on **traditional approaches** to:

- Accelerate implementation of the WHO Best Buys and Other Recommended Interventions, and guidance from other international frameworks for health and development, emphasising government policy, legislation, and regulations for prevention, and protecting the policy space from industry and vested interests;
- Enable integrated, multisectoral, health-in-all-policies, whole-of-government, and whole-of-society partnerships and interventions to address the social and other determinants of health;
- Promote strong, resilient health systems and universal health based on the PHC strategy, addressing multimorbidity and lifelong care of chronic diseases; and
- Enhance the accountability of civil society, government, and private sector, including policies to identify and manage conflict of interest and improve leadership, governance, and transparency.

Priority areas of focus

The **five priority areas of focus** in the TNA-NCDs are:

1



Life course prevention

working to prevent NCDs using a life course approach that addresses the five main risk factors and emphasises early prevention and interventions among children, including childhood obesity prevention.

2



Social inclusion and participation for policy development

with meaningful engagement of PLWNCDs, children, adolescents, youth, and other persons in conditions of vulnerability in policy and programme development, implementation, and assessment.

3



People-centred, primary health care-based health systems for universal health

improving the leadership, governance, and resilience of adequately-resourced health systems and offering accessible, client-focused health services that do not result in financial hardship for users, that have the primary health care (PHC) strategy as the core component, and that realise a return on investments in the form of health, a public good.

4



Partnerships, networks, and resource mobilisation

with establishment of links among entities with common interests and objectives; increased multisectoral, multidisciplinary collaboration and partnerships at national and regional levels; institutionalisation of mechanisms for effective joint action; and mobilisation of resources that benefit PLWNCDs and other persons in conditions of vulnerability.

5



Accountability for decision making

strengthening information systems for health and digital strategies to facilitate monitoring of progress toward national, regional, and international agreements and indicators; identification and management of conflict of interest; reduction of inequities; and progressive realisation of the right to health.

Key strategies

Advocacy and communication that re-frame NCDs to emphasise their threat to equity and the progressive realisation of the right to health, and to strengthening human security and human capital in Caribbean countries;

Greater engagement with PLWNCDs, children, adolescents, youth, and other persons in conditions of vulnerability to amplify their voices and share their stories and experiences;

Involvement and centring of PLWNCDs, children, adolescents, youth, and other persons in conditions of vulnerability in interventions that affect them to ensure appropriateness and facilitate success;

Enhanced investment in, and capacity building of, civil society to perform its functions, including to mobilise people, act as a catalyst for NCD social activism and movements, and galvanise action;

Raising awareness, sharing information, and building capacity regarding NCDs, risk factors, equity, human rights, human security, and human capital;

Involvement of an informed public that can make healthy choices and demand policies that provide healthy options;

Engagement with traditional and new media using NCD champions and policy entrepreneurs to contribute to the crafting and dissemination of audience-appropriate messages;

Use of settings for health promotion and preventive interventions, including schools, workplaces, faith-based organisations, and communities;

Integration of multisectoral actions that address NCD reduction and related issues, including food and nutrition security, the climate crisis, and preparedness for future pandemics, emergencies, and disasters;

Partnerships, networking, and resource mobilisation, including promotion of a social impact business model for healthy commodity industries such as those providing financial, insurance, telecommunications, media, agricultural, and transportation services, identifying shared value and win-win situations for private sector and public health, tailored to Caribbean realities;

Research, including political economy and behavioural economics analyses, which, respectively, catalyse evidence-based interventions and effective stakeholder partnerships, and nudge persons toward desired behaviour change;

Surveillance, monitoring, and evaluation, for assessment of the NCD situation, trends, and the progress and impact of interventions, and to hold governments, civil society, and private sector accountable, and monitor conflict of interest;

Identification and implementation of sustainability mechanisms, to preserve and build on gains made, through institutional and other systems and structures;

Use of digital strategies and platforms, which is cross-cutting, with implementation of digital strategies to promote the TNA-NCDs, support interventions, strengthen health literacy, improve equitable access to accurate information, and enhance telehealth interventions; and

Promotion of the development of plans to implement the TNA-NCDs by key stakeholders and sectors.

Overall outcome

The TNA-NCDs' **overall outcome** is NCD reduction in the Caribbean, focusing on the “5x5” priorities: five major NCDs—cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, and mental, neurological, and substance use disorders, and five main risk factors—tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, and air pollution.



At the centre of the TNA is a call for empowered and mobilized Caribbean citizens to ‘stand up’ for their fundamental human right to live in an equitable world where CARICOM governments take responsibility for creating environments that support and promote human and planetary health.

Maisha Hutton, Executive Director, HCC

The Transformative New Agenda for NCDs in the Caribbean during and post-COVID-19 - recognising that to achieve different and better results, interventions must be different and better - provides a framework that all stakeholders can buy into and use to develop people-centred plans, programmes, and interventions to reduce NCDs in the region, enhance human security and human capital, advance equity and the progressive realisation of human rights, foster sustainable national and regional development, and accelerate equitable progress to the SDGs.

INTRODUCTION

In December 2019, an infectious disease initially characterised by respiratory symptoms emerged in Wuhan, China, and was identified as being due to a novel coronavirus, SARS-CoV-2. The illness, dubbed coronavirus disease of 2019 (COVID-19), rapidly spread across the globe, and on 11 March 2020, the Director-General of the World Health Organization (WHO) declared the disease a pandemic. Countries took action to respond to the pandemic with measures that had a multifaceted impact.¹ The responses included travel restrictions, border closures, curfews, and closure of schools, churches, businesses, and other entities.

The responses, including in Caribbean countries, led to adjustments in health systems that, understandably, focused on containing COVID-19, but resulted in delays in the continuation of priority public health programmes such as immunization, and delayed or disrupted services at hospitals and clinics. The postponement of clinics, screening programmes, and elective surgeries, among other important health services, as well as the disruption of global supply chains, resulted in—most notably for PLWNCDs—delayed management, shortages in medications, and limited access to nutritious food. Curfews, closures, and stay-at-home orders led to reduced opportunities for regular physical activity, including for children, and facilitated increases in domestic violence and abuse, and exacerbation of some mental, neurological, and substance use disorders.

The pandemic has resulted in health, social, and economic emergencies, and highlighted troubling inequities and gaps, with dire outcomes for PLWNCDs and others in conditions of vulnerability, including poor people; persons with disabilities; afro-descendants; indigenous people; and migrant populations.² COVID-19

has called attention to the failure of governments to live up to their global, regional, and national commitments to reduce NCDs, and the need for greater focus on prevention, starting in childhood and taking a life course approach. The pandemic has highlighted the need for stronger, more equitable health systems that advance universal health³ with the [primary health care \(PHC\) strategy](#)⁴ at their core, based on principles of equity and human rights, aiming to enhance human security and human capital. It has also underscored the imperative of addressing the social, political, commercial, and other determinants of health through multisectoral, whole-of-government (WoG), whole-of-society (WoS), and health-in-all-policies (HiAP) approaches.

[The Healthy Caribbean Coalition](#),⁵ a registered not-for-profit regional network and alliance of over 100 civil society organisations (CSOs) focused on NCD prevention and control, therefore calls for a **Transformative New NCD Agenda** that changes regional and national approaches to the prevention and control of NCDs. The TNA-NCDs advocates for greater participation of PLWNCDs, children, adolescents, youth, and other persons in conditions of vulnerability; promotes engagement with healthy commodity industries based on a social impact business model that emphasises shared value and creates economic benefits in a way that also generates value for health and society;⁶ negates undue influence of unhealthy commodity industries and promotes the identification and management of conflict of interest; makes recommendations for accelerated implementation of the proven, effective interventions for NCD reduction; and advances the achievement of SDG 3, other SDGs, and sustainable national and regional development.

¹ Kluge HH, Wickramasinghe K, Rippin H, et al. Prevention and control of non-communicable diseases in the COVID-19 response. *Lancet* 2020; 395(10238): 1678-1680, published online May 8, 2020. DOI: [https://doi.org/10.1016/S0140-6736\(20\)31067-9](https://doi.org/10.1016/S0140-6736(20)31067-9).

² Economic Commission for Latin America and the Caribbean (ECLAC) and Pan American Health Organization (PAHO). Health and the economy: a convergence needed to address COVID-19 and retake the path of sustainable development in Latin America and the Caribbean. COVID-19 report, 30 July 2020. ECLAC-PAHO. Available at: https://iris.paho.org/bitstream/handle/10665.2/52535/PAHOHSSCOVID-19200027_eng.pdf?sequence=5&isAllowed=y.

³ Pan American Health Organization (PAHO). Health in the Americas 2017. Washington, D.C.: PAHO; 2017. Available at: <https://www.paho.org/salud-en-las-americas-2017/?p=1993>.

⁴ World Health Organization. Fact sheet 27 February 2019. Primary health care. Available at: <https://bit.ly/31RUyMb>.

⁵ <https://www.healthycaribbean.org/>

⁶ Porter ME and Kramer M. The Big Idea: Creating Shared Value. Posted online 25 May, 2011. Available at: https://www.huffpost.com/entry/the-big-idea-creating-sha_b_815696

The HCC was established in 2008 to contribute to the fulfilment of commitments in the ground-breaking [2007 Declaration of Port of Spain: 'Uniting to Stop the Epidemic of Chronic NCDs'](#)⁷ by the Heads of State and Government (HoSG) of the Caribbean Community (CARICOM),⁸ the main political integration entity in the region. The Declaration of Port of Spain (POSD), with subsequent advocacy by Caribbean leaders, acted as a catalyst for global recognition of the importance of NCDs as a public health issue.⁹ The HCC collaborates closely with government, health-supporting private enterprise, international partners, and other CSOs—including academia, faith-based organisations, trade unions, and youth groups—to leverage the power of civil society, strengthening and supporting its membership to implement NCD reduction programmes.

The HCC responded to a July 2020 Call for Proposals from the [NCD Alliance \(NCDA\) Civil Society Solidarity Fund](#) (SF)¹⁰ on NCDs and COVID-19 aimed at accelerating the response to the pandemic, and was awarded a grant under Category 2 of the SF, *Developing a comprehensive and cohesive NCD advocacy and communications strategy for the COVID-19 response, to implement the project A*

New Transformative NCD Agenda for Building Back Better in the Caribbean. This report, *NCDs and COVID-19 in the Caribbean: a call to action—the case for a transformative new NCD agenda* is one of the main outputs of the project. It examines international, regional,¹¹ and national responses to NCDs and COVID-19; identifies lessons of the COVID-19 pandemic and its intersections with NCDs; presents a case for a transformative new approach to the prevention and control of NCDs in the Caribbean to contribute to efforts to build back better during and post-COVID-19; and presents the proposed TNA-NCDs.

The call to action will be used to inform an advocacy and communication campaign with the theme: *Building back better: A transformative new NCD agenda*, as a component of the HCC's [COVID-19 Advocacy and Communication Strategy](#),¹² NCD advocates' contributions to national COVID-19 planning and priority setting processes; and the development of an HCC Transformative New NCD Agenda: Action Plan 2021-2022 that will detail HCC's contribution to the promotion, implementation, monitoring, and evaluation of the Transformative New NCD Agenda.



HEALTHY CARIBBEAN COALITION ADVOCACY AND COMMUNICATION STRATEGY

5
OBJECTIVES



INCREASE KNOWLEDGE ABOUT COVID-19 AND NCDs



PROMOTE GOOD MENTAL AND PHYSICAL HEALTH



PROMOTE ACCESS TO, AND CONSUMPTION OF, HEALTHY FOODS



ENGAGE YOUNG PEOPLE AS KEY PLAYERS IN THE COVID-19 RESPONSE



PROMOTE ACCESS TO CONTINUOUS CARE, ESSENTIAL MEDICINES AND LIVE-SAVING TREATMENTS FOR PLWNCDs



⁷ <https://caricom.org/declaration-of-port-of-spain-uniting-to-stop-the-epidemic-of-chronic-ncds/>.

⁸ <https://caricom.org/>

⁹ Chattu VK and Knight AW. Port of Spain Summit Declaration as a successful outcome of global health diplomacy in the Caribbean region: a systematic review. *Health Promotion Perspectives* 2019; 9(3):174-180. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6717929/>.

¹⁰ <https://ncdalliance.org/news-events/news/ncda%E2%80%99s-new-solidarity-fund-will-support-20-ncd-alliances-to-strengthen-civil-society%E2%80%99s-response-to-covid-19>.

¹¹ In this context, 'regional' refers to Member States and Associate Members of the Caribbean Community.

¹² <https://bit.ly/30Hjikq>.

METHODOLOGY

The report and call to action were informed by a review of relevant international and regional frameworks and mandates; materials available on the websites of regional and international entities, including political integration entities, intergovernmental development agencies, and civil society organisations working in health and NCD prevention and control; emerging public health and scientific papers and articles; information from webinars related to COVID-19 and NCDs; and public statements made on the issues by national and regional policymakers.

Importantly, virtual interviews were conducted with selected HCC member CSOs and key stakeholders/thought leaders in NCDs in the region to ensure relevance to the Caribbean context. Nine (9) CSOs were interviewed regarding their response to COVID-19, their operational needs, and their priorities and challenges for the future, while 11 key stakeholders/thought leaders were consulted to obtain information on regional and national responses. Both groups were asked to provide recommendations for priority NCDs to be included in the TNA-NCDs, and for health system strengthening strategies and interventions to accelerate and strengthen NCD prevention and control in the Caribbean during and post-COVID-19.

The HCC developed a questionnaire/interview guide and disseminated it in advance of the interviews to facilitate

responses; the instrument was formatted to allow insertion of the responses by the consultant conducting the interviews and an HCC tertiary-level student intern during the virtual interaction. The list of persons interviewed is in **Annex 1**, and the questionnaires/interview guides used (combined for ease of reference) are in **Annex 2**.

Early drafts of the report and call to action were reviewed by the HCC Secretariat and feedback incorporated as agreed. The penultimate draft was sent for review to all the persons interviewed, the HCC Board of Directors and technical advisors, and representatives of a wide range of national, regional, and international entities; responses were received from the persons listed in **Annex 3**. Feedback was incorporated as appropriate to produce the final draft, which then underwent editing and graphic design.

Limitations of the methodology included the length of the questionnaires/interview guides; limited review of the instruments by a few respondents, resulting in interviews that significantly over-ran the scheduled 60 minutes and some responses that did not directly address the questions asked; and one incomplete interview due to time constraints and difficulty in scheduling follow-up with the respondent.

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BACKGROUND

3.1 Epidemiological considerations

The [Political Declaration from the Third United Nations \(UN\) High-level Meeting \(HLM\) on the Prevention and Control of NCDs in 2018](#),¹³ recognised five major NCDs and five main risk factors—the “5x5” priorities¹⁴ —for global attention in efforts to reduce the significant burden of these disorders. The five major NCDs are cardiovascular diseases (CVD), including coronary artery disease (heart attack), cerebrovascular disease (stroke), and hypertension (high blood pressure); diabetes; cancer; chronic respiratory diseases; and mental health and neurological conditions (more recently termed mental, neurological, and substance use disorders). The five main risk factors are tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, and air pollution.

A significant information gap in the region is updated NCD epidemiological data from CARICOM Member States and Associated Members aggregated to provide regional averages. Selected global, regional, and national NCD statistics are presented below.

Major NCDs

NCDs are the major causes of death and illness globally, and their prevalence increases with age.¹⁵ In the Region of the Americas, CVD, diabetes, cancer, and chronic respiratory diseases are responsible for 3 out of every 4 deaths, and the Caribbean region has the highest mortality from these NCDs in the Americas, with seven countries—Guyana, Haiti, Belize, Saint Vincent and

the Grenadines, Trinidad and Tobago, Suriname, and Grenada, in rank order—having mortality rates above 583.5 per 100,000 population.¹⁶ Forty percent of those deaths occur prematurely, in persons aged 30–69 years, with heart attack, stroke, and diabetes causing most premature deaths, followed by cancer; hypertension is the leading contributor to heart attack and stroke; and the prevalence of diabetes in the Caribbean is twice the global average.¹⁷

- The estimated prevalence of diabetes in adults in the Caribbean was 1.3% in 1960 and 17.9% in 1995, while the overall prevalence of diabetes in the region has been estimated at 9%, with a high burden of complications.¹⁸
- A review of studies on diabetes in the Caribbean from 1989 to 2002 showed a prevalence of the disease among adults ranging from 11.1% to 18%, associated with increases in obesity.¹⁹
- The prevalence of hypertension in the Caribbean was estimated to be 26% and as high as 55% in studies of populations over 25 years of age and over 40 years of age, respectively.²⁰

Mental disorders have significant health, social, human rights, and economic consequences globally,²¹ and the Caribbean is not exempt.

- Depression accounts for 4.3% of the global burden of disease, and is one of the main causes of disability worldwide—11% of all years lived with disability—affecting more women than men, and bipolar disorder, schizophrenia and other psychoses, dementia, and developmental

disorders, including autism, contribute significantly to the burden of mental disorders.²¹

- People with mental disorders experience disproportionately higher rates of disability and mortality, and mental disorders often affect, and are affected by, other diseases such as cancer, CVD and human immunodeficiency virus (HIV).²² Persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended—such as cancers, CVD, diabetes, and HIV—and suicide, which is the second most common cause of death among young people worldwide.²²
- In the Caribbean, studies have shown an incidence rate of schizophrenia of 2.0–3.0 per 100,000 population; a prevalence of depression ranging from 20% to 45%; and a rate of 0.8 per 1,000 hospital admissions in Trinidad and Tobago and 12 per 100,000 in Jamaica for bipolar disorder.²³ Suicide was associated with a psychiatric illness in 70% of cases, with depression being the most frequently occurring psychiatric diagnosis (60% of cases), and suicide rates varied from 2.0–2.7/100,000 in Jamaica and 4.0/100,000 in Barbados, to 12.3/100,000 in Trinidad and Tobago. Suicide rates were particularly high among persons of East Indian descent, perhaps reflecting cultural differences²³ and constituting a challenge for multi-ethnic countries such as Guyana, Suriname, and Trinidad and Tobago.
- The stress and upheaval that usually accompany disasters and emergencies increase not only the risk of the development of new mental disorders, but also the exacerbation of pre-existing ones. Persons with psychiatric conditions are at risk for decreased ability to carry on activities of daily living in the face of stressful circumstances such

as disasters,²³ and are therefore a vulnerable group in the face of situations such as the COVID-19 pandemic.

Main risk factors

Four of the five main NCD risk factors—tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol—also remain problematic in the Caribbean, despite some advances in tobacco control. Unhealthy dietary patterns are of particular concern, as almost all CARICOM countries import more than 60% of the food they consume, with half of them importing more than 80% of the food they consume—only Belize, Guyana, and Haiti produce more than 50% of their consumption—and much of the imported food comprises energy-dense, nutrient-poor products, high in fats, oils, sweeteners, and sodium, linked to the epidemic of overweight and obesity in the region.²⁴ Worldwide, providing the growing global population with healthy diets from sustainable food systems poses a significant challenge. Many people consume low-quality diets that not only cause micronutrient deficiencies, but also contribute to substantial increases in obesity and NCDs—unhealthy diets pose a greater risk to morbidity and mortality than does unsafe sex, and alcohol, drug, and tobacco use combined.²⁵

- Globally, in 2016, 39% of adults aged 18 years and over were overweight (39% men and 40% women), and 13% were obese (11% men and 15% women); 18% of children and adolescents aged 5–19 years were overweight or obese—in 1975 that figure was 4%. The increase has occurred similarly among both boys and girls: in 2016, 18% of girls and 19% of boys were overweight, and 6% of girls and 8% of boys were obese.²⁶
- In the Caribbean, overweight and obesity, which predispose to CVD, diabetes, and certain types of cancer, and which can aggravate chronic respiratory diseases, are also on the rise; obesity

¹³ <https://undocs.org/pdf?symbol=en/A/RES/73/2>.

¹⁴ United Nations (UN), Together Let’s Beat NCDs, and World Health Organization (WHO). Brochure – Time to Deliver: Third UN High-level Meeting on NCDs. Geneva: WHO; 2018. Available at: <https://www.who.int/ncds/governance/third-un-meeting/brochure.pdf?ua=1>.

¹⁵ World Health Organization. Fact sheet: Non-communicable diseases, 1 June 2018. Available at: <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.

¹⁶ Pan American Health Organization. Noncommunicable diseases in the region of the Americas: facts and figures. Washington, D.C.: PAHO; 2019. Available at: https://iris.paho.org/bitstream/handle/10665.2/51483/PAHONMH19016_eng.pdf?sequence=6&isAllowed=y.

¹⁷ Port of Spain Declaration Evaluation Research Group. Accelerating Action on NCDs: Evaluation of the 2007 CARICOM Heads of Government Port of Spain Declaration. <https://onecaribbeanhealth.org/wp-content/uploads/2016/10/ACCELERATING-ACTION-ON-NCDS-POSDEVAL-Report-1.pdf>.

¹⁸ Ferguson TS, Tulloch-Reid MK, and Wilks RJ. The epidemiology of diabetes mellitus in Jamaica and the Caribbean: a historical review. *West Indian Med J* 2010; 59(3):259–264. Available at: <https://pubmed.ncbi.nlm.nih.gov/21291103/>.

¹⁹ Boyne MS. Diabetes in the Caribbean: trouble in paradise. *Insulin* 2009; 4(2):12. Available at: https://www.researchgate.net/publication/236892880_Diabetes_in_the_Caribbean_Trouble_in_paradise.

²⁰ Caribbean Health Research Council (CHRC) and Pan American Health Organization. Managing hypertension in primary care in the Caribbean. Trinidad and Tobago: CHRC; 2007. Available at: <http://www.caribgp.org/files/Hypertension.pdf>.

²¹ World Health Organization. Mental disorders: Fact sheet. Geneva: WHO; 28 November 2019. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders>.

²² World Health Organization. Mental Health Action Plan 2013–2020. Geneva: WHO; 2013. Available at: https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf?jsessionid=93476B888ED3EBC1661CD4D232D1EBAE?sequence=1.

²³ Abel W, Baboolal N, and Gibson R. The epidemiology of mental health issues in the Caribbean. In PAHO. Mental health and psychological support in disaster situations in the Caribbean: Core knowledge for emergency preparedness and response (Chapter 5). Washington, D.C.: PAHO, 2012. Available at: https://www.paho.org/disasters/index.php?option=com_docman&view=download&category_slug=books&alias=1973-mental-health-and-psycho-social-support-in-disaster-situations-in-the-caribbean-chapter-5&Itemid=1179&lang=en.

²⁴ Food and Agricultural Organization (FAO). State of food insecurity in the CARICOM Caribbean – Meeting the 2015 hunger target: taking stock of uneven progress. Bridgetown: FAO; 2015. <http://www.fao.org/3/a-i5131e.pdf>.

²⁵ Willett W, Rockstrom J, Loken B, et al. Food in the Anthropocene: the EAT–Lancet Commission on healthy diets from sustainable food systems. *Lancet* 2019; 393(10170):447–492. Available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31788-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31788-4/fulltext).

²⁶ World Health Organization. Fact sheet: Obesity and overweight, 1 April 2020. Available at: <https://www.who.int/en/news-room/fact-sheets/detail/obesity-and-overweight>.

and diabetes are more common in women.¹⁷ It is estimated that more than 60% of the adult Caribbean population is overweight.²⁷

- The increasing trends in overweight and obesity also affect children and adolescents in the region, with approximately one in three being overweight or obese;²⁸ prevalence rates of between 28% and 35% have been found,²⁹ 27% among boys and 33% among girls.²⁷

Data on air pollution in the Caribbean and its impact are scarce, but in Haiti, the use of solid fuels and inefficient cookstoves has a significant impact on health outcomes and livelihoods, particularly for women. Household air pollution (HAP) from cooking is the second leading risk factor for mortality in Haiti—the only greater risk factor for mortality in that country is hypertension. In 2015, over 8,000 deaths were attributable to HAP from cooking with solid fuels, with women accounting for approximately 58%; 13% of HAP-attributable deaths are among children under 5 years of age.³⁰

Related issues

The [2030 Agenda for Sustainable Development](#),³¹ endorsed in 2015 by UN Member States, includes 17 Sustainable Development Goals (SDGs). [SDG 3](#)³² is the goal most directly related to health: “Ensure healthy lives and promote wellbeing for all at all ages” and [target 3.4](#)³³ specifically includes NCDs and mental health: “By 2030, reduce by one-third premature mortality from

non-communicable diseases through prevention and treatment, and promote mental health and well-being”, with indicators addressing mortality rates from CVD, diabetes, cancer, chronic respiratory diseases, and suicide.

NCDs and their risk factors have strategic links to health systems and universal health coverage (UHC); environmental, occupational, and social determinants of health; communicable diseases; maternal, child and adolescent health; reproductive health; ageing; and palliative care.³⁴ Multimorbidity, defined as the coexistence of two or more chronic conditions in the same individual,³⁵ is a particular challenge. A study of multimorbidity in six countries in Latin America and the Caribbean (LAC) showed a multimorbidity prevalence of 37.3% in Jamaica; noted that multimorbidity increased with age, was higher in women, and was more frequent in persons of lower socioeconomic status; and found that diabetes and heart disease were the two disorders most associated with other conditions.³⁶ The study also showed that the proportions of adults with high out-of-pocket payments, difficulties in paying their medical bills, seeing multiple doctors, being in only fair or poor health, and with poorer primary care experiences were higher among those with greater levels of multimorbidity. However, adults with multimorbidity were more likely to have received lifestyle advice and to be up to date with preventive exams.

3.2 Economic considerations

(We)...Note with grave concern the vicious cycle whereby non-communicable diseases and their risk factors worsen poverty, while poverty contributes to rising rates of non-communicable diseases, posing a threat to public health and economic and social development.

*Paragraph 22
Political Declaration by Heads of State and Government
Third UN High-level Meeting on the Prevention and Control of NCDs, 2011*³⁷

The cost of NCDs to society is not only reflected in poor health, but also in reduced productivity, stymied economic growth, and delayed sustainable national development. The five papers published by the [Lancet Taskforce on NCDs and Economics](#)³⁸ in 2018 show that though poverty drives and is driven by NCDs, financial protection from high medical costs can break this cycle; that price policies and taxation are effective means to reduce NCD risk factors, such as tobacco use, harmful use of alcohol, and unhealthy diet, and can reduce inequalities; and that investment in NCD control results in increased economic growth.

A 2015 investment case for NCD prevention and control in Barbados showed that over the 15-year SDG period (2016-2030), scaling up prevention interventions, combined with diagnostic and treatment coverage over the next 5 years, and then holding coverage constant, would give a return on investment (ROI) of 4.1—that is, a 4.1 Barbados dollar (BBD) return for every dollar invested (6.3 with health returns included). This represents a total of BBD 580 million (approximately 290 million

US dollars, USD) in increased productivity, around 1% of annual gross domestic product (GDP)³⁹. A similar analysis in Jamaica in 2018 showed that over the period 2017 to 2032, scaling up the recommended package of interventions would avoid labour productivity losses of over 47.3 billion Jamaican dollars (JMD),⁴⁰ save over 29.8 billion JMD of direct medical costs to treat diseases, grow GDP by an extra 0.11 percentage points by year five alone, and give a minimum ROI of 2.1.⁴¹ The studies demonstrated, respectively, that increased preventive actions will yield a greater ROI than diagnostic and treatment interventions, and that the ROI from increases in taxation of tobacco and alcohol is high.

The COVID-19 pandemic dealt a severe blow to the region’s economic prospects. In July 2020, the UN Economic Commission for Latin America and the Caribbean (ECLAC) forecast an average decline of 9.1% in GDP in 2020 in LAC, with decreases of 9.4% in South America, 8.4% in Central America and Mexico, and 7.9% in the Caribbean, excluding Guyana.⁴² Caribbean countries face additional challenges related to their high debt levels and their significant dependence on the tourism sector, remittances, and food imports.² Contributing factors in the Caribbean context include:⁴³

- The sudden cessation of economic activity, which affects both fiscal and external accounts. Most countries will end up at least partially financing their COVID-19 response with debt;
- Decreases in tax revenues across the board, combined with rising demands on governments for COVID-19 containment actions and social protection measures, which will put further strains on fiscal accounts;

²⁷ Henry, F. Obesity in the Caribbean: a case for public policies. J Nutr Disorders Ther 2016; 6:3 DOI: 10.4172/2161-0509.1000194. Available at: <https://www.longdom.org/open-access/obesity-in-the-caribbean-a-case-for-public-policies-2161-0509-1000194.pdf>.

²⁸ Healthy Caribbean Coalition (HCC). Civil Society Action Plan 2017-2021: Preventing Childhood Obesity in the Caribbean. Bridgetown: HCC; 2017. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2017/10/Preventing-Childhood-Obesity-in-the-Caribbean-CSAP-2017-2021.pdf>.

²⁹ Caribbean Public Health Agency. Plan of action for promoting healthy weights in the Caribbean: Prevention and control of childhood obesity 2014- 2019. Port of Spain, Trinidad and Tobago: CARPHA, 2014. Available at: <http://carpha.org/Portals/0/docs/HealthyWeights.pdf>.

³⁰ Clean Cooking Alliance. Haiti—Cookstoves and Fuels Market Assessment: Preliminary Report, 2016. Available at: <https://www.cleancookingalliance.org/resources/529.html>.

³¹ <https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf>.

³² <https://www.who.int/sdg/targets/en/>.

³³ <https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.4>

³⁴ World Health Organization. Time to deliver: report of the Independent High-level Commission on NCDs. Geneva: WHO; 2018. Available at: <https://apps.who.int/iris/bitstream/handle/10665/272710/9789241514163-eng.pdf?ua=1>.

³⁵ World Health Organization. Multimorbidity: Technical Series on Safer Primary Care. Geneva: WHO; 2016. Available at: <https://apps.who.int/iris/bitstream/handle/10665/252275/9789241511650-eng.pdf?sequence=1>.

³⁶ Macinko J, Andrade FCD, Nunes BP, et al. Primary care and multimorbidity in six Latin American and Caribbean countries. Rev Panam Salud Publica. 2019; 43:e8. <https://doi.org/10.26633/RPSP.2019.8>. Available at: <https://iris.paho.org/bitstream/handle/10665.2/49746/v43e82019.pdf?sequence=5&isAllowed=y>.

³⁷ <https://undocs.org/en/A/66/L.1>.

³⁸ The Lancet Taskforce on NCDs and economics. Series. Lancet 2018; 391:2029-2078. Available at: <https://www.thelancet.com/series/Taskforce-NCDs-and-economics>.

³⁹ Ministry of Health, UN Interagency Task Force (UNIATF), World Health Organization, and UN Development Programme (UNDP). The Investment Case for Non-communicable Disease Prevention and Control in Barbados. WHO and UNDP; 2015. Available at: <https://apps.who.int/iris/bitstream/handle/10665/259689/WHO-NMH-NMA-17.97-eng.pdf?sequence=1>.

⁴⁰ Average exchange rate in 2018: 1 USD = 129.72 JMD. http://boj.org.jm/foreign_exchange/fx_rates_annual.php.

⁴¹ UN Interagency Task Force on NCDs (UNIATF), UN Development Programme, and Pan American Health Organization. The Case for Investment in Prevention and Control of Noncommunicable Diseases in Jamaica: Evaluating the return on investment of selected tobacco, alcohol, diabetes, and cardiovascular disease interventions. Washington, D.C.: UNIATF, UNDP, and PAHO; 2018. Available at: https://iris.paho.org/bitstream/handle/10665.2/49693/9789275120545_eng.pdf?sequence=5&isAllowed=y.

⁴² Economic Commission for Latin America and the Caribbean (ECLAC). Special Report COVID-19 No. 5: Addressing the growing impact of COVID-19 with a view to reactivation with equality: new projections. ECLAC; Santiago; 15 July 2020. Available at: https://repositorio.cepal.org/bitstream/handle/11362/45784/1/S2000470_en.pdf.

⁴³ Dukharan M. COVID-19 Caribbean economic impact report, March 30, 2020. Available at: <http://www.slhta.com/wp-content/uploads/2020/03/MD-COVID-19-Caribbean-Economic-Impacts.pdf>.

- Lower remittance inflows—the Caribbean region receives roughly 15.8 billion USD in remittances each year—thereby amplifying economic pressures on the most vulnerable in the region;
- The severe fall in tourist arrivals and tourism spending, given that the tourism sector employs about 2.4 million people in the Caribbean and accounts for 15.5% of GDP.² The tourism sector’s performance affects government revenue, the wider economy, and GDP, based on direct and indirect effects, especially on the labour force, unemployment, and household income;
- A fall in the price of oil and other commodities due to reduced demand; and
- The threat to supply chains based on the region’s high dependence on imported food and other goods.²

3.3 Equity, human rights, human security, and human capital

- **Health is a political choice. Political decisions can impact on economic and social inequities, including through policies which shape unhealthy living and working environments, or which fail to address inequities of gender, race, and ethnicity. Faced with the many complex existing and emerging challenges to health and wellbeing in countries and globally, including rapid urbanisation, climate change, pandemic threats, and the proliferation of unhealthy commodities, practical responses are urgently needed.**
- **The SDGs are indivisible and universal. They provide a road map for all countries to societal wellbeing by integrating actions across the social, economic, and ecological domains. Within the SDG context, good health is a precondition for, and an outcome and indicator of, sustainable development. Health is core to the SDGs with their focus on people, planet, peace, prosperity, and partnerships.**
- **Transformative strategies for implementing the SDGs. A transformative approach requires joint action and policy coherence. Good governance for health and wellbeing will be a crucial strategy in achieving the SDGs, in line with the emphasis in the Shanghai Declaration.⁴⁴**

*Excerpt from the Introduction of the Adelaide Statement II
Outcome Statement from the [2017 International Conference Health in All Policies:
Progressing the Sustainable Development Goals](#)⁴⁵*

*Implementing the Sustainable Development Agenda through good governance for health and wellbeing: building on the
experience of Health in All Policies*

We, Heads of State and Government and representatives of States and Government, ...

- **Recognize that health is an investment in the human capital and social and economic development, towards the full realization of the human potential and significantly contributes to the promotion and protection of human rights and dignity, as well as the empowerment of all people**
- **Recognize the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic, environmental, and other determinants of health**

*Paragraphs 7 and 10
Political Declaration of the United Nations High-level Meeting on Universal Health Coverage September 2019⁴⁶*

Despite the higher risk and mortality among men, the COVID-19 pandemic is having a disproportionate impact on women in LAC, due to their excessive burden of unpaid work, increased poverty and job insecurity, limited access to public services, and insufficient financing for gender equality policies.⁴² Women are on the first line of response to the health crisis and are more exposed to infection, as they account for 72.6% of those employed in the LAC health sector. In addition, women’s occupations are concentrated in sectors that have been particularly hard hit, such as services, trade, and tourism.⁴² Furthermore, confinement has added to the burden of women in terms of caregiving, and exposed them to higher risks of domestic violence, including femicide. Similarly, across LAC, indigenous populations and afro-descendant people are being disproportionately affected, since they tend to live in worse socio-economic conditions, have limited access to social protection compared to the rest of the population, and face high levels of discrimination in the labour market. COVID-19 will also exacerbate the vulnerability of migrants and refugees.²

Globally, and in the Caribbean, the significant burden and impact of NCDs and their risk factors negatively affect equity and the progressive realisation of the right to health and other human rights. NCD reduction is critical not only for advancing these overarching principles, but also for the enhancement of human security and human capital.

Equity

Many of the determinants of health are outside the direct purview of the health sector. The social determinants of health are defined by the WHO as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.⁴⁷ These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. The social determinants of health are mostly responsible for health inequities, which are the unjust,

unfair, and avoidable or remediable differences in health outcomes and health status seen within and between countries.⁴⁷ Inequities can be identified among groups of people defined socially, economically, demographically, geographically, or by any other means of stratification, and the acronym PROGRESS serves as a reminder of the main equity stratifiers: **p**lace of residence (urban/rural); **r**ace or ethnicity; **o**ccupation; **g**ender; **r**eligion; **e**ducation; **s**ocio-economic status; and **s**ocial capital or resources.⁴⁸ Health equity or equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential;⁴⁹ it is at the core of the SDG pledge to “leave no one behind”.

Given the impact of social, commercial, political, and other determinants of health on NCD occurrence, outcomes, and increasing inequities, it is critical that NCD prevention and control measures include multisectoral WoG, WoS, and HiAP approaches. These approaches should identify and prioritise the needs of PLWNCDS, children, adolescents, and youth, as well as other persons in situations of vulnerability, including persons with disabilities; persons of non-heterosexual orientation; women; older persons; and certain racial and ethnic groups. Consideration should also be given to gender issues. Notwithstanding the need for multisectoral, integrated action, the health sector has essential roles to play in achieving health equity, including the imperative to advance universal health based on the PHC strategy, with provision of equitable access for all people to timely, quality, comprehensive, and people- and community-centered services that do not cause their impoverishment.^{3, 4}

Human rights

Most Caribbean countries have ratified major human rights treaties, including the [International Covenant on Economic Social and Cultural Rights](#),⁵⁰ Article 12 of which expresses “the right of everyone to the highest attainable standard of physical and mental health”; the [International Covenant on Civil and Political Rights](#),⁵¹

⁴⁴ <https://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration.pdf?ua=1>.

⁴⁵ <https://www.who.int/phe/events/HiAP-conference-March2017/en/>.

⁴⁶ <https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>.

⁴⁷ https://www.who.int/social_determinants/en/

⁴⁸ World Health Organization. Handbook on health inequality monitoring: with a special focus on low- and middle-income countries. Geneva: 2013; WHO. Available at: https://www.who.int/docs/default-source/gho-documents/health-equity/handbook-on-health-inequality-monitoring/handbook-on-health-inequality-monitoring.pdf?sfvrsn=d27f8211_2

⁴⁹ https://www.who.int/topics/health_equity/en/.

⁵⁰ <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

⁵¹ <https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>.

Article 2 of which argues against discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, and birth or other status; the [Convention on the Rights of the Child \(CRC\)](#),⁵² Article 24 of which sets out the right of the child to the enjoyment of the highest attainable standard of health and specifically obliges States Parties to “combat disease and malnutrition, including within the framework of primary health care ... through the provision of adequate nutritious foods and clean drinking water...”; and the [Convention on the Rights of Persons with Disabilities](#),⁵³ Article 25 of which addresses health.

In 2013, the Committee on the Rights of the Child detailed the obligations in CRC Article 24 and specifically indicated that States Parties should address obesity in children.⁵⁴ In July 2020, the [Statement by the UN Special Rapporteur on the right to health on the adoption of front-of-package warning labelling to tackle NCDs](#)⁵⁵ noted that within the framework of the right to health, States are required to adopt regulatory measures aimed at tackling NCDs, such as front-of-package nutrition warning labelling on foods and beverages containing excessive amounts of critical nutrients.

As the main duty-bearers for the progressive realisation of these rights—to respect, protect, and fulfil—national governments must be held accountable for implementing policies and programmes that enable the rights-holders—all people—to achieve the highest attainable standard of health. Similarly, they must be held accountable for implementing policies or enabling actions by others, including Industry, which threaten these rights.

Human security

Human security is characterised as freedom from fear (peace), freedom from want (development), and freedom

from indignity (human rights), and as a multisectoral concept with seven essential dimensions: economic security, food security, health security, environmental security, personal security, community security, and political security.⁵⁶ In 2012 the UN General Assembly (UNGA) noted that “Human security is an approach to assist Member States in identifying and addressing widespread and cross-cutting challenges to the survival, livelihood and dignity of their people.” The 2012 UNGA also noted that human security:

- a.includes the right of people to live in freedom and dignity, free from poverty and despair. All individuals, in particular vulnerable people, are entitled to freedom from fear and freedom from want, with an equal opportunity to enjoy all their rights and fully develop their human potential;
- b.calls for people-centred, comprehensive, context-specific and prevention-oriented responses that strengthen the protection and empowerment of all people and all communities; and
- c.recognises the interlinkages between peace, development, and human rights, and equally considers civil, political, economic, social and cultural rights.⁵⁷

A case has been made for the recognition of NCDs as a threat to both personal and global security, given their long-lasting impact on individual health and well-being; increasing prevalence; global costs; potential to overwhelm the response capacity of low-income countries; and contribution to health inequalities.⁵⁸

Human capital

Human capital is defined variously as the skills, knowledge, and experience possessed by an individual or population viewed in terms of their value or cost to an organisation or country⁵⁹ and as an intangible asset or quality that can be classified as the economic

value of a worker’s experience and skills, including assets like education, training, intelligence, skills, and health.⁶⁰ The improvement of a country’s human capital is essential for social and economic progress, and for sustainable human and national development, and health is an essential ingredient for the full development of this invaluable asset. In most Caribbean countries, which are, or have the characteristics of, small island developing states (SIDS), such as vulnerability to global economic shocks, disasters due to natural hazards and the climate crisis; dependence on a few industries, including tourism; and insufficient economies of scale,⁶¹ their human capital is their greatest asset. NCDs therefore pose an existential threat to the development of the region’s human capital.

NCDs are increased and exacerbated by population ageing. Over the period 2015-2035, Caribbean countries will see a rapid and dramatic ageing of their populations, with the number of persons aged 60 years and over increasing from 1.1 million (13% of the population) in 2015 to 2 million (22%) in 2035, and the number of people aged 70 years and over increasing from 500,000 (6%) to 1 million (11%). Caribbean pension systems, and health and social care services, already unable to meet the needs of the current generation of older persons, will experience even more challenges, and there is urgent need for governments to strengthen social protection against a wide range of risks associated with ageing, including loss of income, ill-health, disability, loss of independence, and isolation.⁶² NCD prevention and control, adopting a life-course approach that focuses on prevention and contributes to building and maintaining

human capital, assumes even greater importance in these circumstances.

3.4 COVID-19 and NCDs

As at 10:36 a.m. CET, 5 November 2020, WHO reported 47,596,582 cases of COVID-19 globally, with 1,216,357 deaths, including 21,001,318 cases and 647,393 deaths in the Americas, the highest numbers among all WHO regions.⁶³ As at 2 November 2020, the Caribbean Public Health Agency ([CARPHA](#)),⁶⁴ the specialised health agency of CARICOM, reported 277,170 cases of COVID-19 in 33 countries and territories in the Caribbean, with 4,564 deaths.⁶⁵

Internationally, evidence has emerged that older persons, and persons with underlying conditions, including obesity, CVD, diabetes, cancer, and chronic respiratory diseases, are at greater risk of developing severe illness and dying from COVID-19, and more men than women die of the disease. A meta-analysis of seven studies of patients with COVID-19 in China showed that the most prevalent comorbidities were hypertension (21.1%) and diabetes (9.7%), followed by CVD (8.4%) and respiratory system disease (1.5%).⁶⁶ A study in Italy reported that the majority of patients who died in hospital from COVID-19 had comorbidities, primarily NCDs, with the most prevalent being hypertension (69.2%), type 2 diabetes (31.8%), ischaemic heart disease (28.2%), chronic obstructive lung disease (16.9%), and cancer (16.3%).⁶⁷ An association between COVID-19 severity and NCDs was also found in patients in the United States of America,⁶⁸ and a meta-analysis of 75 studies confirmed that persons with obesity are linked with significant

⁶⁰ Investopedia. See: <https://www.investopedia.com/terms/h/humancapital.asp#>.

⁶¹ Samuels TA. UHC in small island developing states. In Kirtton J and Kickbusch I (Eds.). Delivering Universal Health Coverage 2030. Health: a political choice. London: Global Governance Project; 2019. Available at: <https://www.healthpolicy-watch.org/wp-content/uploads/2019/06/f736fefa-3c34-47e2-b6f7-0218bffe0075.pdf>.

⁶² Jones F (Economic Commission for Latin America and the Caribbean, ECLAC). Ageing in the Caribbean and the human rights of older persons: twin imperatives for action. Santiago: ECLAC; January 2016. Available at: https://repositorio.cepal.org/bitstream/handle/11362/39854/1/S1501220_en.pdf

⁶³ <https://covid19.who.int/>.

⁶⁴ <https://carpha.org/>

⁶⁵ Caribbean Public Health Agency. CARPHA situation reports: coronavirus disease (COVID-19) pandemic. Port of Spain: CARPHA; 2020. Available at: <https://www.carpha.org/What-We-Do/Public-Health/Novel-Coronavirus/CARPHA-Situation-Reports-for-COVID-19>.

⁶⁶ Yang J, Zheng Y, Gou X, et al. Prevalence of co-morbidities and its effects in coronavirus disease 2019 patients: a systematic review and meta-analysis. Int J Infect Dis 2020; 94:91-95. Available at <https://www.ijidonline.com/action/showPdf?pii=S1201-9712%2820%2930136-3>.

⁶⁷ Istituto Superiore di Sanità. Characteristics of SARS-CoV-2 patients dying in Italy. Report based on available data on April 29, 2020. COVID-19. 2020. Available at: https://www.epicentro.iss.it/en/coronavirus/bollettino/ReportCOVID-2019_29_april_2020.pdf.

⁶⁸ Richardson S, Hirsch JS, Narasimhan M, et al. Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized with COVID-19 in the New York City area. JAMA 2020; 323 (20): 2052-2059, published online April 22, 2020. DOI:10.1001/jama.2020.6775. Available at: <https://pubmed.ncbi.nlm.nih.gov/32320003/>.

⁵² <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.

⁵³ <https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx>.

⁵⁴ Committee on the Rights of the Child. General comment No. 15 (2013), paragraph 42. Available at <http://www.refworld.org/docid/51ef9e134.html>

⁵⁵ <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26130&LangID=E%3E>.

⁵⁶ Gomes OA and Gasper D. Human security: a thematic guidance note for regional and national human development report teams. New York: 2013; United Nations Development Programme. Available at: http://hdr.undp.org/sites/default/files/human_security_guidance_note_r-nhdrs.pdf.

⁵⁷ United Nations General Assembly. Resolution adopted by the General Assembly on 10 September 2012: Follow-up to paragraph 143 on human security of the 2005 World Summit Outcome. Document A/RES/66/290. Available at: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/66/290.

⁵⁸ Saha A and Alleyne G. Recognizing noncommunicable diseases as a global health security threat. Bull World Health Organ 2018; 96:792-793. Published online 1 October 2018. DOI: <http://dx.doi.org/10.2471/BLT.17.205732>.

⁵⁹ Oxford Dictionary. See https://www.lexico.com/definition/human_capital.

increases in morbidity and mortality from COVID-19.⁶⁹ A modelling study estimated that, worldwide, one in five people is at increased risk of severe COVID-19 should they become infected, mostly as a result of underlying NCDs; that 6% of males are at high risk compared with 3% of females; and that the proportion of the global population at increased risk was higher in countries with older populations and small island nations with high diabetes prevalence,⁷⁰ criteria fulfilled by most Caribbean countries.

The nature of NCDs and their risk factors demands continuity of access to prevention, care, and treatment to reduce risk and enable quality management of the conditions. However, national responses to COVID-19, especially in the limited-resource setting of the Caribbean, resulted in diversion of resources—human, financial, infrastructural, and technical—to deal with the pandemic. A rapid assessment of the impact of the pandemic on NCD services in the Americas in May 2020 among the 35 Member States of the Pan American Health Organization (PAHO),⁷¹ received responses from 28 countries, including 12 of the 13 Member States in the Caribbean.⁷² The assessment found that:

- NCD services were partially or completely disrupted in 24 (85.7%) of the responding countries.
- The main reasons for service disruption were cancellation of elective care services (14/24, 58.3%); clinical staff being re-allocated to the COVID response (12/24, 50%), and patients not presenting for care (12/24, 50%).
- The partial or complete disruption affected all types of care for PLWNCDs, but more so diabetes and dental care, and rehabilitation services.
- The main strategies used to minimize the disruption in NCD services were triage of patients

and prioritisation of care based on the severity of the condition; use of telemedicine to replace in-person consultations; and novel dispensing for NCD medicines.

- Other planned NCD activities were suspended or postponed, including implementation of NCD surveys (16/28, 57.1%); screening for cancer, diabetes, and other NCDs (12/28, 42.8%); [HEARTS](#)⁷³ programme (8/28, 28.6%); and mass communication campaigns (7/28, 25%).

There have been indications that the pandemic, in common with other emergencies and disasters, has affected people's mental health.⁷⁴ Many people are anxious and fearful about either contracting the virus or that it may affect family members or friends. Fear of severe illness and death from COVID-19 is compounded by feelings of loneliness and loss of social contact due to physical distancing, often for extended periods of time. Persons who have been furloughed or lost their jobs due to the lockdown of businesses, schools, and other entities face economic hardship and associated anxiety and depression regarding payment of bills and other financial obligations. Lockdowns and physical distancing also offer opportunities for increases in the harmful use of alcohol and other substances. Adding to the psychological distress are rumours, myths, and unscientific information about the virus, COVID-19, and management of the disease, spread widely through social media and other communication platforms. Some specific population groups showing high degrees of COVID-19-related psychological stress, include:⁷⁴

- Workers designated as essential, who have to continue working during lockdowns, are at higher risk of infection with COVID-19, and worry about taking infection home to their families, notably including frontline health care workers;

- Older adults and people with pre-existing health conditions;
- Children and adolescents, who are out of school, facing family stress, social isolation, and, in some cases, increased abuse;
- Women, given their pre-eminent role as caregivers both in the formal health system and in the home, and the greater likelihood that they may be victims of domestic violence;
- Persons with disabilities; and
- People caught in humanitarian and conflict settings.

A WHO rapid assessment of mental, neurological, and substance use services during COVID-19⁷⁵ revealed that of the 130 countries that responded (including 11 Caribbean countries), although 89% included mental health and psychosocial support (MHPSS) as part of their national COVID-19 response plans, and 51% reported inclusion of all services for MNS disorders in the list of essential services during COVID-19, there were significant disruptions in services. The assessment found that:

- In almost 33% of countries, at least 75% of MNS-related services were completely or partially disrupted; 35% of countries reported disruption of the management of emergency MNS manifestations, and 30% reported disruption of medications for people with MNS disorders.
- Preventive and promotive services and programmes for mental health were most severely affected, with about 75% of school

and workplace mental health services fully or partially disrupted.

- Other MNS-related interventions and services with complete disruption in more than 20% of countries included suicide prevention programmes (24%), home or community outreach services (24%), and interventions for caregivers (21%).
- MNS services for the most vulnerable were disrupted, including for children and adolescents, older adults, and antenatal and postnatal women. Almost 60% of all psychotherapy and counselling services were reported as partially disrupted.
- The leading causes of disruption were decreases in outpatient volume due to patients not presenting and cancellation of elective care; travel restrictions hindering access to health facilities; and repurposing of staff or facilities.
- The countries' approaches to overcome the disruptions included telemedicine/teletherapy (70%); helplines for MHPSS (67.7%); specific measures for infection prevention and control in MNS services (65.4%); self-help or digital format of psychological interventions (53.8%); triaging to identify priorities (49.2%); and training of COVID-19 health care providers in basic psychosocial skills (44.6%).
- More than 40% of health ministries are not collecting any data on MNS disorders or manifestations in people with COVID-19.

⁶⁹ Popkin B, Shufa D, Green WD, et al. Individuals with obesity and COVID-19: a global perspective on the epidemiology and biological relationships. *Obesity Reviews* 2020;1-17. DOI:10.1111/obr.13128. Available at: <https://onlinelibrary.wiley.com/doi/epdf/10.1111/obr.13128>.

⁷⁰ Clark A, Jit M, Warren-Gash C, et al. Global, regional, and national estimates of the population at increased risk of severe COVID-19 due to underlying health conditions in 2020: a modelling study. *Lancet Glob Health* 2020; 8:e1003-1017. Published online June 15, 2020. Available at: [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(20\)30264-3/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30264-3/fulltext).

⁷¹ The Pan American Health Organization is the Regional Office for the Americas of the World Health Organization.

⁷² Pan American Health Organization. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic in the Americas, 4 June 2020. Washington, D.C.: PAHO; 2020. Available at: https://iris.paho.org/bitstream/handle/10665.2/52250/PAHONMHNVCovid-19200024_eng.pdf?sequence=6&isAllowed=y.

⁷³ https://www.paho.org/hq/index.php?option=com_content&view=article&id=15056:hearts-in-the-americas&Itemid=3465&lang=en

⁷⁴ United Nations Policy Brief: COVID-19 and the need for action on mental health, 13 May 2020. Available at: <https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf>.

⁷⁵ World Health Organization. The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment. Geneva: WHO; 2020. Available at: <https://www.who.int/publications/i/item/978924012455>.

SNAPSHOT OF RESPONSES TO COVID-19 AND NCDs

COVID-19 galvanized action at national, regional, and international levels, and resulted not only in a pandemic, but also an infodemic—a plethora of information aimed at various audiences, including policymakers and the public, amplified by both traditional and social media. The infodemic included accurate information based on scientific data that observed standards, including peer-review; misinformation, the result of erroneously produced and disseminated data; and disinformation, data deliberately crafted and disseminated to confuse.^{76,77,78} Many national, regional, and international media, agencies, and organisations, as well as scientific journals, published information, guidance, and evidence on COVID-19, with updates as additional studies were completed and further information became available.

The PAHO rapid assessment of NCD service delivery during the pandemic⁷² reported specific requests for technical cooperation from the responding countries to strengthen their response from the NCD perspective. Requests were made for communication materials and social media messages; public education and communication messages on COVID-19 and its associations with NCDs and risk factors; promotion of healthy eating and healthy lifestyles during confinement; data and information; modelling on underlying conditions and projections of the impact of COVID-19 on NCDs, risk factors, and NCD mortality; and technical guidance on data collection for NCD-related comorbidities in COVID-19 patients, as well as on registration and reporting of underlying conditions for those who die from COVID-

19. There were also requests for capacity building, including for telemedicine and virtual consultations, the management of persons with COVID-19 and NCDs, and the management of mental health conditions, with a special focus on the prevention and recognition of depression.

4.1 International

Intergovernmental

Numerous resources were established to provide accurate information, advice, and guidance on COVID-19 and NCDs, and related themes, especially using digital platforms. The [PAHO NCDs and COVID-19 portal](#)⁷⁹ includes resources for health care professionals, covering topics such as the management of specific diseases during the pandemic; resources for the public; communication materials, including “Ask the Expert” videos; and information on capacity building events such as webinars. Other platforms include the [WHO NCDs and COVID-19 portal](#)⁸⁰ and those providing specific guidance on mental health issues, including [UN COVID-19 and Mental Health and Wellbeing](#),⁸¹ and [WHO mental health and psychosocial guidance during the COVID-19 outbreak](#).⁸² Other UN agencies also established platforms, such as the [UN Children’s Fund \(UNICEF\) information centre](#)⁸³ and the [UN Food and Agriculture Organization \(FAO\) COVID-19 Response and Recovery Programme](#).⁸⁴

Both the WHO Director-General and the PAHO Director held—and continue to hold, at the time of writing—regular media briefings and interactions with HoSG and Ministers of Health to discuss issues and provide guidance. In addition, both PAHO and WHO established and strengthened bilateral and multilateral partnerships with countries and other development agencies to mobilise resources for the COVID-19 response, document and learn from global, regional, and national experiences, and initiate collaborative planning to build back better. PAHO partnered with entertainers and media houses in the Region of the Americas, including popular shows such as Sesame Street, for communication initiatives to promote public health measures for COVID-19 containment.⁸⁵

PAHO and ECLAC collaborated to provide high-level guidance for countries on the need for convergence between health and the economy as a crucial aspect of the response to COVID-19 and its aftermath. The agencies developed a report² that highlighted four core principles for policy convergence: i) health and well-being as prerequisites for reactivating the economy; ii) reduction of inequalities as a linchpin for all phases of the recovery process; iii) strengthening health systems based on the PHC approach as the foundation of the recovery pathway; and iv) strengthening interaction and agreements among government, civil society, and the private sector to formulate strategies.

Civil society

Civil society entities established online platforms to provide accurate information, disseminate resources, and serve their constituents’ needs. Examples include scientific journals, such as [The Lancet COVID-19 Resource Centre](#),⁸⁶ which includes NCD-related

documents, the [British Medical Journal COVID-19 hub](#),⁸⁷ and the [Journal of the American Medical Association \(JAMA\) COVID-19 page](#),⁸⁸ as well as CSOs, such as the [NCD Alliance coronavirus resources relevant to NCDs](#)⁸⁹ and [World Obesity COVID-19 and obesity/NCDs](#).⁹⁰ The WHO Civil Society Working Group on NCDs and the NCD Alliance organised online events that gave civil society and PLWNCDs a voice⁹¹ and issued statements⁹² relating to NCDs and COVID-19, while the NCD Alliance collaborated to track private sector actions that might negatively impact the health and wellbeing of PLWNCDs, and published a preliminary report in September 2020.⁹³

Private sector

It is well recognised that both the public sector and the health-supporting private sector are needed to meet SDG 3, including target 3.8 on UHC, but often there is no consensus about the role that the private sector should play.⁹⁴ Private sector interventions are often supply- rather than demand-driven, but the latter are needed, aligned and coordinated with national priorities; determined with the participation of government and local stakeholders, including patient/consumer groups such as PLWNCDs; subject to domestic accountability; and based on context-specific approaches, given the heterogeneity of the private sector.⁹⁴

Interactions with the private sector must differentiate between industries that produce, distribute, and promote unhealthy commodities, and the healthy commodity industries, including those that provide financial, insurance, telecommunications, media, agricultural, and transportation services. Even as intergovernmental agencies and CSOs working in health, and specifically in NCDs, made efforts to support governments, and keep their constituents and the general public informed

⁷⁶ Editorial. The COVID-19 infodemic. *Lancet Infectious Diseases*, August 2020. Published online July 17, 2020. Available at: <https://www.thelancet.com/action/showPdf?pii=S1473-3099%2820%2930565-X>.

⁷⁷ Pan American Health Organization. Fact Sheet N.5. Understanding the infodemic and misinformation in the fight against COVID-19. Washington, D.C.: PAHO; 2020. Available at: https://iris.paho.org/bitstream/handle/10665.2/52052/Factsheet-infodemic_eng.pdf?sequence=14.

⁷⁸ Zoracostas J. How to fight an infodemic. *Lancet* 2020; 395 (10225):676. Published February 29, 2020. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930461-X>.

⁷⁹ <https://www.paho.org/en/ncds-and-covid-19>.

⁸⁰ <https://www.who.int/teams/ncds/covid-19>.

⁸¹ <https://www.un.org/en/coronavirus/mental-health-and-wellbeing>.

⁸² https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_2.

⁸³ <https://www.unicef.org/coronavirus/covid-19>.

⁸⁴ <http://www.fao.org/partnerships/resource-partners/covid-19/en/>.

⁸⁵ Pan American Health Organization. Annual Report of the Director of the Pan American Sanitary Bureau: Saving Lives and Improving Health and Well-being. Document CD58/3. Washington, D.C.: PAHO; August 2020. Available at: <https://www.paho.org/en/documents/cd58-3-e-annual-report-director>.

⁸⁶ <https://www.thelancet.com/coronavirus>.

⁸⁷ <https://www.bmj.com/coronavirus>.

⁸⁸ <https://jamanetwork.com/journals/jama/pages/coronavirus-alert>.

⁸⁹ <https://ncdalliance.org/what-we-do/knowledge-exchange/coronavirus-covid-19-resources-relevant-to-ncds>.

⁹⁰ <https://www.worldobesity.org/resources/resource-library/covid-19-obesity-resources>.

⁹¹ <https://globalhealth.org/event/civil-society-working-group-on-ncds-people-at-the-centre-challenges-and-solutions-of-plwncds-during-the-covid-pandemic/>.

⁹² <https://ncdalliance.org/news-events/news/ncd-alliance-reaction-statement-wha73-resolution-on-covid-19-response>.

⁹³ Collin J, Ralston R, Hill SE, et al. Signalling virtue, promoting harm: unhealthy commodity industries and COVID-19. NCD Alliance and SPECTRUM Research Consortium, September 2020. Available at: https://ncdalliance.org/sites/default/files/resource_files/Signalling%20Virtue%2C%20Promoting%20Harm_Sept2020_FINALv.pdf.

⁹⁴ Clarke D, Doerr S, Hunter M, et al. The private sector and universal health coverage. *Bull World Health Organ* 2019; 97:434–435. Published online April 1, 2019. DOI: <http://dx.doi.org/10.2471/BLT.18.225540>.

and up-to-date on COVID-19 and its interaction with NCDs, some private sector purveyors of unhealthy commodities seized the opportunity to promote and market their brands and products. A preliminary report of the mapping of actions by unhealthy commodity industries globally demonstrated that the pandemic created new opportunities for companies to position themselves as partners in progress with governments, international organisations, health agencies, and leading non-governmental organisations (NGOs).⁹³

The authors of the preliminary report raised concerns about a “corporate capture of COVID-19”, where the involvement of the unhealthy commodity industries in the pandemic response may divert public policy efforts away from health and social goals and facilitate inimical industry interests. The industry has presented initiatives as contributions to national or international efforts to combat the pandemic and support communities, but which are designed to promote brands, products, and corporations with economic interests that often conflict with public health goals. The preliminary report categorised these companies’ actions into four broad strategic responses: *adapting marketing and promotion of product; corporate social responsibility and philanthropy; pursuing partnerships and collaborations; and shaping policy environments*. Their efforts involved donations, ostensibly to assist frontline health workers, communities, governments, and NGOs; contributions to funding for the pandemic response; and lobbying to have unhealthy products designated as “essential” during the pandemic.

Notwithstanding, it is recognised that during emergencies, financial and in-kind contributions from the private sector can provide important support to health and other programmes by providing resources, channelling important messages through their

networks, or adapting their production and innovation processes to secure supplies of essential goods.⁹⁵ In this regard, UNICEF produced guidance for its country offices regarding the acceptance of financial or in-kind contributions from food and beverage companies in the context of the pandemic response, to recognise and manage conflict of interest, and mitigate risks.⁹⁵

Some industries adapted their manufacturing processes to produce supplies needed for the COVID-19 response, including personal protective equipment (PPE), hand sanitisers, testing kits, and therapeutic agents,⁹⁶ while others worked, or are working, to streamline supply logistics; improve connectivity to enable access to online platforms; develop safe and effective vaccines; identify the best policies for economic rebounds; and explore new, more inclusive, and socially responsible ways of doing business.⁹⁷

4.2 Regional

Intergovernmental

CARICOM has been active in the COVID-19 response, establishing a [CARICOM Secretariat COVID-19 page](#)⁹⁸ and a [CARICOM COVID-19 communications page](#)⁹⁹ with information pertaining to the regional impact of the pandemic from policy and operational perspectives. A critical development was enhanced focus on food and nutrition security (FNS) in the Caribbean. In February 2020, CARICOM announced its commitment to reducing the region’s food import bill by at least 25% over the next five years, and the related development of a [CARICOM COVID-19 Response Agri-Food Plan](#) or “25 in 5”.¹⁰⁰ The Plan, underpinned by the [2011 CARICOM Agricultural Policy](#),¹⁰¹ the [2010 Regional Food and Nutrition Security Policy](#),¹⁰² and the [2011 Regional Food and Nutrition Security Action Plan](#),¹⁰³ focuses on effective access and the optimisation of production, and outlines specific

steps to prevent the health crisis from becoming a food crisis.

In addition, CARICOM established an [Action Committee on Food and Nutrition Security](#),¹⁰⁴ which held its inception meeting in March 2020. The Action Committee, supported by FAO, will share best practices and resources on FNS through effective interaction, communication, enhanced synergies, and capacity-building in CARICOM Member States. In a complementary initiative, the Caribbean Agricultural Research and Development Institute (CARDI), developed a comprehensive plan to minimise future disruptions to agri-food supply chains in the region.¹⁰⁵

The Organisation of Eastern Caribbean States (OECS)¹⁰⁶, the other major integration entity in the region, responded to the pandemic and provided support to its Member States through several interventions:

- The OECS Commission:
 - published a joint statement with the HCC “[Strengthening Food and Nutrition Security in the Caribbean: A Legacy Response to the COVID-19 Pandemic](#)”,¹⁰⁷ “[COVID-19 and Beyond, impact assessment and responses](#)”¹⁰⁸ and the “[OECS Education Sector Response and Recovery Strategy to COVID-19](#)”¹⁰⁹ early in the pandemic. The latter two documents speak to needed responses to NCDs, including psychosocial support;
 - mobilised funds from private sector, development partners, and international NGOs to respond to COVID-19, including new donor funds from the Global Partnership for Education (GPE) to support the education sector response, and redirected funds from UNICEF to address areas of social protection and psychosocial support; and

- established an [OECS COVID-19 Dashboard](#)¹¹⁰ and the [OECS COVID-19 policy tracker](#).¹¹¹
- The OECS Pharmaceutical Procurement Service (PPS) continued to facilitate the supply of essential medicines and medical supplies, giving extra support to Member States in areas that were initially neglected during the COVID-19 response, including chronic disease medications and supplies.
- The OECS Health and Agriculture Units, in collaboration with HCC and Diabetes Associations, supported backyard gardening for persons with diabetes and other chronic diseases in Member States.
- The OECS Regional Health Project enabled rapid access to funds to respond to the pandemic and to strengthen health systems.

CARPHA has been the regional technical lead for the COVID-19 response, collating statistics and providing information and guidance to its Member States. However, there was collaboration among CARPHA, the Caribbean Disaster Emergency Management Agency (CDEMA), CARICOM, OECS, the University of the West Indies (UWI), and PAHO to develop protocols to guide countries’ actions in balancing public health and economic interests during the emergency. The [CARPHA COVID-19 page](#)¹¹² includes information on Caribbean countries’ preventive measures, travel advisories and briefs, and re-opening plans, as well as laboratory updates, media releases, and communication materials.

Several of the 11 key stakeholders/thought leaders interviewed for this report and call to action expressed the view that overall, the Caribbean region’s response to the pandemic exhibited good coordination, reflected well the attention paid to the region’s public health services, and provoked minimal social unrest. The coordination

⁹⁵ United Nations Children’s Programme (UNICEF). Response to COVID-19: guidance note on financial contributions or contributions in-kind from food and beverage companies, Version 2. New York: UNICEF; 29 April 2020. Available at: https://www.nutritioncluster.net/Resources_Financial_In-kind_contributions_Food_Beverage_companies.

⁹⁶ <http://www.gbchealth.org/reimagining-the-private-sectors-role-in-health-amid-covid-19/>.

⁹⁷ World Economic Forum (WEF). How are companies responding to the coronavirus crisis? WEF online article, 23 March 2020. Available at: <https://www.weforum.org/agenda/2020/03/how-are-companies-responding-to-the-coronavirus-crisis-d15bed6137>.

⁹⁸ <https://caricom.org/tag/covid19/>.

⁹⁹ <https://today.caricom.org/covid19/regional/>.

¹⁰⁰ <https://caricom.org/caricom-covid-19-response-agri-food-plan/>.

¹⁰¹ https://agricarib.org/images/docs/Community_Agricultural_Policy_JULY_24_2012.pdf.

¹⁰² http://www.fao.org/fileadmin/templates/righttofood/documents/project_m/caricom/CARICOMRegionalFoodandNutritionSecurityPolicy-5october2010.pdf

¹⁰³ <http://www.fao.org/3/a-bs907e.pdf>.

¹⁰⁴ <https://today.caricom.org/2020/03/04/action-committee-on-food-and-nutrition-security-holds-inception-meeting/>

¹⁰⁵ <https://today.caricom.org/2020/05/13/cardi-unveils-comprehensive-plan-to-strengthen-regional-agri-food-chains-in-wake-of-covid-19-crisis/>.

¹⁰⁶ <https://www.oecs.org/>.

¹⁰⁷ <https://pressroom.oecs.org/strengthening-food-and-nutrition-security-in-the-caribbean-a-legacy-response-to-the-covid-19-pandemic>.

¹⁰⁸ <https://drive.google.com/file/d/1W7QTdbTTzNB-4CtOZeYmHYB2CoEy3-rS/view>.

¹⁰⁹ <https://www.oecs.org/our-work/knowledge/library/oecs-education-sector-response-strategy-to-covid-19/viewdocument/2115>.

¹¹⁰ <https://oecs-region-covid-19-oecsmaps.hub.arcgis.com/>.

¹¹¹ <https://datastudio.google.com/reporting/1S1ba3gzl-FN604czZlunPf3Q0w-iSfFw/page/RR7XB?s=g-Vz01Us20k>.

¹¹² <https://carpha.org/What-We-Do/Public-Health/Novel-Coronavirus>.

including adoption of a pooled procurement approach for PPE, medical devices, and test kits, a model that can be applied to improve access to essential NCD medicines in the future. However, the key stakeholders/thought leaders also noted gaps in the provision of MHPSS and in the maintenance of essential health services, including at the first level of care; lack of a harmonised regimen for COVID-19 testing; and inadequate integration of both information systems for health and patient records, with resulting limitations in information available to guide policy decisions and clinical management, and enable better outcomes.

COVID-19 revealed the soft underbelly of management and leadership of the health systems across the region. The health system depends on many other entities across the government landscape, but some people failed to understand that health is determined by sectors other than Health, and that the whole-of-government approach is critical.

From: Interviews with CSOs and key stakeholders/thought leaders in NCDs in the Caribbean

Civil society

Civil society’s involvement in the response at regional level was exemplified by the Healthy Caribbean Coalition and the UWI. The HCC, among other actions:

- Wrote an [Open Letter to CARICOM HoSG about processed food imports](#)¹¹³ on 28 February 2020;
- Wrote an [Open Letter to CARICOM HoSG calling for urgent action to protect PLWNCDs from COVID-19](#),¹¹⁴ dated 27 March 2020;
- Developed an [HCC COVID-19 Advocacy and Communication Strategy](#)¹¹⁵ in late March 2020 (updated early June 2020);

- Co-authored and disseminated an [HCC-OECS Joint Statement on Strengthening Food and Nutrition Security in the Caribbean: A Legacy Response to the COVID-19 Pandemic](#),¹¹⁶ dated 15 April 2020;
- Enhanced its Food and Beverage Industry Tracking Database, after noting a surge in pervasive online marketing and acts of so-called “corporate social philanthropy” during the COVID-19 crisis, based on its regular monitoring of regional food and beverage industry actors.
- Convened a series of [webinars on COVID-19 and NCDs in the Caribbean](#),¹¹⁷ including a ‘Civil society roundtable: COVID-19 and NCDs in the Caribbean’; ‘Weighing the impact of COVID-19: nutrition, overweight, obesity and NCDs’; ‘Reopening schools: shared perspectives on navigating mental health during COVID-19’; and ‘The Future Talks’, this last providing youth with a forum to discuss their experiences and perspectives of the pandemic and its legacy;
- Promoted webinars organised by other entities, including PAHO, WHO, NCDA, and World Obesity;
- Established an [HCC COVID-19 page](#),¹¹⁸ and
- Launched a [Backyard Garden Initiative](#)¹¹⁹ to encourage healthy eating and food and nutrition security.

The UWI established a [COVID-19 Task Force](#)¹²⁰ and a [UWI COVID-19 page](#)¹²¹ that includes situation reports; a question and answer section; resources targeting public health and health care professionals, policymakers, journalists, and the general public; and a “Find an Expert” search facility that provides access to experts in various disciplines from among its faculty. The institution played a significant role in modelling the COVID-19 pandemic and making projections to guide policy and protocol

development in the region; is involved in the [WHO Solidarity Trial regarding therapeutic interventions for COVID-19](#),¹²² and is conducting research on mental health and COVID-19 in the Caribbean.

Private sector

Between March and September 2020, the internally-held HCC Food and Beverage Industry Tracking Database identified 47 instances of donations of products—most high in fats, salt, and sugar—to vulnerable persons in the region, including PLWNCDs and children. There were 18 instances of donations of fast food, mostly to children and health care workers, and in some instances, these foods, paired with branded paraphernalia, were provided to persons in conditions of vulnerability, including residents of children’s homes.

However, some private sector industries in the region made health-supporting interventions as part of the COVID-19 response, similar to their international counterparts, through financial donations in support of PPE for health workers; adapting their manufacturing processes to produce supplies for public health measures; and complying with government regulations and protocols.

In August 2020, despite the economic challenges, CIBC First Caribbean International Bank renewed its memorandum of understanding with the HCC to focus on workplace wellness and a community volunteer initiative,¹²³ and collaborated in the implementation of HCC workplace wellness webinars related to COVID-19.

4.3 National

Government

Governments in many countries reacted swiftly to contain the disease, using curtailment of activities as their main strategy. Most mounted national responses to COVID-19 led by the HoSG, guided by scientific evidence, and advised by Ministers of Health, their technical staff, and public health agencies. Though initially focused on the health sector, the evolving response quickly became a multisectoral one, as the effects of the pandemic

spread beyond health to affect every aspect of life, requiring the engagement of the education, agriculture, tourism, social security, transportation, business, trade, and finance sectors. Some countries declared States of Emergency and passed legislation or put in place special regulations to enable the response, and some services and workers were deemed essential, allowing them to continue working under agreed protocols.

Several countries in LAC implemented measures in areas such as prevention of violence among women, promotion of co-responsibility for care, protection of women’s jobs and income, and access to benefits; The Bahamas, Belize, and Jamaica instituted support for the tourism sector, which contributed to the liquidity of micro, small, and medium enterprises and the informal sector, which employ a significant proportion of women.⁴²

In Caribbean countries, as elsewhere, lockdowns went into effect. There were, and in some instances still are at the time of writing, border closures; restriction of air and other modes of travel; curfews and stay-at-home orders; closure of schools, universities, and other learning institutions, and of churches and non-essential businesses; and suspension of sports, construction, and meetings. These responses complemented public health measures such as hand sanitising, mask wearing, physical distancing, contact tracing, quarantine, isolation, and clinical management of the disease. With business closures, persons became unemployed and incomes plummeted; with physical distancing, social interaction was limited, but with curfews and stay-at-home orders, in-home interaction became more intense in many cases, and physical distancing proved challenging in some situations. There were increases in sedentarism and screen time as meetings, communications, and social interactions moved online and burgeoned.

The containment measures also affected access to nutritious food for many, including for children, as with the closure of schools, there were no school meals, and—at least initially—there were restrictions on the opening hours of supermarkets, closure of markets, prohibition

¹¹³ <https://www.healthycaribbean.org/hcc-open-letter-to-caricom-heads-of-state-and-government-about-processed-food-imports/>

¹¹⁴ <https://www.healthycaribbean.org/hcc-open-letter-to-caricom-heads-of-state-and-government-about-ncds-and-covid-19/>.

¹¹⁵ <https://www.healthycaribbean.org/wp-content/uploads/2020/04/HCC-Coronavirus-Communication-Strategy-31-March-2020-FINAL.pdf>.

¹¹⁶ <https://www.healthycaribbean.org/wp-content/uploads/2020/04/HCC-OECS-Joint-statement.pdf>.

¹¹⁷ <https://www.healthycaribbean.org/category/webinars/>.

¹¹⁸ <https://www.healthycaribbean.org/coronavirus-covid-19/>.

¹¹⁹ <https://www.healthycaribbean.org/accessing-nutritious-foods-backyard-gardening/>.

¹²⁰ <https://www.uwi.edu/covid19/taskforce>.

¹²¹ <https://www.uwi.edu/covid19/>.

¹²² <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov/solidarity-clinical-trial-for-covid-19-treatments>.

¹²³ <https://www.barbadosadvocate.com/news/cibc-firstcaribbean-promotes-workplace-wellness>.

of food vending, and limited provision or sale of fresh produce by farmers and roadside vendors. These measures, coupled with the limitations imposed on outdoor movement, and sports facility, gym, and school closures, aggravated the obesogenic environment.

In some countries physical activity demonstrations and classes strengthened their online presence, as occurred with the [Jamaica Moves: Get Moving Home Workout](https://www.loopjamaica.com/content/jamaica-moves-encourages-home-exercise)¹²⁴ series, which targeted both adults and children, and initiatives to address nutrition and food security were implemented. After initial restrictions, food vendors were allowed to ply their trade and supermarkets were allowed to open for longer periods. In Guyana, the Ministry of Agriculture's Rural Entrepreneurship Agricultural Project (REAP) launched its [COVID-19 Relief Kitchen Garden Initiative](https://dpi.gov.gy/maas-kitchen-garden-project-ensuring-food-security-amid-covid-19/)¹²⁵ to promote self-sufficient, healthier eating and enable food security during the pandemic; Jamaica launched its [Say Yes To Fresh campaign](https://www.forbes.com/sites/daphneewingchow/2020/04/30/jamaica-responds-to-covid-19-by-ramping-up-healthy-food-consumption/#5f18ad792ab5),¹²⁶ collaborating with the private sector to absorb produce that would normally have been used in the tourism sector, and re-educating consumers on the importance of buying local; and Saint Lucia implemented the [Good Food Initiative](https://stluciatimes.com/fresh-produce-delivered-to-vulnerable-families/),¹²⁷ in which local produce bought directly from local farmers, fishermen, and chicken producers was delivered to vulnerable families across the country.

Also threatened were access to essential health services, including medicines, vaccines, and health technologies, as supply chains were disrupted and the health workforce was diverted to deal with the emergency situation. Empty schools and other infrastructure were co-opted to serve as health facilities when needed, and efforts were made to continue essential health services, with emphasis on calling ahead, unless an emergency situation occurred. Though governments designated health services, pharmacies, and the farming industry as essential, and sought to maintain access to medical care, essential medicines, and food supplies, there was no initial focus on PLWNCDs or other vulnerable groups.

As lockdowns continued, some countries permitted pharmacies in the public sector to fill multiple months of medication, and social protection mechanisms came into play, including provision of national insurance payments and stimulus packages to offset losses in income due to unemployment. Governments also provided benefits and care packages for households identified as poor or in other conditions of vulnerability, and made requests to utility companies and financial institutions to defer usual action for non-payment of, respectively, bills and loans by consumers. Some countries established funds to support persons' livelihoods, such as the [COVID-19 Technical Assistance Grant](http://www.ncf.bb/covid-19-creatives-technical-assistance-grant-cctag-application-form/)¹²⁸ in Barbados, established by the National Cultural Foundation to provide grant funding for the development of new ideas and cultural products.

In several countries, including Antigua and Barbuda, The Bahamas, Barbados, Guyana, Jamaica, and Trinidad and Tobago, Ministers of Health seized opportunities to emphasise the burden of NCDs, the greater likelihood of COVID-19 complications in PLWNCDs, and the importance of risk factor reduction and NCD control. Some countries, including Antigua and Barbuda and Barbados, not only closed bars during their lockdowns, but also prohibited the sale of alcohol for a period of time. In Barbados and Guyana, the Ministers used Caribbean Wellness Day, 12 September 2020, to highlight the impact of COVID-19 on mental health and promote coping skills and mental wellness, and in October 2020, Jamaica's Minister of Health announced that a COVID-19 Mental Health Response Programme would be implemented to mitigate mental health issues that have emerged, or are anticipated to emerge, as a result of the pandemic.¹²⁹

Key stakeholders/thought leaders interviewed for this report and call to action indicated that in Caribbean countries, though assistance included food supplies to vulnerable households, there was no certainty that the packages comprised nutritious foods. They also noted that:

- In most countries there was resource reallocation to address the pandemic, as well as resource mobilisation with explicit partnerships between countries and regional and international agencies offering technical and financial support. These agencies included, respectively, CARPHA, CDEMA, PAHO, and other UN agencies, and the Caribbean Development Bank, Eastern Caribbean Central Bank, InterAmerican Development Bank, and World Bank. Countries also collaborated closely with the main regional integration entities, CARICOM and OECS.
- In one country, the World Bank provided an education grant to the government for at-risk youth, to mitigate the interruption of their studies and enable the transition to e-learning and retrofitting of schools for the maintenance of COVID-19 protocols, with an emphasis on equity in the community.
- There was cooperation and mutual assistance among CARICOM Member States themselves, regarding supplies, funding, and sharing of experiences, facilitated by the establishment of online groups comprising Chief Medical Officers and Ministers of Health.
- Selected Caribbean countries were provided with PPE by the Government of China; with medical personnel by the Government of Cuba; and with health technology, PPE, and funding by the Governments of Spain and Turkey; and
- Some countries established, or used existing, multisectoral entities and mechanisms to address COVID-19; some, including Barbados, Saint Lucia, and Trinidad and Tobago expanded their implementation of the HEARTS programme⁷³ for CVD reduction; and others, including The Bahamas and Trinidad and Tobago, provided starter kits for households to establish backyard gardens to grow healthy foods.

The key stakeholders/thought leaders also identified [challenges](#) that Caribbean countries encountered in responding to COVID-19, including:

- Underestimation of the threat posed by COVID-19 to the region, its widespread impact, including the

negative effect on the Blue Economy and tourism, and the severe economic downturn;

- Little or no strategic planning, with delayed implementation of lockdown measures, as well as attempts to re-open too early in some countries, resulting in re-imposition of restrictions;
- Inadequate resources – financial, human, and infrastructural;
- Inadequate mechanisms for synergistic actions among responding entities;
- Difficulties in reorganising health services to respond to COVID-19 cases;
- Insufficient or delayed procurement of PPE and COVID-19 test kits, the latter leading to delays in identifying cases and contact tracing;
- Inadequate and ineffective risk communication to influence behaviour, leading to a “trust deficit” and difficulty in maintaining and enforcing public health protocols, including physical distancing, mask wearing, and quarantine;
- Difficulties in meeting the needs of the population while responding to COVID-19;
- Weak surveillance systems, including failure to capture clinical information from the private sector;
- Limited meaningful involvement of multisectoral National NCD Commissions and, in some countries, exclusion of civil society and the health-supporting private sector as part of an integrated response;
- Societal inequities and inadequate social protection mechanisms for groups in conditions of vulnerability, including PLWNCDs, persons with disabilities, women, children, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) people;
- Difficulties in ensuring the continuation of quality education, especially for children in conditions of vulnerability;
- Over-emphasis on the recovery phase—opening of borders, schools, and re-starting the economy—to the detriment of strategic planning for the post-COVID-period with policies and

¹²⁴ <https://www.loopjamaica.com/content/jamaica-moves-encourages-home-exercise>.

¹²⁵ <https://dpi.gov.gy/maas-kitchen-garden-project-ensuring-food-security-amid-covid-19/>.

¹²⁶ <https://www.forbes.com/sites/daphneewingchow/2020/04/30/jamaica-responds-to-covid-19-by-ramping-up-healthy-food-consumption/#5f18ad792ab5>.

¹²⁷ <https://stluciatimes.com/fresh-produce-delivered-to-vulnerable-families/>.

¹²⁸ <http://www.ncf.bb/covid-19-creatives-technical-assistance-grant-cctag-application-form/>.

¹²⁹ <https://jis.gov.jm/covid-19-mental-health-response-programme-to-be-implemented/>.

initiatives that improve resilience to pandemics and health challenges in general; and

- For certain countries, unregulated and illegal cross-border migration of persons from countries in Central and South America experiencing high prevalence of COVID-19.

Civil society

Despite the challenging circumstances of restricted movement, curfews, business and other entity closures, and limited attendance at health facilities, as well as the perennial challenge of limited resources, national CSOs played a significant role in working to serve the needs of their constituents. Information shared during the June 2020 [HCC Civil Society Roundtable: COVID-19 and NCDs in the Caribbean](https://www.healthycaribbean.org/civil-society-roundtable-covid-19-and-ncds-in-the-caribbean/)¹³⁰ confirmed CSOs' embrace of technology to serve their constituents, with the Barbados Diabetes Foundation expanding its telemedicine services, and the Diabetes Association of Trinidad and Tobago increasing its social media presence, convening a virtual camp for children with diabetes, and initiating the development of a diabetes application for mobile devices. The Roundtable also reported that the Bahamas Red Cross provided training in MHPSS and that trade unions supported their members during furlough or loss of employment. In August 2020, the Heart & Stroke Foundation of Barbados conducted a virtual launch of its "Act Now!" mass media campaign against childhood obesity.

The interviews with the nine selected CSOs working in NCDs in the region revealed that:

- Only one CSO, an alliance of NGOs, was closed for the duration of the lockdown, but the individual members of the alliance continued to function; another CSO was closed initially, but soon re-opened. All the CSOs that remained open served their constituents as best they could. The Heart Foundation of Jamaica, which provides clinical services, was designated as an essential service by the Government of Jamaica to allow for continuity of care, and the Haiti Diabetes and Cardiovascular Diseases Foundation also

continued its provision of clinical services, focusing on decentralised activities.

- Almost all of the CSOs provided specific COVID-19-related communication targeting their constituents, amplifying messages from Ministries of Health, PAHO, and CARPHA, and countering misinformation and disinformation. They assisted constituents to access health services, care, and medication, including by virtual means; provided medication; established online services, including virtual clinical care, MHPSS, and physical activity programmes; and convened webinars. Several CSOs advocated to government for the needs of their constituents, and one established a call centre to provide information on COVID-19, while
- The Barbados Childhood Obesity Prevention Coalition and the Antigua and Barbuda Diabetes Association provided healthy food packages to address the nutritional needs of their constituents and persons in conditions of vulnerability, exemplified by, respectively, the [Healthy Hampers Initiative](https://www.healthycaribbean.org/barbados-childhood-obesity-prevention-coalition-healthy-hampers-initiative/)¹³¹ and [donations to persons living with diabetes](https://www.healthycaribbean.org/antigua-and-barbuda-diabetes-association-donates-healthy-food-items-to-persons-living-with-diabetes/).¹³²
- The Cancer Society of The Bahamas, mindful of the archipelagic nature of the country, ensured that its members in the Family Islands were kept abreast of public health measures for COVID-19, while the Belize Cancer Society (BCS) liaised with various government agencies to support access to food pantries, COVID-19 relief funds, and psychosocial support for patients. The BCS also provided navigation and logistic support for patients to visit neighbouring Mexico, Guatemala, and El Salvador for continuity of urgent tertiary care not available in Belize.
- All CSOs faced challenges related to limited resources—*financial*, due to suspended fundraising events, reduced collection of user fees (for those providing paid services), economic hardship among their clients, decreases in client numbers due to physical distancing demands, and

increased spending to put mandatory COVID-19 control measures in place; *human*, as employees observed curfews, the CSOs reduced their opening hours and introduced staggered working hours for staff, and the volunteer pool shrunk due to fear and caution; and *infrastructural*, with a few CSOs lacking an office location and adequate technological capacity to fully transition into remote services, as well as limited access to the Internet by some of their constituents.

- However, though some of the larger CSOs had to temporarily lay off or reduce the hours of work of their staff, no staff lost jobs; some CSOs received donations from various sources, while others were able to use resources from pre-COVID fundraising. In one case, the government provided funding to the CSO on an emergency, one-time basis to ensure continuity of out-of-country care for a few patients.
- Other challenges identified included fully understanding the needs of the public; keeping updated with constantly changing COVID-19 protocols; and, in one case, having to assume a leadership role in the NCD arena, given weak national health systems and leadership in the pandemic. One CSO experienced difficulties with the regular importation procedures for supplies to serve its constituents.
- All the CSOs identified financial and human resources as their main needs and operational priorities for the ongoing COVID-19 pandemic, with one indicating devaluation of the national currency as an important factor in its need for significant financial support. Some CSOs highlighted capacity strengthening in understanding and addressing their constituents' needs; support and/or recognition from government; and support from the HCC and international CSOs as important factors for their operations. A few indicated collaboration with other national CSOs as a crucial area for action, and one noted that it needed a meeting place and reorganisation of its communication links to facilitate interaction with its constituents.

Private sector

The lockdowns drove many consumers to stock up on ultra-processed products high in fats, salt, and sugar, and led some private sector entities in the food and beverage industry in countries to seize the opportunity to promote, market, and deliver these unhealthy commodities to households. In further demonstration of the strategies outlined in the global mapping of the actions of unhealthy commodity producers during the pandemic,⁹³ a fast food entity in Barbados made an innovation with likely health-harming effects by procuring a fleet of small cars to deliver its products island-wide, once it was allowed to re-open.

However, several private sector entities supported health, health workers, and vulnerable communities. Some supermarkets began taking orders for kerbside collection or delivery to households, and some entrepreneurs made a business of the mobile sale of fish, fruits, vegetables, and ground provisions. In campaigns such as the 'Say Yes to Fresh' in Jamaica, public-private partnerships were established that saw entrepreneurs and agro-processors assisting with the storage of excess produce and innovating, developing new value-added products and expanding existing product lines.¹²⁶ In collaboration with NGOs and social sector entities, the Private Sector Organisation of Jamaica (PSOJ) launched a [COVID-19 Jamaica Response Fund](https://psoj.org/archives/7176)¹³³ in April 2020 to provide services for vulnerable communities across the island, including the provision of free screening for NCDs by some health NGOs. By September 2020, the Fund had reached 200 million JMD, 80% of the target set. In Jamaica and Trinidad and Tobago, Nestlé donated food items, PPE, and cash, collaborating with the International Federation of Red Cross and Red Crescent Societies and their local branches.¹³⁴

In addition, since curfews and sports facility closures severely limited out-of-home physical activity, trainers in some countries made paid online sessions available for those who wished to continue their physical activity regimens.

¹³⁰ <https://www.healthycaribbean.org/civil-society-roundtable-covid-19-and-ncds-in-the-caribbean/>.

¹³¹ <https://www.healthycaribbean.org/barbados-childhood-obesity-prevention-coalition-healthy-hampers-initiative/>.

¹³² <https://www.healthycaribbean.org/antigua-and-barbuda-diabetes-association-donates-healthy-food-items-to-persons-living-with-diabetes/>.

¹³³ <https://psoj.org/archives/7176>.

¹³⁴ <https://www.nestle-caribbean.com/about-us/our-response-covid-19>.

JUSTIFICATION FOR A TRANSFORMATIVE NEW AGENDA FOR NCD PREVENTION AND CONTROL IN THE CARIBBEAN

5.1 Rationale

Globally, regionally, and nationally, NCDs are responsible for the greatest proportion of death and disability, with significant impact on persons in poverty and other conditions of vulnerability. In its September 2020 report, the Lancet Non-communicable Diseases and Injuries (NCDI) Poverty Commission recognised that NCDs and injuries are important, yet under-recognised and poorly-understood, contributors to death and suffering among the poorest billion people.¹³⁵ The report called for the re-framing of the NCD burden to go beyond the “5x5” priorities and address the full scope of the heterogeneous set of conditions that comprise NCDIs among the poorest billion (NCDI Poverty), including rheumatic heart disease, road injuries, congenital defects, and sickle cell disease. The Commission noted that the progressive implementation of affordable, cost-effective, and equitable NCDI interventions between 2020 and 2030 could save the lives of more than 4.6 million of the world’s poorest people, including 1.3 million who would otherwise die before the age of 40 years.¹³⁵

COVID-19 has significantly impacted PLWNCDs and demonstrated the substantial impact on health outcomes

of the social, political, economic, commercial, and other determinants of health. The pandemic provides a unique opportunity to re-imagine NCD prevention and control across the continuum of care, during and post-COVID-19. Since NCDs are major risk factors for severe COVID-19, pandemic control efforts must include interventions to reduce NCDs, including minimising the psychological, psychiatric, and long-term effects of COVID-19. This is especially relevant to the Caribbean, given the pre-eminence of NCDs in the region, the limited resources available, and the inadequate investment in NCD prevention and control to date, factors which demand that urgent attention be given to the situation.

Frameworks for NCD action

There are myriad international frameworks and guidelines for the prevention and control of NCDs and their risk factors, including, but not limited to, the [WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020](#),¹³⁶ the [2016 Report of the WHO Commission on Ending Childhood Obesity](#),¹³⁷ and its [2017 Implementation Plan](#),¹³⁸ the [PAHO Strategy for the Prevention and Control of NCDs 2012-2025](#),¹³⁹ the [PAHO Plan of Action for the Prevention and Control of NCDs in the Americas 2013-2019](#),¹⁴⁰ the Political Declaration from the UN HLM on NCD prevention and control in 2011;³⁷

the [Outcome Document from the 2014 HLM on NCDs](#),¹⁴¹ and the Political Declaration from the 2018 HLM on NCDs,¹³ as well as the widely-promoted [WHO Best Buys \(BBs\) and Other Recommended Interventions \(ORIs\)](#),¹⁴² a suite of evidence-based, cost-effective strategies that address reduction of the main NCD risk factors and management of the major NCDs. The WHO Mental Health Action Plan 2013-2020²² offers global guidance to countries on addressing this underserved area.

In the Caribbean, the 2007 POSD;⁷ the [2007 Declaration of St. Ann: Implementing Agriculture and Food Policies to Prevent Obesity and NCDs in the CARICOM](#),¹⁴³ the CARPHA Plan of Action for supporting Healthy Weights in the Caribbean: Prevention and Control of Childhood Obesity 2014-2019;²⁹ and the [Caribbean Cooperation in Health Phase IV \(CCH IV\) 2016-2025](#)¹⁴⁴ are some of the regional frameworks for NCD prevention and control. These are complemented by many NCD-related [HCC publications](#)¹⁴⁵ that primarily target civil society, but which appeal to a wide range of stakeholders, including governments, and several national plans for NCD prevention and control,¹⁴⁶ and specifically for mental health.¹⁴⁷

However, despite the publication, dissemination, and promotion of these international, regional, and national frameworks and guidelines, there is a recognised implementation deficit in NCD prevention and

control globally and in the Caribbean. Worldwide, the implementation of the WHO BBs and ORIs is lagging, and accelerated action for their further implementation continues to be a priority.¹⁴⁸ With countries already off-track to meet SDG 3 and other SDG targets, and mortality related to some NCDs anticipated to increase, the impact of the COVID-19 pandemic has raised fears of further slowing of progress and a surge in NCDs and their complications.¹⁴⁹ This would aggravate previously documented deficits related to political choices and leadership, health systems, priority-setting, national capacities, accountability, domestic and international financing, and the impact of economic, market, and commercial factors, including industry interference.^{34, 150,151} The policy brief for the Global NCD Alliance Forum in February 2020 identified gaps in the fulfilment of commitments to NCD prevention and control related to leadership, investment, care, community engagement, and accountability.¹⁵²

The situation in the Caribbean reflects these global findings, and the commitments of the POSD also demonstrate an implementation deficit.¹⁵³ The 2016 POSD evaluation¹⁷ found that most CARICOM Member States had difficulty implementing the commitments, and that the main areas of weak policy implementation related to mandates regarding schools, communications, and diet.¹⁵⁴ Key recommendations from the evaluation included:

¹⁴¹ <https://www.who.int/nmh/events/2014/a-res-68-300.pdf?ua=1>.

¹⁴² World Health Organization (WHO). Tackling NCDs: Best buys and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: WHO; 2018. Available at: <https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf?sequence=1&isAllowed=y>.

¹⁴³ <https://caricom.org/declaration-of-st-ann-implementing-agriculture-and-food-policies-to-prevent-obesity-and-non-communicable-diseases-ncds-in-the-caribbean-community/>

¹⁴⁴ https://caricom.org/documents/16429-cch-iv-publication_rev-7_health_sector_development.pdf.

¹⁴⁵ <https://www.healthycaribbean.org/publications/>.

¹⁴⁶ Pan American Health Organization. In-depth qualitative analysis of noncommunicable diseases multisectoral action plans in the Caribbean. Washington, D.C.: PAHO; 2018. Available at: https://iris.paho.org/bitstream/handle/10665.2/49093/9789275120101_eng.pdf?sequence=1&isAllowed=y.

¹⁴⁷ World Health Organization. WHO-AIMS report on mental health systems in the Caribbean region. Geneva: WHO; 2011. Available at: https://www.who.int/mental_health/evidence/mh_systems_caribbeans_en.pdf.

¹⁴⁸ World Health Organization. Assessing national capacity for the prevention and control on noncommunicable diseases: report of the 2019 global survey. Geneva: 2020; WHO. Available at: <https://www.who.int/publications/i/item/ncd-ccs-2019>.

¹⁴⁹ United Nations. The Sustainable Development Goal Report 2020. New York: 2020; UN. Available at: <https://unstats.un.org/sdgs/report/2020/The-Sustainable-Development-Goals-Report-2020.pdf>

¹⁵⁰ United Nations General Assembly. Progress on the prevention and control of non-communicable diseases: Report of the Secretary-General. Document A/72/662, December 2017. Available at: https://www.who.int/ncds/governance/high-level-commission/A_72_662.pdf?ua=1.

¹⁵¹ World Health Organization. Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in September 2018: Report by the Director-General. Document A71/14, 19 April 2018. Geneva: WHO; 2018. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_14-en.pdf.

¹⁵² NCD Alliance (NCDA). Bridging the gap on NCDs: from global promises to local progress. Geneva: NCDA; January 2020. Available at: https://ncdalliance.org/sites/default/files/resource_files/Bridging%20the%20Gap_Brief_FINAL.pdf.

¹⁵³ Healthy Caribbean Coalition. Port of Spain Declaration 10th Anniversary Commemoration Infographic. Bridgetown; HCC; July 1, 2017. Available at: <https://www.healthycaribbean.org/pos-declaration-10th-anniversary-infographic/>.

¹⁵⁴ Summary POSDEVAL. Available at: <https://onecaribbeanhealth.org/fan-posdeval/>.

¹³⁵ Bukhman G, Mocumbi AO, Atun R, et al. The Lancet NCDI (NCDs and Injuries) Poverty Commission: bridging a gap in universal health coverage for the poorest billion. Lancet 2020. Published online September 14, 2020. Available at: [https://doi.org/10.1016/S0140-6736\(20\)31907-3](https://doi.org/10.1016/S0140-6736(20)31907-3).

¹³⁶ https://apps.who.int/iris/bitstream/handle/10665/94384/9789241506236_eng.pdf;jsessionid=374037C18CFB518F5C7BCDE0934737F1?sequence=1.

¹³⁷ https://apps.who.int/iris/bitstream/handle/10665/204176/9789241510066_eng.pdf?sequence=1.

¹³⁸ <https://apps.who.int/iris/bitstream/handle/10665/259349/WHO-NMH-PND-ECHO-17.1-eng.pdf?sequence=1>.

¹³⁹ <https://www.paho.org/hq/dmdocuments/2012/CSP28-9-e.pdf>.

¹⁴⁰ <https://www.paho.org/hq/dmdocuments/2015/action-plan-prevention-control-ncds-americas.pdf>.

- Multisectoral actions at all levels of government and society to tackle NCDs;
- Promotion of healthy living in different settings, such as schools, workplaces, and faith-based institutions;
- Marketing of healthy foods, introduction of compulsory standards for nutrition labelling, and a ban on the advertising, sale, and promotion of unhealthy foods in schools;
- Taxation to decrease consumption of sugar-sweetened beverages (SSBs), and subsidies to increase consumption of fresh fruit and vegetables; and
- Partnerships with civil society and the private sector, and sharing information, experiences, and “best practices” more effectively with local and regional stakeholders.

Though there are efforts to implement these recommendations, with advocacy led by CSOs at regional and national levels, implementation of SSB taxation by some countries (Barbados, Bermuda, Dominica, and St. Vincent and the Grenadines), a ban on SSBs in schools (Jamaica and Trinidad and Tobago), and healthy school nutrition policies, or efforts to develop them (The Bahamas, Barbados, Bermuda, Cayman Islands, Dominica, Grenada, Guyana, Haiti, Jamaica, and Trinidad and Tobago),¹⁵⁵ a significant implementation deficit remains.

Enabling stakeholder action - political economy and behavioural economics analyses

The salutary lessons from COVID-19 have implications for all sectors, and highlight the vulnerability of the private sector to health issues, providing an opportunity for the promotion, development, and implementation of the social impact business model in the Caribbean context. In this model, which identifies shared value and win-win solutions for business and health, healthy commodity industries actively participate in people-centred approaches that ensure both economic success for the industries and greater access for PLWNCDs.⁶ Such models must also include strategies for sustainability, to guard against businesses abandoning the social mission when financial pressure is high.¹⁵⁶

Many of the successful mechanisms used in the COVID-19 response, including public-private collaboration, can be analysed with a view to their extension—or adaptation, as needed—to strengthen the response to NCDs. Possibilities exist in the further development and use of digital platforms, technology, and instrumentation for mobile monitoring of PLWNCDs and detection of the onset of complications, but the private sector and its employees can also function as implementers of, and change agents for, NCD reduction policies and programmes. There is also economic benefit for the private sector in having healthy employees, given that NCDs and their complications comprise major reasons for absenteeism and presenteeism.

The private sector has underestimated what is at risk with infectious diseases. If there was ever a lesson as to what is at stake—the disruption to business and the economy—COVID-19 is that lesson. I hope that when we make it through this pandemic, we remember that there is a very powerful link between the health of the population and its ability to generate wealth. I think COVID-19 could transform the relationship between the business community and health to a much broader engagement than we have achieved thus far.

*Mr. Peter Sands, Executive Director
Global Fund to Fight AIDS, Tuberculosis, and Malaria
GBCHealth webinar “Reimagining commitment to fight against HIV, TB, and malaria during COVID-19: focus on the private sector”, July 2020⁶*

¹⁵⁵ Healthy Caribbean Coalition. Childhood Obesity Prevention Scorecard (COPS), as at 3 October 2020. Available at: <https://www.healthycaribbean.org/cop/country-scorecard.php>.
¹⁵⁶ Cheriakova A. Doing social business right – the need for social business models. The Broker. Published online 29 October, 2013. Available at: <https://www.thebrokeronline.eu/doing-social-business-right/>.

A 2015 political economy analysis (PEA) of NCD policymaking in the Caribbean noted that follow-through on political commitments has been mixed, at best.¹⁵⁷ The PEA identified limited progress on:

- tobacco control. Tobacco legislation has been enacted in some countries, such as Barbados, Guyana, Jamaica, Suriname, and Trinidad and Tobago, and there has been implementation of tobacco taxes, though not always to recommended levels;
- establishment of multisectoral National NCD Commissions (NNCDCs). Though established in several countries, these bodies are not functioning as well as expected; and
- surveillance, education, and promotion. There has been implementation of risk factor surveys among youth (Global Youth Tobacco Survey and Global School-based Student Survey) in several countries, population-based risk factor and NCD surveys among adults in Barbados, Guyana, and Jamaica, and mass media and social media campaigns, but these are often sporadic due to limited resources.

The PEA noted even less progress on mandatory provisions of the [2005 WHO Framework Convention on Tobacco Control](#)¹⁵⁸ with respect to advertising, promotion, and sponsorship bans; alcohol reduction, including legislation on alcohol advertising and

promotion, taxation, and limiting access; healthy nutrition, including negotiation of trans fat-free food trade agreements that are utilised to meet national food security and nutrition goals, and mandatory labelling of packaged foods for nutrition content; and physical activity, including infrastructure to facilitate physical activity in new housing projects.

The PEA linked the following factors to the implementation deficit: absence of leadership among the political class; preoccupation with short-term gains, especially after the 2008 global economic downturn; paucity of government legislation and regulation for NCD reduction; and fear that devoting resources to resolving this issue would hurt the private sector and possible trade, on which most Caribbean states are heavily dependent. The analysis noted a bottleneck at the intersection between policy actions for health and private sector interests, highlighting the power, resources, and political leverage that some of these business interests can bring to bear in their opposition to specific government policies. The tobacco, alcohol, and food and beverage industries were singled out for mention, and the point made that potential conflicts of interest between public health and the private sector must be managed appropriately, so that effective policy action is not compromised. The PEA also noted the multisectoral nature of these initiatives and the number of institutions required to deliver policy outcomes.

Business support organisations and industry associations have been able to acquire privileged access to governments in the region in order to advance their stakeholders’ commercial interests by influencing the policy-making process.... policies around improved nutrition, tobacco control, reduction of the harmful use of alcohol... have been poorly developed in most of the countries of the region, in large part because of the powerful and well-resourced lobby groups from industry that are more intent on sustaining profits than on improving the health of consumers. Alcohol, ultra-processed food, and sugary beverage industries use strategies and tactics similar to those utilized by the tobacco industry to undermine the development of effective public health policies and programmes.

From: Knight A and Hippolyte D (2015). Keeping NCDs as a political priority in the Caribbean: A political economy analysis of NCD policymaking.¹⁵⁷

¹⁵⁷ Knight A and Hippolyte D. Keeping NCDs as a political priority in the Caribbean: a political economy analysis of NCD policymaking. Institute of International Relations, UWI. Presented at Forum of Key Stakeholders in the Caribbean: Advancing the NCD Agenda in the Caribbean, 8-9 June 2015, Bridgetown, Barbados. Available at: https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=forum-key-stakeholders-on-ncd-advancing-ncd-agenda-caribbean-8-9-june-2015-7994&alias=36065-keeping-ncds-as-a-political-priority-caribbean-andy-knight-065&Itemid=270&lang=en.
¹⁵⁸ https://www.who.int/fctc/WHO_FCTC_summary.pdf?ua=1.

Traditional policy tools used to influence behaviour include legislation, regulation, and provision of information. However, there is also interest in policies that “nudge” people toward healthy behaviours. The science of behavioural economics and nudge theory have been cited as strategies worth applying in policy development to influence behaviour change, by making the healthy choice the easy choice¹⁵⁹ and presenting goods in a way that nudges people’s consumption to the desired option.¹⁶⁰

As a necessary condition for health, and thus for equity, human rights, and the strengthening of human security and human capital, NCD prevention and control must be given priority. In light of the documented implementation deficit, worsened by diversion of resources to manage COVID-19, a radical shift in the approach to NCD reduction is needed. There must not only be accelerated and strengthened implementation of proven, cost-effective strategies, such as the WHO BBs and ORIs, according to prioritisation based on the national situation, but also reframing of the NCD agenda to promote justice and equity.¹⁶¹ The involvement of government, civil society, and healthy commodity industries, and the use of champions or policy entrepreneurs – highly-respected individuals able to use their credibility and visibility to gain access and advocate to, and often persuade, high-level policymakers¹⁶² – is critical.

5.2 CSOs and key stakeholders/thought leaders—gaps in NCD prevention and control in the Caribbean

CSOs and key stakeholders/thought leaders interviewed for this report and call to action identified the main causes of the implementation deficit in the Caribbean as limited or constrained political will; limited awareness of the proven interventions, especially by policymakers, technical personnel in ministries other than health, health workers, the private sector, and the general public; and inadequate resources—human, financial, and infrastructural. Some mentioned the need for

more regional collaboration, effective leadership, and a greater sense of urgency for NCD reduction.

Requested to specifically identify reasons for the perceived less-than-optimal functioning of the NNCDs in the region, interviewees’ responses included insufficient multisectorality; insufficient authority; their positioning in and supervision by—in most cases—ministries of health; deficits in human and financial resources; unclear terms of reference/scope of work; unclear accountability; and inadequate promotion of the Commission. Despite these challenges, only two respondents thought that the NNCDs should be abolished. Interviewees’ suggestions for enhancing their functioning included provision of more resources—human, financial and infrastructural; greater authority and autonomy, with easier and more direct access to policymakers, including those in Trade and Finance; a focus on policy, rather than implementation; capacity to develop legislative drafts; clear terms of reference and accountability; politically neutral and respected leadership, with wide knowledge of NCDs; more partnerships and collaborative efforts; and improved promotion of the Commissions.

Other suggestions included implementation of a survey to determine the extent to which the NNCDs’ message is being properly received by the intended audiences, and implementation of recommendations based on the survey findings; reminders to policymakers that the establishment of NNCDs is one of the commitments of the POSD; designation of the respective HoSG as Chair of the Commission to foster effective multisectoral action, “since sectors other than health tend to ignore health matters”; and creation of a regional body comprising representatives of NNCDs.

With regard to actions to facilitate meaningful, effective, multisectoral partnerships for NCD reduction, the CSOs and key stakeholders/thought leaders highlighted the following:

- Establish a grouping, such as an NNCDC, ensuring mutuality of interest; conducting due diligence; identifying and managing conflict of interest; operating within a common framework, such as a national NCD strategic plan; developing a plan for the grouping’s operations, with agreed goals and objectives; identifying each partner’s strengths and resources; and providing clarity on individual roles and responsibilities within the group;
- Have regular meetings and activities, rather than operating only around special events, and ensure open dialogue, with sharing of pertinent information;
- Increase the knowledge of partners around specific NCD and mental health themes and strengthen their capacity to take relevant action, for example in advocacy and communication;
- Seek opportunities for win-win situations, ensure accountability, and acknowledge achievements; and
- Respect the knowledge and skills that representatives from sectors other than health bring to the table—“health cannot do it alone”.

The CSOs and key stakeholders/thought leaders indicated that reasons for the urgency accorded to COVID-19 in the region, compared with the indolent response to NCDs, included:

- The difference in the nature and visibility of the pandemic, as opposed to NCDs—“a fast burn versus a slow burn”;
- Insufficient appreciation of the NCD burden and its economic and social costs by policymakers and the population at large—“people do not know about anything unless it affects them and their families personally ...”, “... unless people feel they are in danger, they won’t react”;
- Industry interference, including exerting undue influence on public health policy and provision of resources to health entities;
- Insufficient and ineffective advocacy and other actions for NCD prevention and control by civil society, which have “failed to capture the hearts and minds of the public”;

- Insufficient appreciation of, and action to address, the social and other determinants of health; and
- Insufficient appreciation and use of the equity, human rights, human security, and human capital approaches.

Other reasons mentioned included conflict of interest; political manipulation; and the high level of acceptance that NCDs have garnered in Caribbean society, almost as an inevitable occurrence, rather than as conditions that can be prevented. Several interviewees noted that political inertia, expressed as lack of/inadequate/limited/constrained political will—despite awareness, commitments, agreements, and the region’s previous position in the vanguard of NCD prevention and control—was an important factor in the limited progress made.

There is public hysteria surrounding all diseases of contagion. Much of public health is governed by public hysteria, and the media has contributed. The nature of NCDs is different, and there is not much enthusiasm for being a standard bearer for NCDs.

From: Interviews with CSOs and key stakeholders/thought leaders in NCDs in the Caribbean

One of the strategies that needs to be thought through carefully is how the problem is framed. NCDs are framed around people who die, rather than what is happening to the people who are alive. They are framed half-heartedly around the economic effect. The issue needs to be framed in terms of human capital, emphasising the focus on health, and therefore on NCDs, with coupling of NCDs and other global agendas such as the climate crisis.

From: Interviews with CSOs and key stakeholders/thought leaders in NCDs in the Caribbean

¹⁵⁹ Vlaev I, King D, Dolan P, et al. The theory and practice of “nudging”: changing health behaviors. Public Administration Review 2016; 76(4): 550-561. Available at: <http://eprints.lse.ac.uk/id/eprint/67963>.

¹⁶⁰ Economics Help. ‘Nudges’. <https://www.economicshelp.org/blog/glossary/nudges/>.

¹⁶¹ Zuccala E and Horton R. Re-framing the NCD agenda: a matter of justice and equity. Lancet 2020; Published online first, 14 September 2020, DOI: [https://doi.org/10.1016/S0140-6736\(20\)31910-3](https://doi.org/10.1016/S0140-6736(20)31910-3) Available at: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31910-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31910-3/fulltext).

¹⁶² Unwin N, Samuels AT, Hassell T, et al. The development of public policies to address non-communicable diseases in the Caribbean country of Barbados: the importance of problem framing and policy entrepreneurs. Int J Health Policy Manag 2017; 6(2):71-82. Available at: https://www.ijhpm.com/article_3222_75340d3b996529e187033bfeca39f3ab.pdf.

LOOKING TO THE FUTURE – COVID-19 LEGACY AND BUILDING BACK BETTER

Health care is a fundamental human right and a public good that must be guaranteed by the State through health policies and intersectoral interventions that address the main economic and social determinants. Thus, comprehensive and universal systems of access to health care and social protection should be promoted, and particular attention paid to gender equality and the increasing demand for both paid and unpaid caregiving.

*Dr. Alicia Bárcena, Executive Secretary, ECLAC, and
Dr. Carissa Etienne, Director, PAHO
Foreword, ECLAC-PAHO COVID-19 Report, 30 July 2020²*

6.1 COVID-19 and NCDs – lessons learned and recommended actions

Lessons learned

Despite the chaos that COVID-19 has caused, the pandemic has shown that it is possible for government, civil society, and the private sector to take rapid action to obtain their desired results. It has provided an environment for creative thinking; shown the advantages and limitations of information and communication technology; encouraged efforts towards digital transformation and strengthening information systems for health; and spurred the development of innovative, cost-effective local solutions to identified challenges.

The intersection of COVID-19 and NCDs offers yet another example of lessons for policy development and alignment that can be learned from the interaction of various global issues with NCDs and their risk factors. In 2019, the Lancet Commission on Obesity described

a global syndemic¹⁶³ of obesity, undernutrition, and climate change, linking the conditions to focus attention on the scale and urgency of addressing the combined challenges and to emphasise the need for common solutions. Common drivers of food and agriculture, transportation, urban design, and land use were identified, with an indication that systems-level interventions could serve as double-duty or triple-duty actions to address all three components of the syndemic simultaneously.¹⁶⁴

Similarly, as a consequence of the climate crisis, the occurrence of severe heat waves, droughts, storms, and floods will increase and become more severe, and will likely exacerbate the incidence of some NCDs, including CVD, some cancers, respiratory issues, mental disorders, injuries, and malnutrition.¹⁶⁵ There are numerous synergies between NCDs and climate change, with both having their root causes across multiple sectors and co-benefit solutions that tackle

both challenges, exemplified by policies to address air pollution, energy, transport, and food and agriculture systems.¹⁶⁶ Alignment of the NCD prevention and control policy agenda with the climate change mitigation and adaptation policy agenda can provide synergies for the health of both humans and the planet.

COVID-19 and NCDs form a dangerous relationship, experienced as a syndemic that is exacerbating social and economic inequalities.

*Lancet 2020. COVID-19:
a new lens for non-communicable diseases¹⁶⁷*

With the ravages of the COVID-19 and NCDs syndemic evident, an appreciation of the need for equity- and human rights-based approaches to strengthen human security and human capital, build back better, and place people and health at the centre of sustainable development is gaining traction globally.¹⁶⁸ Regionally, the CARICOM HoSG have been cognisant of the health, social, and economic burden of NCDs in the Caribbean, and have expressed strong support for addressing the NCD-COVID-19 interface. However, this needs to be translated into acceleration of policy development and implementation for more equitable and effective approaches to NCD reduction in the region, and is especially relevant in light of the limited fiscal space available to governments, made worse by the economic impact of COVID-19.

The PAHO rapid assessment of NCD services during the pandemic⁷² concluded that more effort is needed to ensure that NCDs are included in national COVID-19 response plans; that surveillance systems include data collection on NCD-related comorbidities in COVID-19 patients; and that infrastructure and methods for

telemedicine, virtual consultations, and other strategies be put in place to continue NCD service delivery during outbreaks and other health emergencies. COVID-19 has demonstrated that many of the tools required for fighting a pandemic are also those required to fight NCDs: disease surveillance, strong civil society, robust public health, clear communication, and equitable access to resilient health systems that advance universal health.¹⁶⁷

The WHO rapid assessment of MNS services during the pandemic⁷⁵ concluded that mental health systems have been compromised at a time when they are needed most, and though innovative methods are being applied in many countries, limited resources pose a challenge to using these tools in lower-resource settings. Global advocacy for the inclusion of mental health in COVID-19 responses has resulted in better integration into plans, multisectoral coordination platforms, and regular data collection, but there is still a gap in the financial and human resources allocated to integrate mental health into the emergency response. The COVID-19 pandemic emphasises the value of including MHPSS not only in response to emergencies and recovery, but also before emergencies, through integrating measures into preparedness plans and efforts.⁷⁵ Without a focus on mental health, any response to COVID-19 will be deficient, reducing individual and societal resilience, and impeding social, economic, and cultural recovery.¹⁶⁹

COVID-19 is interacting with NCDs and inequalities to form the “perfect storm” of avoidable death and suffering.

From: WHO and UNDP (2020). Responding to NCDs during and beyond the COVID-19 pandemic¹⁷⁰

¹⁶³ The Commission defined a syndemic as “two or more diseases that co-occur, interact with each other, and have common societal drivers”. [https://www.thelancet.com/action/showPdf?pii=S0140-6736\(2018\)2932822-8](https://www.thelancet.com/action/showPdf?pii=S0140-6736(2018)2932822-8).

¹⁶⁴ Swinburn B, Kraak VI, Allender s, et al. The global syndemic of obesity, undernutrition, and climate change: The Lancet Commission report. Lancet 2019; 393:791-846. Available at: [https://www.thelancet.com/action/showPdf?pii=S0140-6736\(2018\)2932822-8](https://www.thelancet.com/action/showPdf?pii=S0140-6736(2018)2932822-8).

¹⁶⁵ Friel S, Bowen K, Campbell-Lendrum D, et al. Climate change, noncommunicable diseases, and development: the relationships and common policy opportunities. Annu Rev Public Health 2011; 32:133-47. Available at: <https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-071910-140612>.

¹⁶⁶ NCD Alliance and Global Climate & Health Alliance. NCDs and climate change: Shared opportunities for action. Geneva: NCDA; 2016. Available at: https://ncdalliance.org/sites/default/files/resource_files/NCDs_%26_ClimateChange_EN.pdf.

¹⁶⁷ Editorial. COVID-19: a new lens for non-communicable diseases. Lancet 2020; 396:649, September 5, 2020. Available at: [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(20\)31856-0.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)31856-0.pdf).

¹⁶⁸ World Health Organization. COVID-19 response, resolution WHA73.1. Geneva: WHO; 19 May 2020. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA73/A73_R1-en.pdf.

¹⁶⁹ Editorial. Mental health: time to invest. Lancet 2020; 396(10257): P1045. Published October 10, 2020. DOI: [https://doi.org/10.1016/S0140-6736\(20\)32110-3](https://doi.org/10.1016/S0140-6736(20)32110-3).

¹⁷⁰ World Health Organization and United Nations Development Programme (UNDP). Responding to NCDs during and beyond the COVID-19 pandemic. Geneva: WHO and UNDP; 2020. Available at: <https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/responding-to-non-communicable-diseases-during-and-beyond-the-co.html>.

Selected recommended actions

A WHO and UN Development Programme (UNDP) policy brief released in early September 2020 describes reasons why strong action on NCDs must be an integral part of the COVID-19 response, recovery, and building back better; notes that these efforts will also contribute to achievement of the SDGs; and suggests steps that should be taken immediately and in the longer-term.¹⁷⁰ The brief includes a road map that identifies *health sector-specific actions*, which include raising awareness, strengthening the health system response, research and development, and surveillance and monitoring. It also identifies *broader sectoral actions*, including the integration of NCD prevention and control measures into national COVID-19 response and recovery plans; ensuring that expertise in NCDs is represented on COVID-19 task forces and that expertise in COVID-19 is represented in NCD coordination mechanisms; and ensuring that PLWNCDs are engaged in work on NCDs and COVID-19. Further, the brief presents examples of actions that HoSG, parliamentarians, and sectors other than health—agriculture, information and media, education, environment and energy, finance and economy, foreign affairs, labour, local government, social protection, trade and industry, and transport—can take for an integrated, multisectoral response.

The policy brief urges the use of digital technology to support the activities; advocates for increased funding for NCDs at all levels, commensurate with their social and economic burden; and endorses advancing UHC, ensuring that benefit packages include NCDs. The brief also recommends collecting better data and making better use of data; increasing digital and health literacy, which are becoming the new faces of health inequality; fostering partnerships with civil society and the private sector; holding government and other stakeholders accountable; and involving youth advocates and youth groups. Overall, these actions should be grounded in inclusive, rights-based, gender-responsive approaches.¹⁷⁰

Also in September 2020, the Inter-American Task Force on NCDs, comprising PAHO, ECLAC, the Organization of American States (OAS), and the World Bank, warned that the slow implementation of solutions to prevent or control NCDs is contributing to the pandemic and may have long-term consequences. In a [Joint Statement](#),¹⁷¹ the agencies noted the existence of effective solutions and the need for multisectoral action across all government sectors and civil society, and pledged to work together to highlight the adverse impact of NCDs and their risk factors on SDG achievement. They also undertook to promote multisectoral engagement to strengthen NCD risk factor policies and improve the health system response for NCDs, and to foster policy and regulatory interventions in support of health protection, reduction of NCD risk factors, and health care services that are equitable, accessible, and affordable. In addition, the agencies will advocate for sustainable, health-promoting food systems and encourage the use of taxes to reduce health risks, build better health systems, and help finance COVID-19 recovery efforts.

The need for effective multisectoral action to enable an integrated response that addresses the social and other determinants of health cannot be overstated, and demands efficient mechanisms for integration across sectors. Recognition of the fact that many health determinants lie outside the sphere of the health sector has led to repeated calls for intersectoral action.¹⁷² However, as is usual with NCDs, rhetoric and calls for intersectoral action have been many, with little to show for it. In 1986 WHO published a report on intersectoral action for health;¹⁷³ in 2013, almost 30 years later, the WHO [Helsinki Statement on Health in all Policies](#)¹⁷⁴ from the 8th Global Conference on Health Promotion called for much the same actions to be taken.

In the region, the [1993 Caribbean Charter for Health Promotion](#)¹⁷⁵ included the formulation of healthy public policy as one of its six pillars, and recognised the

critical importance of multisectoral, multidisciplinary considerations in the process. However, though there may be high political attention to NCDs, work in silos continues to a significant extent, with government responses being almost exclusively through ministries of health and very limited success in engaging other ministries.¹⁶²

An effective response to NCDs demands multisectoral, multidisciplinary, collaborative, integrated action, with policy coherence across sectors and pooling of resources for greater efficiency. This approach also applies to other issues such as COVID-19, the climate crisis, disaster preparedness and mitigation, food and nutrition security, and poverty reduction—among others—that are driven or worsened by the social and other determinants of health and structural inequalities. It is therefore in the interest of Caribbean governments, civil society, and the health-supporting private sector to devise and implement strategies and partnerships to address these issues concurrently, resulting in co-benefits that can be celebrated as models of success and emulated in other regions.

Health is a political choice that depends on national priorities, not income. Countries at all stages of development can make progress towards quality health services. But it is a choice that is often obscured by other, seemingly more urgent priorities, from security concerns to economic austerity measures.

From: Kirton J and Kickbusch I. (Eds.)
Delivering universal health care 2030. Health: a political choice¹⁷⁶

Achieving UHC and enabling everyone to have access to quality, essential health services are pivotal steps to equity, the realisation of human rights, and achievement of the SDGs, and to effectively addressing the COVID-19 and NCDs syndemic. All countries must make tough decisions about what to cover based on the resources they have, and most health funding must come from domestic sources. The key to making progress towards

UHC is political commitment at the highest level, backed by legislation, regulations, and a WoG approach that addresses the social, commercial, economic, and environmental determinants of health.¹⁷⁶

With NCDs as the major causes of ill-health and death in the Caribbean, it is imperative that these conditions be included in the region's advance to UHC, as recommended for the global community in the Political Declaration from the 2019 UN HLM on UHC⁴⁶ and underscored at the 74th Session of the UN General Assembly in September 2020.¹⁷⁷

6.2 CSOs and key stakeholders/thought leaders—perspectives for the future

Seven of the nine Caribbean CSOs interviewed indicated that they intended to develop, or had started the process of developing, specific plans for their operations post-COVID-19, with components including digital advocacy, transition to virtual services, telehealth, community and patient outreach, and education on COVID-19. One CSO noted the need for legislation and regulations to protect both health professionals and clients using telemedicine and virtual consultations, while another speculated that though its activities involve predominantly in-person interactions, telehealth could become a focus of its activities, depending on developments in the pandemic.

All CSOs stated that resource mobilisation was a priority for the post-COVID-19 period, with possible sources including government, private sector, UN agencies, embassies, foundations and funds, and other CSOs. Some interviewees mentioned international financing institutions and national health insurance or social security entities as possible sources, while others were considering introducing membership fees or fees-for-service. Fundraising, volunteerism, direct appeals, engagement with influential persons, and submission of project proposals to funding agencies remained important strategies for many. Some CSOs had already secured funding to better manage their response to the pandemic from organisations such as Bloomberg Philanthropies and the NCDA Solidarity Fund, including the implementation of COVID-19 prevention strategies

¹⁷¹ <https://www.paho.org/en/documents/joint-statement-noncommunicable-diseases-and-covid-19>.

¹⁷² Leeuw E. Engagement of sectors other than health in integrated health governance policies and action. *Ann Rev Public Health* 2017; 38:329-349. Available at: <https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-031816-044309>.

¹⁷³ World Health Organization. *Intersectoral action for health: the role of intersectoral cooperation in national strategies for Health for All*. Geneva: WHO; 1986. Available at: https://apps.who.int/iris/bitstream/handle/10665/41545/9241560967_eng.pdf?sequence=1&isAllowed=y.

¹⁷⁴ https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf?sequence=1.

¹⁷⁵ <http://www.archive.healthycaribbean.org/publications/documents/cchp.pdf>.

¹⁷⁶ Kirton J and Kickbusch I. (Eds). *Delivering universal health coverage 2030. Health: A political choice*. Global Governance Project; London: 2019. Available at: <https://www.healthpolicy-watch.org/wp-content/uploads/2019/06/f736fefa-3c34-47e2-b6f7-0218bffe0075.pdf>.

¹⁷⁷ United Nations General Assembly. *Comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic*. Document A/74/L.92, 10 September 2020. Available at: <https://undocs.org/A/74/L.92>.

and messaging for NCD prevention and management during the pandemic. One CSO underscored the importance of moving toward self-sufficiency to the extent possible, especially for sustainability.

Funding agencies come and go, persons heading agencies may change, and loans have to be repaid. We cannot keep relying on external sources of funding. Also, funders should not set the agenda, and sometimes they do.

From: Interviews with CSOs and key stakeholders/thought leaders in NCDs in the Caribbean

Other important priorities included prevention/promotion, communication, advocacy, and partnerships; service provision was cited as a priority by some—mainly those already providing clinical services—with surveillance and research identified as priorities by only a few.

These priorities echoed those identified by CSOs participating in the June 2020 HCC Civil Society Roundtable on COVID-19 and NCDs in the Caribbean,¹³⁰ where it was agreed that priorities in the post-COVID-19 scenario for building back better included resource mobilisation; partnerships, including among national NGOs and with youth; re-tooling of CSOs’ operations for greater efficiency; and continued use of online platforms, which, in several cases, garnered better participation than in-person meetings.

However, the CSOs interviewed anticipated challenges in the post-COVID-19 environment, including:

- Resuming resource mobilisation activities, especially given the likely increased competition for resources and the negative economic impact of COVID-19 on the usual funding agencies;
- Resuming screening and other in-person services, especially if fear of COVID-19 continues to cause a downturn in requests for services and in attendance at their facilities, resulting in, for some, continued loss of income;

- Continued “COVID-centric” activities, and change in government priorities, with difficulty in creating a sense of urgency for NCD reduction and impactful NCD policy change, and the possibility of further delays in NCD programmes;
- Engaging volunteers, due to fear of COVID-19;
- Keeping COVID-19 infection prevention and control protocols in place at their facilities;
- Implementation of remote and outreach services;
- Determining the long-term effects of COVID-19 on the community, and how to manage them; and
- Continued collaboration for accessing out-of-country treatment, due to travel restrictions.

The key stakeholders/thought leaders, when asked about countries’ planning for health in the post-COVID-19 period, noted that The Bahamas, Barbados, Grenada, Guyana, Jamaica, Saint Lucia, and Trinidad and Tobago had initiated, or intended to initiate, the development of such plans. It was unclear if NCD prevention and control would be specifically addressed, but respondents indicated that CARPHA is promoting their inclusion, and that CARICOM is focusing on human resources for health, and food and nutrition security.

This group of respondents highlighted the opportunity that the pandemic provided for revitalising and reengineering the Caribbean approach to health care in general, and NCD prevention and control in particular. Specific mention was made of catering to the most vulnerable in the society; modernising record keeping, with a transition to electronic health records; and, importantly, increasing the proportion of GDP allocated for public expenditure on health, moving toward the PAHO-recommended benchmark of at least 6% of GDP, with 30% of that allocation invested in the first level of care.¹⁷⁸ They noted that an increase in allocation was justified even in these economically challenging times, since without an emphasis on strengthening public health systems, national economies will not recover from the impact of the pandemic. They suggested that strategies used to find funding for the COVID-19 response be applied to improving funding for NCDs.

¹⁷⁸ Pan American Health Organization. Compact PHC 30-30-30 for universal health. Washington, D.C.: PAHO; 2019. https://www.paho.org/hq/index.php?option=com_docman&view=download&alias=50477-brochure-30-30-30-eng2019&category_slug=health-services-access-1965&Itemid=270&lang=en

6.3 Reflections on enhancing NCD reduction

Governments should identify and implement a specific set of priorities within the overall NCD and mental health agenda, based on public health needs.

Recommendation 02A
Time to Deliver: Report of the WHO Independent High-level Commission on NCDs (2018)³⁴

Especially in the limited-resource settings that characterise Caribbean countries, prioritisation is essential for augmenting prevention and control activities and achieving a transformative new agenda for NCDs. It is highly unlikely that any country can implement the recommended cost-effective and evidence-based interventions for NCDs and mental disorders, such as the WHO BBs and ORIs, all at once. The priorities should be selected based on accurate national and sub-national disaggregated data on morbidity and mortality and their main drivers; behaviour and consumption; areas where maximum impact can be achieved;³⁴ and the capacity of the governments to implement them, the aim being not only to identify interventions to reduce death and illness, but also who and where to target in order to reduce inequities.

Highlighted by the lockdown and other responses to COVID-19, food and nutrition security has emerged as a priority issue at global, regional, and national levels. CARICOM’s recognition of the need to do more in this sphere in the region can act as a catalyst for multisectoral, integrated actions by government, civil society, and the private sector, including smallholder farmers and food vendors, to improve the regional situation in a sustainable manner.

Tobacco and alcohol control, and effective health-system interventions—including hypertension and diabetes treatment; primary and secondary CVD prevention in high-risk individuals; low-dose inhaled corticosteroids and bronchodilators for asthma and chronic obstructive pulmonary disease; treatment of acute CVD, diabetes complications, and exacerbations of asthma and chronic obstructive pulmonary disease; and effective cancer screening and treatment—will reduce NCD causes of death necessary to achieve SDG target 3.4 in most countries.¹⁷⁹

The 2019 WHO global NCD capacity survey¹⁸⁰ found that the BBs were “vastly underutilised globally”. This was especially so in low- and lower-middle-income countries, which do not provide much of the evidence on the BBs.¹⁸¹ It is accepted that “one size does not fit all”, and there are concerns about the extent to which findings from high-income countries, where most of these studies on cost-effectiveness are done, can be applied to other countries with different disease profiles, population characteristics, political and economic structures, health systems platforms, implementation capacities, cultures, and other distinctive local characteristics. Thus, a best buy in one setting could be a wasted or contestable buy in another setting, and an intervention deemed cost-ineffective could be a best buy in a particular setting if it delivers strong equity outcomes.¹⁸²

Participatory priority-setting processes with consideration of available evidence by a cross-sectoral group of stakeholders and involving PLWNCDs are essential for scaling up NCD reduction interventions, and tools such as health technology assessment (HTA) and systematic thinking for evidence-based and efficient decision making (SEED) are available to assist.¹⁸² Similarly, once priorities are set, WHO policy and technical guidance is available, including the [Package of Essential NCD Interventions \(PEN\) for PHC in Low-Resource Settings](#),¹⁸³ [MPOWER](#)¹⁸⁴ for tobacco

¹⁷⁹ Lancet Countdown 2030 collaborators. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. Published online September 3, 2020 [https://doi.org/10.1016/S0140-6736\(20\)31761-X](https://doi.org/10.1016/S0140-6736(20)31761-X).

¹⁸⁰ World Health Organization. Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2019 global survey. Geneva: WHO; 2020. Available at: <https://www.who.int/publications/i/item/ncd-ccs-2019>.

¹⁸¹ Allen LN, Pullar J, Wickramasinghe KK, et al. Evaluation of research on the interventions aligned to WHO ‘Best Buys’ for NCDs in low-income and lower-middle-income countries: a systematic review from 1990-2015. *BMJ Global Health* 2018; 3:e000535. Available at: <https://gh.bmj.com/content/bmjgh/3/1/e000535.full.pdf>.

¹⁸² Isaranuwachai W et al. Prevention of non-communicable disease: best buys, wasted buys, and contestable buys. *BMJ* 2020; 369:m141. DOI:10.1136/bmj.m141. Available at: <https://www.bmj.com/content/bmj/368/bmj.m141.full.pdf>.

¹⁸³ https://www.who.int/nmh/publications/essential_ncd_interventions_lr_settings.pdf.

¹⁸⁴ https://www.who.int/tobacco/mpower/mpower_english.pdf.

control, HEARTS⁷³ for CVD prevention, [SHAKE](#)¹⁸⁵ for salt reduction, [REPLACE](#)¹⁸⁶ for trans fat elimination, [SAFER](#)¹⁸⁷ for alcohol reduction, [ACTIVE](#)¹⁸⁸ to increase physical activity, and the Mental Health Gap Action Programme ([mhGAP](#)),¹⁸⁹ which aims to scale up services for MNS disorders, especially in low- and middle-income countries.

6.4 Recommendations from CSOs and key stakeholders/thought leaders for the TNA-NCDs

The CSOs and key stakeholders/thought leaders interviewed made the following recommendations for the TNA-NCDs:

- **NCD priorities.** Of CVD, diabetes, cancer, chronic respiratory diseases, overweight/obesity, and mental health and neurological conditions, with the option to suggest others,
- All CSOs selected overweight/obesity; eight each, CVD, diabetes, and mental health and neurological conditions; six, cancer; and none selected chronic respiratory diseases. Other conditions identified included fibroids, endometriosis, injuries and violence, and substance use disorders.
- Nine key stakeholders/thought leaders selected all the conditions; one omitted cancer and the other omitted overweight/obesity.
- **Health systems strengthening.** In reference to the WHO six health system building blocks¹⁹⁰—leadership and governance; service provision; essential medicines, vaccines, and health technologies; health financing; health workforce; and information systems for health,
- Seven CSOs chose health financing as a priority; six each, leadership and governance, essential medicines, vaccines, and health technologies,

and information systems for health; three, service provision; and two, health workforce.

- One CSO declined to put priorities in the context of the building blocks, noting that if this were to be a transformative agenda, the same issues should not be repeated—rather, there should be progress with implementation of what is known to work; provision of resources; and connection to the public and other stakeholders. Another CSO noted that leadership should not apply only to government—civil society, especially youth, should be included.
- Nine key stakeholders/thought leaders selected all the building blocks; one omitted service provision, health financing, and health workforce, and the other omitted essential medicines, vaccines, and health technologies. A key stakeholder/thought leader indicated that the building block framework was unsatisfactory, since the health system comprises open, horizontally connected systems, and noted that leadership should be separated from governance, since leadership is needed to achieve good governance.
- **Strategies.** Considering the suggested strategies of service provision, advocacy, communication, prevention/promotion, research, surveillance, social inclusion and participation, partnerships, resource mobilisation, and sustainability mechanisms,
- Eight CSOs selected partnerships, with one specifically mentioning the model of the United Kingdom-based [The Partnering Initiative](#),¹⁹¹ seven CSOs each, service provision, advocacy, prevention/promotion, and sustainability mechanisms; six each, communication and resource mobilisation; five, research; and four

each, surveillance, and social inclusion and participation.

- One CSO commented that these “traditional” strategies should be replaced by different, innovative methods, given the intent to transform the NCD agenda, and suggested more partnerships between CSOs and marketing and media agencies to improve the promotion of NCD reduction strategies; inclusion of all partners from the planning phase of interventions to establish not only collaboration, but also camaraderie; and contractual agreements between government and CSOs for the latter to implement certain activities.
- Eight key stakeholders/thought leaders selected all the strategies, most indicating that service provision should be addressed at all levels of care—first, second, third, rehabilitative, and palliative—and a few indicating focus on the first level. One omitted communication, social inclusion and participation, and resource mobilisation; another omitted surveillance and resource mobilisation; and another omitted advocacy.
- One key stakeholder/thought leader expressed the view that the “triumvirate of Minister, Permanent Secretary, and Chief Medical Officer”, traditional in health ministries in the Caribbean, was not effective and should be reconsidered. The implication was that a more horizontal, inclusive governance structure might be better, and the respondent stated that health systems governance and management is therefore an important area for research.
- Other areas suggested for research included behavioural change—how to nudge people in desired directions; factors that “make us uniquely Caribbean, their relation to our lifestyle, and how to make it clear that we can be happy and still have fun with healthy eating and not drinking too much”; health financing for cash-strapped countries such as those in the region; and air pollution in Caribbean countries;
- Other views expressed were that:
 - insufficient focus is placed on PLWNCDs as advocates, especially since their numbers

outweigh those of persons with other diseases in most countries;

- communication should be aimed at behaviour change, not simply raising awareness;
- NCD advocates should seek specific entry points for communicating with CARICOM HoSG regarding NCDs, such as climate change and the Caribbean Single Market and Economy, which are standing items on the HoSG agenda—the current focus on COVID-19 provides another entry point;
- there is a clear need for continued investment to strengthen the first level of care through community-based, patient-centred services, especially since the importance of a strong first level of care has become even more relevant during the COVID-19 pandemic;
- there are gaps in partnerships with associations of health and allied professionals, who are important stakeholders in NCD reduction, and with women's groups, to highlight gender issues;
- health financing would benefit from taxing unhealthy products at national level and putting at least a portion of the revenue into specific health promotion activities;
- resource mobilisation efforts should target national health insurance and social protection programmes, credit unions, private insurance companies, and the hotel and tourism sector, the last-mentioned as a major employer in the region. NCDs and their complications are a drain on the resources of these entities, and, in the case of private companies, erode their profits;
- consideration should be given to the provision of financial (or other) incentives for healthy behaviours;
- NCD advocates should demonstrate the strategic links between COVID-19 and NCDs, and try to tap into resources committed or provided for the COVID-19 response, including from international financing institutions and intergovernmental agencies;

¹⁸⁵ <https://apps.who.int/iris/bitstream/handle/10665/250135/9789241511346-eng.pdf;sequence=1>.

¹⁸⁶ <https://www.who.int/docs/default-source/replace-transfat/1-replace-framework-updated-june-2019-ke.pdf>.

¹⁸⁷ <https://www.who.int/publications/i/item/the-safer-technical-package>.

¹⁸⁸ <https://apps.who.int/iris/bitstream/handle/10665/275415/9789241514804-eng.pdf?sequence=1&isAllowed=y>.

¹⁸⁹ https://www.who.int/mental_health/mhgap/en/.

¹⁹⁰ World Health Organization. Everybody's business: strengthening health systems to improve health outcomes. Geneva: WHO; 2007. Available at: https://www.who.int/healthsystems/strategy/everybodys_business.pdf.

¹⁹¹ <https://thepartneringinitiative.org/>.

- divisions of labour are important, and consideration should be given to conducting an audit to determine the strengths of CSOs in certain areas, then building the capacity of selected CSOs to specialise in various areas, such as advocacy, capacity building, and policy development;
 - the WHO HEARTS technical package, already being implemented in several countries in the region, may be considered as one of the top interventions and an entry point to reorienting health systems and facilitating implementation of several of the WHO BBs; and
- the model of the Caribbean regional response to HIV, regarding leadership and governance, resource mobilisation, social inclusion and participation, partnerships, and other aspects, can be applied to the transformative new agenda for NCDs; successful arguments for the HIV regional response included equity, human rights, human security, and human capital considerations.
 - WHO BBs and ORIs, and POSD commitments. The interviewees were asked to select their top WHO BBs and ORIs (maximum of ten), and top POSD commitments (maximum of five), for inclusion in the TNA-NCDs. **Table 1** indicates their selections.

Table 1. Interviewees’ top selections from WHO BBs and ORIs, and POSD commitments, for inclusion in TNA-NCDs (In rank order, with selections common to both groups in bold)

CSOs	Key stakeholders/thought leaders
BBs and ORIs	
1. Reduce sugar consumption through effective taxation on sugar-sweetened beverages	a. Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and non-fatal cardiovascular event in the next 10 years
2. Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables	b. Increase excise taxes and prices on tobacco products
3. Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals	c. Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programmes to support physical activity for all children
4. Implement community-wide public education and awareness campaign for physical activity which includes a mass media campaign combined with other community-based education, motivational and environmental programmes aimed at supporting behavioural change of physical activity levels	d. Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics)

CSOs	Key stakeholders/thought leaders
5. Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programmes to support physical activity for all children	e. Reduce sugar consumption through effective taxation on sugar-sweetened beverages
6. Increase excise taxes and prices on tobacco products	f. Vaccination against human papillomavirus (2 doses) of 9–13 year old girls
7. Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages	g. Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people
8. Increase excise taxes on alcoholic beverages	h. Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)
9. Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics)	
POSD commitments	
1. Mandate re-introduction of physical exercise in schools and ensure that education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating	a. Mandate labelling of foods or measures to indicate their nutritional content
2. Use public revenue from tobacco, alcohol, or other such products to prevent NCDs, promote health and support the work of the NNCDs	b. Mandate re-introduction of physical exercise in schools and ensure that education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating
3. Promote increased physical activity in the entire population, e.g. at work sites and through sport, and increase adequate public facilities such as parks and other recreational spaces to encourage physical activity	c. Strengthen regional health institutions to provide critical leadership for NCD reduction
4. Mandate labelling of foods or measures to indicate their nutritional content	d. Establish National NCD Commissions (or analogous bodies to plan and coordinate NCD prevention and control
5. Establish comprehensive national plans for the screening and management of NCDs and risk factors	e. Establish comprehensive national plans for the screening and management of NCDs and risk factors

- **HCC's September 2019 Call to Urgent Action.**

Of the three priorities for policy development to accelerate nutrition policies for the creation of healthy environments for Caribbean children—mandatory 'high in' front of package nutrition warning labelling; banning the sale and marketing of sweet beverages in school settings; and taxation of sweet beverages of at least 20%,

- Eight CSOs chose all three; one CSO chose mandatory 'high in' front of package nutrition warning labelling only, and
- All key stakeholders/thought leaders chose all three.

- **Actions to enable implementation of evidence-based, cost-effective NCD prevention and control interventions.** CSOs and key stakeholders/thought leaders made many suggestions for specific actions by civil society, government, and private sector, as well as actions relevant to all three sectors.

Civil society

- Continue to advocate, strengthen awareness, and share information on NCD risk factors and the manifestations of NCDs with more targeted campaigns, including for children and youth; mobilise adequate supporting resources.
- Advocate for the involvement of mothers, older persons, and other societal groups, for public-private partnerships, and for accountability.
- Strengthen the advocacy movement to reach vulnerable groups who might not have access to information, and build the capacity of CSO workers.
- Lobby, and hold governments accountable, for the implementation of existing global, regional, and subregional commitments to address NCDs, with stronger support from PAHO/WHO at country level.
- Document Caribbean experiences, build Caribbean evidence, and develop recommendations tailored for the region, rather than simply accepting global recommendations verbatim.

- Support research in the region on the impact of COVID-19 on PLWNCDs, including the effect of containment measures on disease progression.
- Mobilise resources for longer-term interventions that address local needs, articulating next steps for sustainability and developing effective partnerships.
- Involve PLWNCDs, empower patient groups, and establish strong legislators in civil society.
- Map, expose, and counter industry interference.
- Demand that governments place NCDs and their burden in the context of human rights, hold industry accountable, and introduce policies for supportive environments.

Government

- Advocate in regional and international fora for Caribbean-tailored solutions to the NCD burden.
- Improve strategic, evidence-based policy development and planning that will span changes in government.
- Improve policy coherence, collaboration, and coordination among government sectors and departments, taking a HiAP approach to NCD reduction.
- Strengthen reliance on experience and advice from technical personnel to inform policy development, and implement a human rights-based approach to NCD prevention and control.
- Develop a more robust legislative environment, introducing legislation, regulations, and taxation to enable behavioural change, with enforcement measures that include both rewards and sanctions.
- Improve implementation of, and accountability for, policies and plans, and share progress with stakeholders, including the public.
- Effect sustained investment in health systems, with a focus on primary health care and increased attention to financing.
- Provide financial resources to support CSOs in their work for NCD prevention and control, and offer incentives for workplace- and school-based wellness programmes involving nutrition and physical activity,

Private sector

- Comply with national laws and government regulations for health, and implement health-supporting policies and regulations—including mandatory front-of-package nutrition warning labelling, product reformulation, and bans on the advertising and marketing of health-harming products—and increase the availability and accessibility of healthy, nutritious foods.
- Promote and provide a healthy and empowering environment for workers, and establish programmes not only for their safety at the workplace, but also to maintain their health at home and in their communities, including MHPSS; distribute healthy food to communities; and focus on corporate social responsibility for health.
- Develop partnerships with CSOs and other NCD advocates to reduce NCDs and risk factors, working to strengthen and support policies for risk reduction and communication for health.
- Cease policy interference and political manipulation, and provide NCD-related data when needed or requested.

General

- Strengthen partnerships and collaboration among government, civil society, and private sector to develop and implement interventions related to the BBs, ORIs, and POSD commitments.
- Develop a communication strategy to spur people into action, and allocate or mobilise supporting financial resources.
- Acknowledge the importance and impact of NCDs from the perspectives of each sector—government, civil society, and private sector, and implement strategies to ensure that the population understands the full impact of these conditions, working through faith-based organisations, schools, universities, patient groups, trade unions, chambers of commerce, and other stakeholders.
- Develop and implement a plan to impact NCD reduction, and include an engagement or feedback mechanism.

- Develop or update, and disseminate clinical guidelines for management of NCDs and monitor their implementation.
- Measure the effect of investments and interventions in NCD prevention and control through surveillance and other methods.
- Strengthen research and its application to enable evidence-based policies and a better understanding of the recommended policy options for NCD reduction, so that they can be adapted as necessary for SIDS, based on priorities determined and resources available or mobilisable—"not everything that comes down from above fits everyone".

- **Actions to highlight equity and human rights, and enhance human security and human capital.** The suggestions from CSOs and key stakeholders/thought leaders for specific actions by civil society, government, and the private sector, as well as actions relevant to all three sectors are summarised below.

Civil society

- Conduct research among audiences to determine what messages will resonate with them to improve their understanding of these approaches, and conduct campaigns on health as a right; collaborate with UN agencies, which have a remit to integrate human rights into their work; and break the concepts down into simple messages to which the public can relate.
- Give youth the forum to speak on these matters and act as influencers.
- Frame advocacy and communications messages within the context of equity, human rights, human security, and human capital, making them a deliberate part of advocacy through story-telling and allowing people to see themselves in relevant situations, in addition to providing data.
- Hold governments accountable for their human rights commitments, working with UN agencies and human rights entities, and contributing to monitoring activities by the [UN Special Rapporteur on the Right to Health](#),¹⁹² as needed.

- Ensure accountability for external funding, including disclosure of partners and donors.
- Advocate with government, especially the Ministry of Health, for inclusion of these principles in NCD and NCD-related plans, and conduct CSO activities within that framework.
- Take action to move beyond the advocacy role, for example to draft model legislation and present to HoSG; petition the legislature for relevant action; work with human rights organisations and advocate for them to look beyond civil rights and focus on health and equitable access to NCD prevention, care, and treatment.

Government

- Observe the treaties to which governments are signatory, such as the CRC. Children do not have the agency of responsibility, and their health outcomes are more likely to be influenced by others, including governments and parents. The government therefore bears greater responsibility for preventing threats to their health, such as childhood obesity, than it does for preventing threats to adults' health.
- Ensure that these principles are taken into account in the development, implementation, monitoring, and evaluation of strategic plans for NCDs.
- Write these principles into legislation, regulations, employment rules, and other frameworks; work with the Unions on these matters; and perform audits of government and private sector compliance.
- Evaluate whether government's policies are equitable, using tools such as the [Equity Assessment Framework for Public Health Law and Policies \(2019\)](https://www.networkforphl.org/wp-content/uploads/2020/07/Equity-Assessment-Framework-for-Public-Health-Laws-and-Policies.pdf)¹⁹³ developed by the [Network for Public Health Law](https://www.networkforphl.org/).¹⁹⁴
- Demonstrate will and commitment, and provide resources—including health financing—to secure citizens' rights, moving beyond simply

stating that health is human right and drilling down to details, including budgeting.

Private sector

- Engage in more multisectoral collaboration with civil society and government in fighting NCDs.
- Set examples of best practices; provide scholarships for training persons in these matters; work with the Unions; and demonstrate corporate social responsibility to support these principles.
- Ensure proper, safe, and ethical workplace conditions, codes, and procedures, and contribute generally to safe environments, funding, education, and other strategies for NCD prevention and control.

General

- Ensure that gender issues are addressed, making gender equity an explicit objective and adopting equity and human rights as the underpinnings of interventions, including for food and nutrition security; all sectors need to play a role across the board in these interventions.
- Advocate for politicians and policymakers to pay attention to these issues, in order to provide a model for the electorate and general population.
- Determine audiences' ability to understand what the terms mean and which aspects should be highlighted; identify what is good practice in adhering to these obligations. Countries have acceded to them, but cannot always fulfill them, due to resource limitations and other factors.
- Ensure that the observance of these principles, including the progressive realisation of human rights, especially the right to health, is regularly monitored.
- Engage people from all segments of society in the planning, implementation, monitoring, and evaluation of interventions that impact them—participation and inclusion are important.

CALL TO ACTION: A TRANSFORMATIVE NEW AGENDA FOR NCD PREVENTION AND CONTROL IN THE CARIBBEAN

The HCC, as a unique regional civil society leader in NCD prevention and control in the Caribbean, is calling for a new approach and strategies that will transform the response to NCDs in the region—the Transformative New Agenda for NCD Prevention and Control. The TNA-NCDs, to be implemented over at least the next five years in order to accelerate the region's progress to the SDGs, is based on global, regional, and national evidence, the recommendations of selected CSOs and key stakeholders/thought leaders in the region, and validation by a wide range of representatives of influential national, regional, and international entities. Overall, the TNA-NCDs aligns with HCC values as set out in the [HCC Strategic Plan 2017-2021](#).¹⁹⁵ empowerment of people, equity, inclusive partnerships, accountability, simplicity and flexibility, action, independence, and innovation.

The HCC recognises the importance of improving the enabling environment for NCD reduction, moving beyond the established interventions and delving deeper into issues related to equity, human rights, and structural inequalities; enhancement of human security and human capital; and the social, commercial, and other determinants of health.

7.1 Vision, mission, and overall outcome

The **vision** of the TNA-NCDs is a tangible and permanent shift in the Caribbean health and development environment that promotes equity and human rights,

and allows persons living with NCDs to achieve their fullest potential, contributing to sustainable national and regional development, and the attainment of the SDGs.

The **mission** of the TNA-NCDs is to enable people-powered action that galvanises bold political leadership and policies for NCD reduction in the Caribbean, to address the social and other determinants of health, enhance human security and human capital, emphasise prevention, and enable integrated action across themes, sectors, and disciplines.

The **overall outcome** of the TNA-NCDs is NCD reduction in the Caribbean, focusing on the “5x5” priorities: five major NCDs—cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, and mental, neurological, and substance use disorders, and five main risk factors—tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, and air pollution.

7.2 Main approaches

The TNA-NCDs embraces *transformative approaches* that:

- Promote and emphasise equity and human rights as overarching principles for NCD prevention and control, and the critical importance of NCD reduction in developing and strengthening human security and human capital;

¹⁹² <https://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx>.

¹⁹³ <https://www.networkforphl.org/wp-content/uploads/2020/07/Equity-Assessment-Framework-for-Public-Health-Laws-and-Policies.pdf>.

¹⁹⁴ <https://www.networkforphl.org/>.

¹⁹⁵ http://www.healthycaribbean.org/wp-content/uploads/2017/02/HCC-Strategic-Plan_WEB.pdf.

- Enable appreciation of mental, neurological, and substance use disorders as integral components of NCD prevention and control policies and programmes;
- Encourage and empower PLWNCDS, children, adolescents, youth, and other persons in conditions of vulnerability, to participate in NCD policy and programme development, implementation, and assessment;
- Promote strategies to improve health and digital literacy, and communication for health, for an informed public that can make healthier choices;
- Promote research and information systems for health that provide disaggregated data on the impact of the COVID-19 and NCDs syndemic, and enable evidence-based policies and interventions that advance equity and human rights;
- Promote analysis of political economy and behavioural economics in the Caribbean context, with a view to, respectively, catalysing investment and multisectoral collaboration, and influencing behaviour change; and
- Promote a shared value and social impact business model tailored to the Caribbean that enables and enhances investment by, and partnerships with, healthy commodity industries.

However, the proven deficit in implementation of the established interventions for NCD reduction; the current

architecture of global, regional, and national systems for health; regional vulnerabilities and resource limitations; and the imperative to prioritise actions demand that the TNA-NCDs also include efforts to overcome the implementation deficit. Thus, the TNA-NCDs will build on the recommended interventions for the “5x5” priorities, and includes *traditional approaches* that:

- Accelerate implementation of the WHO Best Buys and Other Recommended Interventions, and other guidance from international frameworks for health and development, emphasising government policy, legislation, and regulations for prevention and protecting the policy space from industry and vested interests;
- Enable integrated, multisectoral, health-in-all-policies, whole-of-government, and whole-of-society partnerships and interventions to address the social and other determinants of health;
- Promote strong, resilient health systems and universal health based on the PHC strategy, addressing multimorbidity and lifelong care of chronic diseases;¹⁹⁶ and
- Enhance the accountability of civil society, government, and private sector, including policies to identify and manage conflict of interest and improve leadership, governance, and transparency.

7.3 Priority areas of focus and main interventions

The five priority areas of focus of the TNA-NCDs are:

1



Life course prevention
working to prevent NCDs using a life course approach that addresses the five main risk factors and emphasises early prevention and interventions among children, including childhood obesity prevention.

2



Social inclusion and participation for policy development
with meaningful engagement of PLWNCDS, children, adolescents, youth, and other persons in conditions of vulnerability in policy and programme development, implementation, and assessment.

3



People-centred, primary health care-based health systems for universal health
improving the leadership, governance, and resilience of adequately-resourced health systems and offering accessible, client-focused health services that do not result in financial hardship for users, that have the primary health care (PHC) strategy as the core component, and that realise a return on investments in the form of health, a public good.

4



Partnerships, networks, and resource mobilisation
with establishment of links among entities with common interests and objectives; increased multisectoral, multidisciplinary collaboration and partnerships at national and regional levels; institutionalisation of mechanisms for effective joint action; and mobilisation of resources that benefit PLWNCDS and other persons in conditions of vulnerability.

5



Accountability for decision making
strengthening information systems for health and digital strategies to facilitate monitoring of progress toward national, regional, and international agreements and indicators; identification and management of conflict of interest; reduction of inequities; and progressive realisation of the right to health.

¹⁹⁶ Bermejo RA, Prashant NS, and Sharma SK. Stronger guidance needed on lifelong care for chronic diseases. Lancet 2011; 377:463. Available at: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2811%2960152-9>.

The **main interventions** under each priority area of focus, **to be addressed by government, civil society, private sector and development agencies according to their respective remits, responsibilities, and functions, and applying WHO policy and guidance technical packages where appropriate**, include:

1 Life course prevention



- **Tobacco use**
 - Increasing excise taxes on tobacco products to WHO-recommended levels;
 - Enabling plain packaging and graphic package warnings for tobacco products, bolstered by the World Trade Organization's (WTO's) June 2020 upholding of Australia's right to implement this intervention;¹⁹⁷
 - Strengthening legislation and regulations to ensure smoke-free environments and ban advertising, promotion, and marketing of tobacco products; and
 - Enabling the availability of tobacco cessation services for those who wish to quit.
- **Unhealthy diet**
 - **Food and nutrition security**
 - Promoting exclusive breastfeeding and regulation of the marketing of breastmilk substitutes, as recommended by WHO and UNICEF;¹⁹⁸
 - Implementing mandatory front-of-package nutrition warning labelling, building on work being done by the Caribbean Community Regional Organisation for Standards and Quality (CROSQ);¹⁹⁹
 - Applying/increasing taxation on unhealthy food and beverages to decrease their consumption, such as SSBs (taxation of at least 20%) and foods high in fats, salt and sugar, presenting evidence and justification as needed to ensure that WTO agreements do not impede public health measures;²⁰⁰
 - Elimination of trans fat from the food supply;
 - Implementing regulations and incentives for the reformulation of unhealthy food products and non-alcoholic beverages;
 - **Physical inactivity**
 - Mandating physical activity in schools;
 - Promoting community physical activity, including through online platforms; and
 - Promoting workplace health programmes.
 - **Harmful use of alcohol**
 - Increasing excise taxes on alcohol;
 - Banning the promotion of alcoholic beverages for sponsorships targeting young people; and
 - Conducting research into visits and admissions to public and private health facilities related to alcohol consumption.
 - **Air pollution**
 - Conducting research into factors affecting air quality in the region.
- Increasing production of, and providing subsidies for, healthy foods and beverages, aimed at increasing their consumption;
- Updating and using food-based dietary guidelines for Caribbean countries;²⁰¹ and
- Establishing school and backyard gardening.
- **Childhood obesity prevention, highlighting the context of the CRC**
 - Banning the promotion, advertising, and marketing of unhealthy food and beverages to children; and
 - Banning the sale and marketing of unhealthy foods, including SSBs, in and around schools, and providing incentives for healthy school meals and other products supplied by school vendors.

¹⁹⁷ <https://www.who.int/fctc/mediacentre/press-release/wto-landmark-legal-victory-tobacco-plain-packaging/en/>.

¹⁹⁸ https://www.who.int/health-topics/breastfeeding#tab=tab_1.

¹⁹⁹ <https://website.crosq.org/>.

²⁰⁰ World Trade Organization (WTO) and World Health Organization. WTO agreements and public health: a joint study by the WHO and the WTO Secretariat. Geneva: WTO; 2002. Available at: <https://apps.who.int/iris/bitstream/handle/10665/42535/a76636.pdf?sequence=1&isAllowed=y>.

²⁰¹ <http://www.fao.org/nutrition/education/%20food-dietary-guidelines/home/en/>.

2 Social inclusion and participation for policy development



- **Identification of persons in conditions of vulnerability**
 - Conducting and contributing to the collection and analysis of disaggregated data on NCDs to identify persons in conditions of vulnerability.
- **Meaningful engagement of persons in conditions of vulnerability**
 - Building an understanding of, and demand for, a human rights- and equity-based NCD response among persons in conditions of vulnerability and wider communities
 - Promoting social activism, including expanding the HCC Our Views, Our Voices,²⁰² Healthy Caribbean Youth,²⁰³ and The Future Talks programmes,²⁰⁴ and promoting these inclusive models beyond the Coalition, to give a voice not only to PLWNCDs, children, adolescents, and youth, but also to persons with disabilities, women, indigenous people, and other persons in conditions of vulnerability;
 - Building the capacity of, and empowering, these persons or their legitimate representatives to participate meaningfully in policy development, planning, and programming for NCD prevention and control; and
 - Promoting the involvement of these persons or their legitimate representatives in policy development, planning, and programming for NCD prevention and control.

3 People-centred, equitable health systems for universal health



- **Leadership and governance**
 - Establishing mechanisms for effective multisectoral, integrated, coherent action, including by NNCDs or equivalent bodies, with political economy analysis to identify stakeholder interests, strengths, and resources, as well as barriers to success and strategies to overcome them, and exploration of behavioural economics and nudge theory to effect behaviour change;
 - Promoting and supporting multisectoral collaboration and policy coherence at political, administrative, and technical levels of the public sector, taking advantage of frameworks and tools for HiAP, such as those developed by WHO;^{205,206}
- Increasing awareness of NCDs and issues related to equity and human rights, and strengthening human security and human capital, among key stakeholders from government, civil society, and healthy commodity industries;
- Building capacity among key stakeholders from government, civil society, and the healthy commodities industry, including in the formulation and implementation of conflict of interest policies;
- Developing the shared value and social impact business model in the Caribbean context, and promoting its application by the healthy commodity industries; and
- Developing national NCD strategic plans, with multisectoral participation, identification of roles

²⁰² <https://www.healthycaribbean.org/our-views-our-voices/>.

²⁰³ <https://www.healthycaribbean.org/category/our-work/youth4ncds/>.

²⁰⁴ <https://www.healthycaribbean.org/the-future-talks-covid-19-and-ncds-in-the-caribbean/>.

²⁰⁵ World Health Organization. Draft framework for country action across sectors for health and health equity. Annex in Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion). Report of the Secretariat. Document A68/17, 18 May 2015. Geneva: WHO; 2015. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_17-en.pdf.

²⁰⁶ World Health Organization. Key learning on health in all policies implementation from around the world: information brochure. Geneva: WHO; 2018. Available at: <https://www.who.int/publications/i/item/WHO-CED-PHE-SDH-18.1>.

²⁰⁷ Caribbean Community. Chronic care policy and model of care for the Caribbean Community (CARICOM). Georgetown: CARICOM Secretariat; 2011. Available at: https://caricom.org/documents/12061-chronic_care_policy__model_of_care_for_the_caribbean_community.pdf.



- and responsibilities, provision and mobilisation of adequate resources, and wide promotion.
- **Service delivery**
 - Enhancing the first level of care, follow-up and care in the community, outreach, and self-care and self-management, with promotion of the chronic care model²⁰⁷ and focus on increasing people's awareness of available services.
 - Strengthening screening for, and management of, the major NCDs and multimorbidity;
 - Developing/updating guidelines for the care of persons with NCDs and multimorbidity, including MHPSS;
 - Promoting lifelong care for chronic diseases;¹⁹⁶ and
 - Strengthening telemedicine and virtual delivery of services.
 - **Essential medicines, vaccines, and health technologies**
 - Enabling access to quality essential medicines and health technologies for the major NCDs, including through strengthened pooled procurement;
 - Promoting models of pooled procurement, such as those implemented by the OECS PPS and PAHO;
 - Developing and promoting a list of essential medicines for NCDs in the Caribbean context;
 - Expanding vaccination against human papillomavirus (HPV) to prevent cervical cancer; and
 - Preparing for the introduction of vaccines against COVID-19.
 - **Health financing**
 - Applying at least a portion of the proceeds of taxation of unhealthy commodities to health financing, including health promotion and preventive interventions;
 - Enabling results-based budgeting and allocation of adequate domestic resources for NCD prevention and control, and progress to self-sufficiency;
 - Increasing public expenditure in health, and at the first level of care to PAHO-recommended levels; and
 - Strengthening social protection strategies and mechanisms, including national health insurance programmes that cover pre-existing conditions and the use of targeted cash transfers.^{208,209}
 - **Health workforce**
 - Expanding the cadre and competencies of persons categorised as health professionals, with greater focus on community health workers who provide care where people live and work, and strengthen community outreach;
 - Promoting the establishment of multidisciplinary teams and task shifting, especially at the first level of care, to enable an integrated and holistic approach to NCD prevention and control; and
 - Involving professional and allied professionals' associations in all aspects of the prevention and control of NCDs.
 - **Information systems for health**
 - Promoting inclusion of the main equity stratifiers in NCD data collection mechanisms to enable the production of disaggregated data;
 - Promoting research into various topics, including the WHO BBs and ORIs most suitable for implementation in the Caribbean context; short-, medium-, and long-term effects of COVID-19 on PLWNCDs in the region; the impact of interventions for NCD reduction; mechanisms to effect healthy public policy development and behaviour change, including, respectively, political economy and behavioural economics analyses; health systems management and leadership in the region; and patient monitoring, all in collaboration with academic and technical cooperation regional institutions, including UWI, CARPHA, PAHO/WHO, and other UN agencies;
 - Contributing to the rationalisation and consolidation of indicators related to the implementation of

²⁰⁸ Slater R. Cash transfers, social protection and poverty reduction. Int J Soc Welfare 2011; 20:250–259. Available at <https://www.calpnetwork.org/wp-content/uploads/2020/01/j.1468-2397.2011.00801.x-1.pdf>.

²⁰⁹ Pega F, Shaw C, Rasanathan K, et al. Climate change, cash transfers and health. Bull World Health Organ 2015; 93:559–565. Available at: <https://www.who.int/bulletin/volumes/93/8/14-150037.pdf>.



- international NCD frameworks, the SDGs, and human rights treaties, aiming to reduce the data collection demands on resource-limited Caribbean countries;
- Contributing to the collection, analysis, and use of data that provide information on national, regional, and internationally-agreed NCD indicators,

in collaboration with academic and regional institutions, including UWI, CARPHA and UN agencies; and

- Promoting and participating in efforts to innovate and strengthen digital strategies that facilitate implementation and assessment of the TNA-NCDs.

4

Partnerships, networks, and resource mobilisation



- *Institutionalisation of mechanisms for multisectoral collaboration and partnerships*
 - Developing and applying mechanisms to enable multisectoral, multidisciplinary actions at national level across government, civil society, and healthy commodity industries, ensuring identification and management of conflict of interest; and
 - Fostering greater information sharing and synergy of action at regional level, including among institutions of the main regional political integration bodies, CARICOM and OECS.
- *Development and promotion of national, regional, and international networks*
 - Enhancing engagement with national and regional media and media houses to enable wide dissemination of information and influence behaviour change, using traditional and new media;
 - Establishing links with national, regional, and international entities and groups addressing human rights, social justice, the climate crisis, disaster preparedness and mitigation, and gender issues—among other related themes—to enable integrated action for NCD prevention and control, inclusion of NCDs in relevant plans and programmes, and realisation of co-benefits; and
 - Keeping abreast of, and participating in, human rights treaty bodies' periodic assessments of progress in the realisation of human rights in Caribbean countries.
- *Identification of possible sources of resources and their interests*
 - Establishing an inventory of possible funding agencies, including foundations, development agencies, international NGOs, and international financing institutions; and
 - Mapping the skills and competencies of regional and national CSOs, and healthy commodity industries—including finance, insurance, telecommunications, media, agriculture, and transportation institutions and agencies—to inform analysis of specific contributions that they could make, foster division of labour and effective partnerships, and amplify domestic resource mobilisation.
- *Development of grant proposals at both regional and national levels*
 - Enabling the development of grant and project proposals that highlight benefits to PLWNCDs, children, adolescents, youth, persons with disabilities, and other persons in conditions of vulnerability, and the potential for reduction in inequities; and
 - Identifying and using opportunities to take advantage of funding for the COVID-19 response to address the COVID-19 and NCDs syndemic.

5 Accountability for decision making



- *Providing and disseminating disaggregated qualitative and quantitative data*
 - Developing messages that provide information on the NCD situation, tailored for the respective audiences.
- *Monitoring and evaluation of the achievement of agreed NCD and related goals and objectives*
 - Developing an implementation plan for the TNA-NCDs, including strategies and mechanisms for its assessing its progress and impact.
- *Performance of the “watchdog” function, holding governments accountable*
- Mapping and monitoring of the unhealthy commodity industries’ tactics of “deny, deceive, delay”, with development of counter-strategies;²¹⁰
- Mapping conflict of interest and its management, and promoting the development of conflict of interest policies, including in the public sector, for improved governance and transparency; and
- Monitoring the fulfilment of commitments to the public’s health, including the progressive realisation of the right to health and related rights, and access of citizens to information.

7.4 Key strategies

The TNA-NCDs will bring to bear several strategies to address the priority areas of focus and interventions proposed. Chief among them will be advocacy and communication that frame the issues in a new light, including their effects on persons living with these conditions; threat to equity and human rights; negative impact on national and regional human security and human capital; and significant return on investment, in the form of health, productivity, and sustainable development, from greater financial and other resource allocation to NCD reduction. These actions will not only target high-level officials—HoSG and policymakers—but also technical advisors in health and other sectors; health professionals; persons across government, civil society, and the private sector, and, as importantly, the general public.

Greater engagement with PLWNCDs, children, adolescents, and youth, and other persons in conditions of vulnerability to amplify their voices and encourage them to share their stories and experiences. There are very many of them, and they can speak with unquestionable authority about their experiences with NCDs and the health system, and can offer solutions to challenges identified from their unique perspectives. Thus, involvement and centring of PLWNCDs, children, adolescents, youth, and other persons of vulnerability

in the development, implementation, and assessment of interventions that affect them is vital to ensure appropriateness and facilitate success, with concurrent steps taken to build their capacity and empower them to do so.

Enhanced investment in, and capacity building of, civil society provides impetus for action by this sector to mobilise people, act as a catalyst for NCD social activism and movements, and galvanise policy development and coherence.

Raising awareness, sharing information, and building capacity on tackling NCDs and their risk factors, as well as on the principles of equity and human rights that underpin the TNA-NCDs, and the resulting strengthening of human security and human capital, will also be critical for all key stakeholders in government, civil society and private sector. The gaps in knowledge and skills in how to effectively address these conditions mandate the development and implementation of communication messages, materials, and platforms suited to the particular audiences, as part of an overall advocacy and communication strategy.

Involvement of an informed public strengthens their concerns about their own risks, the health of their families, their ability to work, to be productive, and to enjoy life, as well as their role as influencers on policymaking for health. Engagement with traditional

and new media, using NCD champions and policy entrepreneurs from all walks of life, including parliamentarians and legislative assemblies, youth advocates, and entertainment personalities, can command audience attention.

The use of settings, including schools, workplaces, faith-based organisations, and communities, for promotion and prevention interventions provides captive audiences, and the school environment in particular offers the bonus of involving teachers, parents, and vendors, as well as students.

Integration of multisectoral actions that address NCD reduction and related issues, including food and nutrition security, the climate crisis, preparedness for future pandemics, emergencies, and disasters, maternal and child health, women’s health, and UHC, will promote cross-sector work and cost-efficiency, and will be critical for the success of the TNA-NCDs.

Partnerships, networking, and resource mobilisation are essential for the promotion, explanation, implementation, and sustainability of the TNA-NCDs. Possible partners, funders, and collaborators, such as intergovernmental agencies, international NGOs, foundations, media houses, and other entities can be engaged through in-person or written approaches, submission of grant and project proposals, and through social media. It is crucial to enable effective partnerships among government, civil society, private sector, and development agencies, each of which brings particular strengths to partnerships. The private sector in particular can be engaged through the social impact business model and shared values, seeking win-win solutions.

Research, including political economy and behavioural economics analyses, which, respectively, catalyse evidence-based interventions and effective stakeholder partnerships, and nudge persons towards desired behaviour change, is essential. Such research provides evidence to determine how best to tailor global recommendations to regional and national realities, form and maintain effective partnerships, and shape behaviour through policies and interventions that make the healthy choice the easy choice.

Surveillance, monitoring, and evaluation are vital to assess the NCD situation, determine progress and trends, celebrate successes, make adjustments based

on challenges and lessons learned, and facilitate accountability, including the monitoring of conflict of interest and its management and mapping/countering interference of the unhealthy commodity industries in public health policy. Research, surveillance, monitoring, and evaluation also inform the identification and implementation of sustainability mechanisms through institutional and other structures and systems, strategies that are crucial if gains in NCD reduction are to be maintained and built on.

The use of digital strategies and platforms is cross-cutting and vital to this effort to launch, implement, and sustain the TNA-NCDs. Digital platforms, including social media, not only enhance participation, especially among youth, but also foster cost-effectiveness and can improve access to health services through telehealth. Notwithstanding, efforts must be made to reach persons who are on the wrong side of the digital divide, using traditional media, in-person outreach, and specially adapted messages and techniques where appropriate.

Lastly, promotion of the development of implementation plans for the TNA-NCDs or stand-alone actions in support of the TNA-NCDs by key stakeholders and sectors is essential to make its recommendations a reality, finding synergies and opportunities for integrating NCD reduction activities with those of other programmes. The implementation plans should:

- Be developed through a participatory process, from the perspective of the respective stakeholders, incorporating the views of other key stakeholders;
- Define the goal, expected outcomes, outputs/expected results, and indicators of achievement, as well as relevant activities, their timelines, and necessary inputs/resources;
- Adapt and integrate WHO and PAHO policy and technical packages as appropriate;
- Outline resource allocation and resource mobilisation strategies;
- Identify partners and stakeholder roles and responsibilities;
- Define risks to implementation and mitigation strategies, and incorporate the latter into the plan; and
- Include a monitoring and evaluation framework to facilitate meaningful evaluation of the progress and impact of the TNA-NCDs in the Caribbean.

²¹⁰ Moodie R, Stuckler D, Monteiro C, et al, on behalf of the Lancet NCD Action Group. Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. Lancet 2013. Published online February 12, 2013. [http://dx.doi.org/10.1016/S0140-6736\(12\)62089-3](http://dx.doi.org/10.1016/S0140-6736(12)62089-3).

Diagram 1. below summarises selected functions of each sector—some apply across specific sectors

Diagram 1. Selected key functions of specific sectors



CONCLUSION

If Caribbean governments and civil society were to accept the myriad international recommendations for NCD prevention and control as priorities for implementation in the region, they would undoubtedly run the risk of “priority paralysis”. In this state, the many recommendations may leave governments feeling overwhelmed, perceiving the agenda as impossible to execute—especially where resources are limited—and moving on to address seemingly more pressing and “do-able” issues.

The HCC’s call for a Transformative New Agenda for NCDs in the Caribbean, in the context of advancing equity and human rights, and enhancing human security and human capital, is timely, in light of lessons from the COVID-19 pandemic. The TNA-NCDs presents five priority areas for attention—life course prevention; people-centred, PHC-based health systems for universal health; social inclusion and participation for policy development; partnerships, networks, and resource mobilisation; and accountability for decision making—and offers practical, meaningful ways to address them.

The CSOs and key stakeholders/thought leaders interviewed for this report and call to action expressed optimism and hope that the TNA-NCDs would fulfil its promise, by framing and doing things differently to achieve desired national and regional NCD outcomes and contribute to global goals for NCD reduction sustainable development. They underscored the importance of improved management and leadership of health systems, with focus on the PHC strategy and universal health; participatory planning, implementation, and monitoring, involving PLWNCDs; and strengthened

advocacy, including on the primacy of equity and the right to health, and the obligations of the duty-bearers for the progressive realisation of human rights.

Their input highlighted the need to place NCDs back on the public health agenda, work to regain lost ground, recognise the benefits of addressing NCDs and COVID-19 concurrently, and focus on a limited number of priority areas, minimising the possibility of overwhelming stakeholders and increasing the chance of success in a resource-limited environment.

It is unthinkable that the havoc caused by COVID-19 and the lessons learned should have been in vain, leaving the Caribbean as unprepared and vulnerable to the next significant health-harming event as it was to COVID-19. With the participation of key stakeholders, including persons living with NCDs themselves and civil society, Caribbean countries and their leaders can tailor globally-recommended interventions for NCD prevention and control to regional and national realities.

The Caribbean must build on the promise and commitments of the Declaration of Port of Spain, recover lost momentum in reducing the health, social, and economic burden of NCDs, strengthen human security, build human capital, reduce inequities, and advance the right of everyone to the highest attainable standard of health. This is an opportunity that must be seized to put people at the centre of all work aimed at reducing NCDs, transform the NCD agenda, and build back better, ensuring that Caribbean countries make progress to achieve SDG 3 and its targets with equity, leaving no one behind.

The pandemic provides an opportunity for the world to use the disaster as a trigger to create more resilient nations and societies than before—to build back better, where health is recognised as a critical, interconnected component of a people-centred, universal framework of equity, human security, human rights, and human capital, and a crucial determinant of economic success.

Sir Trevor Hassell, President, Healthy Caribbean Coalition

ANNEXES

Annex 1 - List of CSO representatives and key stakeholders/thought leaders interviewed

Civil society organisations (9)

- Ms. Juanita James, President, [Antigua and Barbuda Diabetes Association](http://antiguadiabetes.com/)²¹¹
- Dr. Williamson Chea, President, [Cancer Society of The Bahamas](https://cancersocietybahamas.org/)²¹²
- Mr. Suleiman Bulbulia, President, Barbados Childhood Obesity Prevention Coalition
- Honourable Laura Tucker-Longsworth, Speaker of the Belize House of Representatives, Former President of the Belize Cancer Society, Belize Cancer Society
- Dr. Nancy Larco, Executive Director, Haitian Diabetes and Cardiovascular Diseases Foundation
- Ms. Deborah Chen, Executive Director, [Heart Foundation of Jamaica](https://www.heartfoundationja.org/)²¹³
- Ms. Abi Begho, Founder, Director, and Public Health Project Manager, [Lake Health and Wellbeing, St. Kitts and Nevis](https://lakehealthandwellbeing.com/)²¹⁴
- Ms. Sophia Jules, Secretary to the President, [Saint Lucia Diabetes and Hypertension Association](http://sldha.org/)²¹⁵
- Dr. Karen Sealey, Co-founder and Director, Trinidad and Tobago NCD Alliance

Key stakeholders/Thought leaders (11)

- Sir George Alleyne, Patron, HCC; United States of America
- Professor Simon Anderson, Head, George Alleyne Chronic Diseases Research Centre, University of the West Indies; Barbados
- Mr. Pierre Cooke, Jr, Youth Technical Advisor, HCC; Barbados
- Dr. Damian Greaves, Chair, Grenada National NCD Commission
- Dr. James Hospedales, Founder, EarthMedic; Chair, Defeat-NCD Partnership; Former Executive Director, CARPHA; Trinidad and Tobago
- Dr. Elisa Prieto, Advisor, NCDs and Mental Health, PAHO/WHO Subregional Program Coordination-Caribbean; Barbados²¹⁶
- Dr. Carlene Radix, Head, Health Unit, Organisation of Eastern Caribbean States Commission; Saint Lucia
- Dr. Leslie Ramsammy, Advisor to the Minister of Public Health; Ministry of Public Health; Guyana
- Ms. Beverly Reynolds, Programme Manager, Human and Social Sustainable Development, CARICOM Secretariat; Guyana
- Dr. Kavita Singh, Coordinator, Chronic Diseases Unit, Ministry of Public Health; Guyana
- Dr. Joy St. John, Executive Director, Caribbean Public Health Agency; Trinidad and Tobago

²¹¹ <http://antiguadiabetes.com/>

²¹² <https://cancersocietybahamas.org/>

²¹³ <https://www.heartfoundationja.org/>

²¹⁴ <https://lakehealthandwellbeing.com/>

²¹⁵ <http://sldha.org/>

²¹⁶ Dr. Prieto completed and submitted the questionnaire

Annex 2 - Questionnaires/interview guides for CSOs and key stakeholders/thought leaders



“NCDs AND COVID-19 IN THE CARIBBEAN:
THE CASE FOR A TRANSFORMATIVE NEW NCD AGENDA TO BUILD BACK BETTER”²¹⁷

INTRODUCTION

The Healthy Caribbean Coalition (HCC) is a registered not-for-profit regional network and alliance of over 100 civil society organisations (CSOs) focused on the prevention and control of non-communicable diseases (NCDs). The HCC has noted, with alarm, the significant toll that infection with the novel coronavirus, SARS-CoV-2, and the resulting coronavirus disease of 2019 (COVID-19) has taken on the health of persons living with NCDs (PLWNCDs). Studies have shown that persons with underlying conditions, including the major NCDs—cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases—are at greater risk of developing severe illness and dying from COVID-19. The Director-General of the World Health Organization (WHO) declared COVID-19 a global pandemic on 11 March 2020. Governments’ response to the pandemic included travel restrictions, border closures, in-country limits on the movement of people, and closure of schools, churches, and businesses. The response led to health systems that, understandably, focused on containing COVID-19, but also resulted in delays in the continuation of priority public health programmes such as immunization, and limited availability of routine services at hospitals and clinics. The postponement of clinics for PLWNCDs, screening programmes, and elective surgeries, among other important health services, as well as the disruption of global supply chains, resulted in—for many—shortages in medications and limited access to nutritious food, and in-country curfews reduced opportunities for regular physical activity. On the other hand, stay-at-home orders facilitated increases in domestic violence, alcohol and substance use, and exacerbation of some mental health and neurological conditions.

These developments have raised fears of further slowing of progress in the prevention and control of NCDs and of mental health and neurological conditions, aggravating previously documented deficits in the implementation of evidence-based, cost-effective strategies for NCD reduction such as the [WHO Best Buys and Other Recommended Interventions](#)²¹⁸. Though the interventions have been published, disseminated, and promoted in global and regional fora, most countries have not implemented them all. In the Caribbean, the agreements made by the Caribbean Community (CARICOM) Heads of State and Government in their [2007 Declaration of Port of Spain: ‘Uniting to Stop the Epidemic of Chronic NCDs’](#)²¹⁹ are also lagging in implementation.

The pandemic has resulted in health, social, and economic emergencies, and highlighted troubling inequities and gaps, with dire outcomes for persons in conditions of vulnerability, including the poor, persons with underlying conditions such as NCDs, afro-descendants, and indigenous people. More men than women die from COVID-19, but women are at higher risk for contracting the disease, given their major roles as caregivers in the formal and informal sectors, and their increased likelihood to be victims of domestic violence.

COVID-19 has called attention to the need for NCD prevention and control to include stronger, more equitable health systems that advance universal health and have the primary health care (PHC) strategy at their core, based on

²¹⁷ Though disseminated as separate instruments, they are combined here for ease of reference

²¹⁸ <https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf?sequence=1&isAllowed=y>

²¹⁹ <https://caricom.org/declaration-of-port-of-spain-uniting-to-stop-the-epidemic-of-chronic-ncds/>

principles that include human rights, equity, human security, and human capital. The social, political, commercial, and other determinants of health must be addressed through multisectoral, whole-of-government, whole-of-society, health-in-all-policies approaches. HCC therefore proposes a **Transformative New NCD Agenda to Build Back Better** that will bring these principles to the fore; advocate for changes in regional and national approaches to NCD prevention and control; and make recommendations for strategies and mechanisms to accelerate implementation of the proven, effective interventions for NCD reduction in the Caribbean and obtain better results.

In this regard, the HCC responded to a July 2020 Call for Proposals from the NCD Alliance Civil Society Solidarity Fund (SF) on NCDs and COVID-19 aimed at accelerating the response to the pandemic. HCC was awarded a grant under Category 2 of the SF, *Developing a comprehensive and cohesive NCD advocacy and communications strategy for the COVID-19 response, to implement the project A New Transformative NCD Agenda for Building Back Better in the Caribbean*.

In fulfillment of project activity 1.1 “Prepare a report *NCDs and COVID-19 in the Caribbean: the case for a transformative new NCD agenda to build back better*”, HCC will develop a report that examines the international and regional responses to NCDs and COVID-19; identifies lessons of the COVID-19 pandemic and its intersections with NCDs and PLWNCDs; and presents a case for a transformative new approach to NCD prevention and control in the Caribbean, changing regional and national approaches to obtain better results and contribute to building back better post-COVID-19.

A critical component of the development of this report is input from HCC member CSOs regarding their own responses to the COVID-19 pandemic and their priorities and recommendations for accelerating and strengthening NCD prevention and control post-COVID-19 in the context of the Transformative New NCD Agenda (TNA-NCDs). The report will be used to inform:

- A 4-month advocacy and communication campaign with the theme: *Building back better: A transformative new NCD agenda*, as a component of the HCC's COVID-19 Advocacy and Communication Strategy;
- Contributions by advocates to national COVID-19 planning and priority setting processes; and
- The development of an *HCC Transformative New NCD Agenda: Action Plan 2021-2022* that details HCC's contribution to the promotion, implementation, monitoring, and evaluation of the Transformative New NCD Agenda over the stated period.

The HCC appreciates your responses on behalf of your civil society organisation/your responses to this questionnaire/interview guide. The interview will be conducted by a consultant, with support from an HCC student intern, and should last about an hour. All responses will be aggregated and reported anonymously.

1. **Country:**
2. **Name of civil society organisation/organisational/institutional affiliation:**
3. **Name of person responding:**
4. **Title and Position/Post of person responding:**

FOR CIVIL SOCIETY ORGANISATIONS

A. CIVIL SOCIETY ORGANISATION RESPONSES TO COVID-19; FUTURE PLANS

5. What main functions did your civil society organisation (CSO) undertake during the pandemic to assist your members/constituents? *Tick all that apply.*
 - ☐ None, the CSO was closed
 - ☐ Specific COVID-19-related communication targeting members/constituents
 - ☐ Virtual/remote clinical care or facilitating access to care
 - ☐ Provision of medication
 - ☐ Provision of healthy food hampers/packages
 - ☐ Online services, such as physical activity programmes
 - ☐ Virtual/remote mental health and psychosocial support
 - ☐ Advocacy to government for the needs of members/constituents
 - ☐ Provision of assistance to members/constituents, e.g. to access health services, care, medication
 - ☐ Other functions (*please specify*)
6. Did your CSO have adequate resources to continue its usual and customary functions during the pandemic?
 - ☐ Yes
 - ☐ No
 - ☐ If Yes, what was the source of the resources? *Tick all that apply.*
 - ☐ Usual and customary government subventions
 - ☐ Special government subvention/support
 - ☐ Member fees
 - ☐ Proceeds from fundraising
 - ☐ Funds from grants/projects
 - ☐ Other (please specify):
7. What are the top 3 challenges that your CSO encountered in responding to COVID-19?
 - a. ...
 - b. ...
 - c. ...
8. What are your CSO's needs and operational priorities for the ongoing COVID-19 pandemic, to best serve your members/constituents? *Tick all that apply.*
 - ☐ Financial resources
 - ☐ Human resources
 - ☐ Recognition/support from government
 - ☐ Collaboration with other national CSOs
 - ☐ Support from HCC
 - ☐ Support from international CSOs
 - ☐ Capacity strengthening in understanding and addressing members'/constituents' needs
 - ☐ Other (*please specify*):

9. Has your CSO developed/does it plan to develop specific plan(s) for its operations post-COVID-19?
- ☐ Yes
- ☐ No
10. What are your CSO's priorities for the post-COVID-19 period? *Tick all that apply.*
- Service provision (please specify at which level of care – [first](#),²²⁰ [secondary](#),²²¹ [tertiary](#),²²² [rehabilitation](#),²²³ [palliation](#)²²⁴)
- ☐ Advocacy
- ☐ Communication
- ☐ Prevention/promotion?
- ☐ Research
- ☐ Surveillance
- ☐ Social inclusion and participation
- ☐ Partnerships
- ☐ Resource mobilisation? If yes, who/what entities are possible sources of resources for your CSO, and what resource mobilisation strategies would your CSO recommend?
- Possible sources of resources:
- Resource mobilisation strategies:

11. What are the top 3 challenges that your CSO foresees post-COVID-19?
- a.

...
- b.

...
- c.

...

FOR KEY STAKEHOLDERS/THOUGHT LEADERS

5. To the best of your knowledge, what national measures were taken by CARICOM countries in response to the COVID-19 pandemic? *Tick all that apply.*
- ☐ Restrictions on international travel
- ☐ Border closure
- ☐ Closure of schools, universities, and other learning institutions
- ☐ Closure of non-essential businesses
- ☐ Closure of supermarkets, food vending facilities, restaurants
- ☐ Closure of churches
- ☐ Imposition of curfews/stat-at-home orders
- ☐ Provision of financial assistance of households/employees
- ☐ Provision of food supplies to households
- ☐ Provision of healthy nutritious foods to households
- ☐ Provision of mental health and psychosocial support to persons/communities
- ☐ Explicit attention to persons/groups in conditions of vulnerability, e.g. older persons, persons with disabilities, persons living with NCDs, persons living with HIV, persons living with mental health or neurological conditions, persons of lower socio-economic status
- ☐ Arrangements for continuation of non-COVID-19-related essential health services at hospitals and clinics

²²⁰ First level of contact with the health system by individuals or families. <https://bit.ly/3ikfyeC>

²²¹ Services provided by health professionals who generally do not have the first contact with a patient. <https://bit.ly/2PC2GnQ>

²²² Specialized consultative care provided usually on referral from first and second levels of care. <https://bit.ly/3gXSVwp>

²²³ Measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments. <https://bit.ly/2DSxyh2>

²²⁴ Care that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering. <https://bit.ly/33K6hZ7>

- ☐ Access to essential medicines
- ☐ Resource reallocation
- ☐ Resource mobilisation to address COVID-19
- ☐ Establishment/use of multisectoral entities/mechanisms to address COVID-19
- ☐ Explicit partnerships with regional technical cooperation agencies such as CARPHA
- ☐ Explicit partnerships with international technical cooperation agencies such as PAHO/WHO or other UN agencies
- ☐ Explicit partnerships with regional or international financing institutions
- ☐ Other (*please specify*):

6. What do you think are the top 3 challenges that countries have encountered in responding to COVID-19?
- a.

...
- b.

...
- c.

...

7. As far as you know, have any CARICOM countries developed/do any CARICOM countries plan to develop specific plan(s) for health post-COVID-19?
- ☐ Yes
- ☐ No
- If Yes, which countries?
- Does/will the plan include NCD prevention and control?
- ☐ Yes
- ☐ No
- ☐ Don't know

8. Do you have any additional comments on the national responses to COVID-19 in the Caribbean, to date? Please state briefly below.

FOR BOTH CSOs AND KEY STAKEHOLDERS/THOUGHT LEADERS

B. RECOMMENDATIONS FOR THE TNA-NCDS

- CSO 12, KS/TL 9. Which NCDs does your CSO/do you think should be given priority in the TNA-NCDS? *Tick all that apply.*
- ☐ Cardiovascular diseases (heart disease, hypertension, stroke)
- ☐ Diabetes
- ☐ Cancer
- ☐ Chronic respiratory diseases (asthma, chronic obstruction lung disease)
- ☐ Overweight/obesity
- ☐ Mental health and neurological conditions
- ☐ Other (*please specify*):

- CSO 13, KS/TL 10. In strengthening health systems for improved NCD prevention and control, on which health system 'building blocks' should the TNA-NCDS focus? *Tick all that apply.* Please briefly state the reasons for your CSO's/your selection(s) and what interventions your CSO thinks/you think the TNA-NCDS should include.
- ☐ Leadership and governance
- Reason(s):
- Priority interventions:

- ☐ Service provision
Reason(s):
Priority interventions:
- ☐ Essential medicines, vaccines, and health technologies
Reason(s):
Priority interventions:
- ☐ Health financing
Reason(s):
Priority interventions:
- ☐ Health workforce
Reason(s):
Priority interventions:
- ☐ nformation systems for health
Reason(s):
Priority interventions:

CSO 14, KS/TL 11. What strategies does your CSO/do you think should be the focus of the TNA-NCDs? *Tick all that apply.*

- ☐ Service provision? If Yes, which level of the health system should be the focus? *Tick all that apply*

☐ First level of care

☐ Second level of care

☐ Tertiary level of care

☐ Rehabilitation

☐ Palliation
- ☐ Advocacy? If Yes, targeting which priority groups? Who should be the main advocates?
Priority groups:
Main advocates:
- ☐ Communication? If Yes, targeting which priority audiences? What communication methods and media should be used?
Priority audiences:
Communication methods and media:
- ☐ Prevention/promotion? If Yes, focusing on which NCD risk factors/NCD complications? Which settings should be priorities for prevention/promotion interventions, and why?
NCD risk factors/complications:
Settings:
- ☐ Research? If Yes, on what specific topic(s)? Who/which entities are best placed to conduct this research? How best can the research findings be disseminated and used for evidence-based decision making?
Research topics:
Research entities:
Dissemination and use of research:
- ☐ Surveillance? If Yes, in what specific area(s) and through what mechanism(s)? Who/which entities are best placed to conduct surveillance? Who should report and disseminate the findings?
Areas for surveillance:
Surveillance mechanisms:
Surveillance entities:
Surveillance results reporting and dissemination:
- ☐ Social inclusion and participation? If Yes, which are the most important groups that should be included in the planning, implementation, monitoring, and evaluation of the TNA-NCDs?

- Groups for social inclusion/participation:
- ☐ Partnerships? If Yes, who should be the main partners in, respectively, government, civil society, and the private sector? How can meaningful and effective multisectoral partnerships be formed and maintained?
Main government partners:
Main civil society partners:
Main private sector partners:
Strategies for forming and maintaining multisectoral partnerships:
- ☐ Resource mobilisation? If Yes, who/what entities are possible sources of resources for the TNA-NCDs, and what resource mobilisation strategies would your CSO recommend?
Possible sources of resources:
Resource mobilisation strategies:
- ☐ Sustainability mechanisms? If Yes, please state your CSO's top 3 recommendations to enable sustainability
Recommendations:

a.

...

b.

...

c.

...

CSO 15, KS/TL 12. Assessments have shown that progress to global and regional targets for NCD prevention and control is off-track. COVID-19 has highlighted many of the gaps in relevant policies and programmes. Considering a) the WHO Best Buys and Other Recommended Interventions and b) the CARICOM Heads of State and Government Declaration of Port of Spain, which **top 15 interventions** does your CSO/do you think should be included in the TNA-NCDs as priorities for action? *Tick a total of 10 boxes over from category a) and a total of 5 boxes from category b).*

a) WHO Best Buys and Other Recommended Interventions

Reduce tobacco use

- ☐ Increase excise taxes and prices on tobacco products
- ☐ Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages
- ☐ Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship
- ☐ Eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places, and public transport
- ☐ Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second hand smoke
- ☐ Provide cost-covered, effective and population-wide support (including brief advice, national toll-free quit line services) for tobacco cessation to all those who want to quit
- ☐ Implement measures to minimize illicit trade in tobacco products
- ☐ Ban cross-border advertising, including using modern means of communication
- ☐ Provide mobile phone based tobacco cessation services for all those who want to quit

Reduce harmful use of alcohol

- ☐ Increase excise taxes on alcoholic beverages
- ☐ Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)
- ☐ Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)
- ☐ Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints
- ☐ Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use
- ☐ Carry out regular reviews of prices in relation to level of inflation and income
- ☐ Establish minimum prices for alcohol where applicable

- ☐ Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets
- ☐ Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people
- ☐ Provide prevention, treatment and care for alcohol use disorders and co-morbid conditions in health and social services
- ☐ Provide consumer information about, and label, alcoholic beverages to indicate the harm related to alcohol

Reduce unhealthy diet

- ☐ Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals
- ☐ Reduce salt intake through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided
- ☐ Reduce salt intake through a behaviour change communication and mass media campaign
- ☐ Reduce salt intake through the implementation of front-of-pack labelling
- ☐ Eliminate industrial trans-fats through the development of legislation to ban their use in the food chain
- ☐ Reduce sugar consumption through effective taxation on sugar-sweetened beverages
- ☐ Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding
- ☐ Implement subsidies to increase the intake of fruits and vegetables
- ☐ Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal policies or agricultural policies
- ☐ Limit portion and package size to reduce energy intake and the risk of overweight/obesity
- ☐ Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables
- ☐ Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats
- ☐ Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables

Reduce physical inactivity

- ☐ Implement community-wide public education and awareness campaign for physical activity which includes a mass media campaign combined with other community-based education, motivational and environmental programmes aimed at supporting behavioural change of physical activity levels
- ☐ Provide physical activity counselling and referral as part of routine primary health care services through the use of a brief intervention
- ☐ Ensure that macro-level urban design incorporates the core elements of residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport
- ☐ Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programmes to support physical activity for all children
- ☐ Provide convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling
- ☐ Implement multi-component workplace physical activity programmes
- ☐ Promote physical activity through organised sport groups and clubs, programmes, and events

Manage cardiovascular disease and diabetes

- ☐ Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and non-fatal cardiovascular event in the next 10 years

- ☐ Treatment of new cases of acute myocardial infarction with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis, or primary percutaneous coronary interventions (PCI)
- ☐ Treatment of acute ischemic stroke with intravenous thrombolytic therapy
- ☐ Primary prevention of rheumatic fever and rheumatic heart disease by increasing appropriate treatment of streptococcal pharyngitis at the primary care level
- ☐ Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin
- ☐ Treatment of congestive cardiac failure with angiotensin converting enzyme inhibitor, beta-blocker and diuretic
- ☐ Cardiac rehabilitation post-myocardial infarction
- ☐ Anticoagulation for medium-and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation
- ☐ Low-dose acetylsalicylic acid for ischemic stroke
- ☐ Care of acute stroke and rehabilitation in stroke units

Manage diabetes

- ☐ Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics)
- ☐ Diabetic retinopathy screening for all diabetes patients and laser photocoagulation for prevention of blindness
- ☐ Effective glycaemic control for people with diabetes, along with standard home glucose monitoring for people treated with insulin to reduce diabetes complications
- ☐ Lifestyle interventions for preventing type 2 diabetes
- ☐ Influenza vaccination for patients with diabetes
- ☐ Preconception care among women of reproductive age who have diabetes, including patient education and intensive glucose management
- ☐ Screening of people with diabetes for proteinuria and treatment with angiotensin-converting-enzyme inhibitor for the prevention and delay of renal disease

Manage cancer

- ☐ Vaccination against human papillomavirus (2 doses) of 9–13 year old girls
- ☐ Prevention of cervical cancer by screening women aged 30–49, either through: visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions; Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions; or human papillomavirus (HPV) test every 5 years linked with timely treatment of pre-cancerous lesions
- ☐ Screening with mammography (once every 2 years for women aged 50–69 years) linked with timely diagnosis and treatment of breast cancer
- ☐ Treatment of colorectal cancer stages I and II with surgery +/- chemotherapy and radiotherapy
- ☐ Treatment of cervical cancer stages I and II with either surgery or radiotherapy +/- chemotherapy
- ☐ Treatment of breast cancer stages I and II with surgery +/- systemic therapy
- ☐ Basic palliative care for cancer: home-based and hospital care with multi-disciplinary team and access to opiates and essential supportive medicine
- ☐ Prevention of liver cancer through hepatitis B immunization
- ☐ Oral cancer screening in high-risk groups (for example, tobacco users, betel-nut chewers) linked with timely treatment
- ☐ Population-based colorectal cancer screening, including through a faecal occult blood test, as appropriate, at age >50 , linked with timely treatment

Manage chronic respiratory disease

- ☐ Symptom relief for patients with asthma with inhaled salbutamol
- ☐ Symptom relief for patients with chronic obstructive pulmonary disease with inhaled salbutamol
- ☐ Treatment of asthma using low dose inhaled beclometasone and short-acting beta agonist
- ☐ Access to improved stoves and cleaner fuels to reduce indoor air pollution
- ☐ Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica, asbestos
- ☐ Influenza vaccination for patients with chronic obstructive pulmonary disease

b) CARICOM Heads of State and Government Declaration of Port of Spain

- ☐ Strengthen regional health institutions to provide critical leadership for NCD reduction
- ☐ Establish National NCD Commissions (NNCDCs) or analogous bodies to plan and coordinate NCD prevention and control
- ☐ Pursue legislation for implementation of the WHO Framework Convention on Tobacco Control
- ☐ Use public revenue from tobacco, alcohol, or other such products to prevent NCDs, promote health and support the work of the NNCDCs
- ☐ Establish comprehensive national plans for the screening and management of NCDs and risk factors
- ☐ Mandate re-introduction of physical exercise in schools and ensure that education sectors promote programmes aimed at providing healthy school meals and promoting healthy eating
- ☐ Enhance food security and elimination of trans fats from diet
- ☐ Pursue fair trade policies in all international trade negotiations to promote greater use of indigenous agricultural products and foods, and reduce negative effects of globalisation on the food supply
- ☐ Mandate labelling of foods or measures to indicate their nutritional content
- ☐ Promote increased physical activity in the entire population, e.g. at work sites and through sport, and increase adequate public facilities such as parks and other recreational spaces to encourage physical activity
- ☐ Take account of the gender dimension in NCD prevention and control programmes
- ☐ Provide incentives for public education programmes in support of wellness, healthy lifestyle changes, and self-management of NCDs, and embrace the role of the media in NCD prevention and control
- ☐ Establish programmes for NCD risk factor surveillance with the support of academia, the Caribbean Public Health Agency (CARPHA), and the Pan American Health Organization (PAHO)
- ☐ Support CARICOM and PAHO as the joint secretariat for the Caribbean Cooperation in Health initiative, to be responsible for the revision of the regional NCD prevention and control plan, and the monitoring and evaluation of the Declaration

CSO 16, KS/TL 13. The HCC's September 2019 Call to Urgent Action for the Caribbean region to accelerate nutrition policies for creation of healthy environments for Caribbean children includes 3 priorities for policy development, as set out below. Which does your CSO/do you think should be included in the TNA-NCDs as priorities for action? *Tick all that apply.*

- ☐ Mandatory 'high in' front of package nutrition warning labelling
- ☐ Banning the sale and marketing of sweet beverages in school settings
- ☐ Taxation of sweet beverages of at least 20%

CSO 17, KS/TL 14. What does your CSO/do you think are the main barriers to implementation of evidence-based, cost-effective NCD prevention and control interventions such as the WHO Best Buys and Other Recommended Interventions? *Tick all that apply.*

- ☐ Limited awareness of these proven interventions:
 - ☐ By policymakers
 - ☐ By technical personnel in ministries of health

- ☐ By technical personnel in other ministries
- ☐ By health workers
- ☐ By civil society
- ☐ By the general public
- ☐ By the private sector
- ☐ Inadequate resources:
 - ☐ Human
 - ☐ Financial
 - ☐ Infrastructural
 - ☐ Other resources (*please specify*):
- ☐ Limited political will
- ☐ Insufficient regional support
- ☐ Insufficient international support
- ☐ Other (*please specify*):

CSO 18, KS/TL 15. Multisectoral National NCD Commissions (NNCDCs) or analogous multisectoral bodies have been established in several CARICOM Member States in fulfillment of the commitment in the CARICOM Heads of State and Government Declaration of Port of Spain, but the perception is that the NNCDCs/analogous bodies are not functioning optimally. What does your CSO/do you think is the cause/are the causes of this less-than-optimal functioning? (*Tick all that apply*)

- ☐ Based in/supervised by the Ministry of Health
- ☐ Not multisectoral enough
- ☐ Insufficient authority
- ☐ Insufficient resources
- ☐ Human
- ☐ Financial
- ☐ Infrastructural
- ☐ Other (*please specify*)
- ☐ Unclear terms of reference/scope of work
- ☐ Unclear accountability
- ☐ Inadequate promotion/not well known
- ☐ Other (*please specify*):

CSO 19, KS/TL 16. Should the NNCDCs/analogous multisectoral bodies be abolished?

- ☐ Yes
- ☐ No

If No, what are your CSO's/your top 3 recommendations for improving the NNCDCs/analogous bodies and their functioning?

- a. ...
- b. ...
- c. ...

CSO 20, KS/TL 17. Governments in CARICOM Member States have responded quickly to the COVID-19 pandemic, re-allocating and mobilising resources, collaborating regionally and internationally, and developing and enforcing protocols to control the outbreak. The Caribbean has one of the highest levels of NCDs globally, but has made relatively slow progress in reducing the burden, e.g. with taxation on unhealthy products, tobacco control, front-of-package labelling, and other actions. Why does your CSO/do you think that this is the case? Why have governments not responded to the NCD burden as they have to COVID-19, despite the greater illness and death caused by NCDs? *Tick all that apply.*

- ☐ Difference in the nature and visibility of COVID-19, as opposed to NCDs
- ☐ Insufficient appreciation of the NCD burden and its economic and social costs
- ☐ Insufficient advocacy and other actions by civil society
- ☐ Industry interference, e.g. influence on public health policy, provision of resources
- ☐ Conflict of interest
- ☐ Insufficient appreciation of, and action to address, the social and other determinants of health
- ☐ Insufficient appreciation and use of human rights, equity, human security, and human capital approaches
- ☐ Other (*please specify*):

CSO 21, KS/TL 18. What does your CSO/do you think are the top 3 actions that civil society, government, and the private sector could each take to promote and enable the implementation of evidence-based, cost-effective NCD prevention and control interventions such as the WHO Best Buys and Other Recommended Interventions? And accelerate fulfillment of the commitments of the Declaration of Port of Spain?

Civil society

- a. ...
- b. ...
- c. ...

Government

- a. ...
- b. ...
- c. ...

Private sector

- a. ...
- b. ...
- c. ...

CSO 22, KS/TL 19. What does your CSO/do you think are the top 3 actions that civil society, government, and the private sector could each take to highlight principles of human rights, equity, human security, and human capital, and integrate them in the TNA-NCDs and its implementation, monitoring, and evaluation?

Civil society

- a. ...
- b. ...
- c. ...

Government

- a. ...
- b. ...
- c. ...

Private sector

- a. ...
- b. ...
- c. ...

CSO 23, KS/TL 20. Does your CSO/do you have any additional comments on the **Transformative New NCD Agenda to Build Back Better?**

- ☐ Yes
- ☐ No

If Yes, please state briefly below.

Thank you for your participation in this process!

Annex 3 - List of entities that provided feedback on the penultimate draft of the document, and their representatives

National

Civil society organisations

- Antigua and Barbuda Diabetes Association – Ms. Juanita James, President

• Belize Cancer Society (BCS) – Honourable Laura Longworth, Speaker of the House of Representatives former President of the BCS (also a member of the HCC Board of Directors), and Ms. Heather Reneau, Administrator, BCS

• Cancer Society of The Bahamas – Dr. Christine Chin, Coordinator, Healthy Lifestyle Programme (also a member of the HCC Board of Directors)

• Lake Health and Wellbeing – Ms. Abi Begho, Founder, Director, and Public Health Project Manager

Government entities

- Ministry of Health and Wellness, Barbados – Dr. Arthur Phillips, Senior Medical Officer of Health (Acting) and Coordinator, National NCD Programme

• National NCD Commission, Grenada – Dr. Damian Greaves, Chair

Regional

- Caribbean Development Bank – Ms. Deidre Clarendon, Chief, Social Sector Division

• CARICOM Secretariat – Ms. Beverley Reynolds, Programme Manager, Human and Social Development

• Healthy Caribbean Coalition – Sir George Alleyne, Patron; Sir Trevor Hassell, President; Ms. Maisha Hutton, Executive Director; Ms. Nicole Foster, Policy Advisor; Ms. Barbara McGaw, Tobacco Control Advisor; Ms. Tara Lisa Persaud, Our Views Our Voices Advisor; Ms. Danielle Walwyn, Advocacy Officer; Mr. Ian Pitts, Digital Content Coordinator; Mr. Pierre Cooke, Jr, Youth Technical Advisor; and Ms. Kerrie Barker, Project Assistant

• OECS Commission – Dr. Carlene Radix, Head, Health Unit

• University of the West Indies – Professor Simon Anderson, Head, George Alleyne Chronic Diseases Research Centre (GA-CDRC); Dr. Natasha Sobers, Lead Researcher of the Barbados National Registry for NCDs, GA-CDRC; and Dr. Madhuvanti Murphy, Deputy Dean, Research and Postgraduate Studies, Cave Hill Campus

International





- EarthMedic – Dr. James Hospedales, Founder (and Special Advisor, HCC)

• NCD Alliance – Mr. Luis Manuel Encarnación, Capacity Development Manager, and Ms. Diana Gittens, Our Views Our Voices Global Advisory Committee Member

• Pan American Health Organization – Dr. Anselm Hennis, Director, Department of Noncommunicable Diseases and Mental Health, and Dr. Elisa Prieto, Advisor, Noncommunicable Diseases and Mental Health, Subregional Program Coordination/Caribbean

• United Nations Children’s Fund, Office for the Eastern Caribbean Area – Dr. Aloys Kamuragiye, Representative, and Dr. Lisa McLean Trotman, Communication for Development Specialist

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