



AN ANALYSIS OF NATIONAL NCD COMMISSIONS IN THE CARIBBEAN: **FIT FOR PURPOSE?**

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome	OECS	Organisation of Eastern Caribbean States
CARICOM	Caribbean Community	PAHO	Pan American Health Organization
CARPHA	Caribbean Public Health Agency	PANCAP	Pan Caribbean Partnership Against HIV/ AIDS
CCH	Caribbean Cooperation in Health	PLWNCDs	people living with non-communicable diseases
COVID-19	coronavirus disease of 2019	POSD	Declaration of Port of Spain
CROSQ	CARICOM Regional Organisation for Standards and Quality	PS	permanent secretary
CSO	civil society organisation	PSA	public service announcement
ECLAC	Economic Commission for Latin America and the Caribbean	SDGs	Sustainable Development Goals
FCTC	Framework Convention on Tobacco Control	SEARO	South-East Asia Regional Office (World Health Organization)
GAP	global action plan	SIDS	small island developing states
GDP	gross domestic product	TNA-NCDs	Transformative New Agenda for NCD Prevention and Control in the Caribbean
HCC	Healthy Caribbean Coalition	UN	United Nations
HIV	human immunodeficiency virus	UNAIDS	Joint United Nations Programme on HIV/ AIDS
HoSG	heads of state and government	UNDP	United Nations Development Programme
M&E	monitoring and evaluation	UNIATF	United Nations Interagency Task Force
MoH	ministry of health	UWI	University of the West Indies
NCDs	non-communicable diseases	WHO	World Health Organization
NCM-TC	national coordination mechanism for tobacco control		
NGO	non-governmental organisation		
NNCDC	national non-communicable diseases commission		

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EXECUTIVE SUMMARY

The Healthy Caribbean Coalition, in collaboration with the Pan American Health Organization and with support from the International Union Against Tuberculosis and Lung Disease and Bloomberg Philanthropies, undertook an analysis of national non-communicable diseases commissions—or their equivalents—in the Caribbean. The analysis sought to determine the status of the NNCDs/equivalents and provide recommendations for strengthening their role and performance, as the Caribbean region, like the rest of the world, continues to struggle with the onerous burden of non-communicable diseases (NCDs), made worse by the coronavirus disease of 2019 (COVID-19) pandemic. The analysis also explored the possibility of having the NNCDs/equivalents function as multisectoral national coordination mechanisms for tobacco control (NCMs-TC).

Building on HCC's previous analyses and reports on NNCDs/equivalents, and the Coalition's collaboration with the entities to enhance their capacity, a survey was conducted among the 15 entities listed in the NNCD/equivalent portal on the HCC website. Eight responses were received (53% response rate), from entities in Antigua and Barbuda, The Bahamas, Bermuda, Belize, Grenada, Guyana, Jamaica, and St. Lucia, and two—Belize and St. Lucia—indicated that the NNCDs/equivalents were inactive. Most of the analysis was therefore based on the information provided by the entities in the other six countries, two of which had been re-constituted in 2021 after varying periods of dormancy. However, all eight entities provided recommendations for enhancing the functions and performance of the NNCDs/equivalents.

Organisational location

Only the Guyana NNCD/equivalent was located in the Office of the President, the others being located in the ministry of health (MoH), an organisational location perceived as not conducive to effective multisectoral action. All entities had government sector representation from health and education, with varied representation from other sectors; all had civil society representation that included civil society organisations (CSOs) or non-governmental organisations (NGOs) addressing specific NCDs, but some entities also had representation from trade unions, academia, support groups, and faith-based organisations. All except one had private sector representation.

Guiding frameworks and resources

All the NNCDs/equivalents had terms of reference or mandates to guide their actions, which included providing advice to government on NCD issues, advocacy, and health promotion, among other functions. However, frameworks to improve governance and transparency, such as standard operating procedures, codes of ethics, and conflict of interest policies or mechanisms were not ubiquitous. Most entities had their own strategic plan, functioned in the framework of a national NCD prevention and control strategy or plan of action, and had mechanisms for accountability that comprised periodic reports submitted to the relevant authority. Resources were provided through the MoH for the most part, supplemented by funds from partners such as PAHO and the Organisation of Eastern Caribbean States (OECS), though one entity received a subvention from the national budget and funding for another was included in the Cabinet Conclusion that led to its establishment.

Autonomy/decision-making authority, level of influence, and partnerships/networks

The entities' assessment of their degree of autonomy/decision-making authority and level of influence on key stakeholders, including policymakers, was disappointing. Only one assessed its autonomy/decision-making authority as 'very high' and most assessed their level of influence as 'medium' or 'low'. The

INTRODUCTION

The [Healthy Caribbean Coalition](#)¹ has been an ardent supporter of, and contributor to, multisectoral National NCD Commissions or their equivalents in Caribbean countries as an important aspect of its work to prevent and control non-communicable diseases in the Caribbean region. This is in keeping with the imperative of whole-of-government, whole-of-society, health-in-all-policies approaches to NCD prevention and control in order to effectively address the social, economic, environmental, commercial, and other determinants of health that impact NCDs, their risk factors, and their complications.

The need for multisectoral action to effectively address NCDs is widely recognised and recommended, including in international frameworks such as the PAHO NCD Strategy 2012–2025² and the WHO NCD Global Action Plan (GAP) 2013–2020.³ Even before those frameworks, the establishment of these multisectoral NNCDs/ equivalents was recommended in the groundbreaking 2007 [Declaration of Port of Spain \(POSD\): “Uniting to Stop the Epidemic of Chronic NCDs”](#)⁴ by the Heads of State and Government (HoSG) of the Caribbean Community (CARICOM), the main Caribbean regional political integration entity.

According to the [HCC NNCDs/equivalent portal](#),⁵ of the [15 CARICOM Member States and five Associate Members](#),⁶ NNCDs/equivalents were established in 12 CARICOM Member States,⁷ and three CARICOM Associate Members.⁸ The entities have achieved varying degrees of success since 2007, but despite governments’ endorsement and the HCC’s contributions to improving their visibility, functioning, and influence through creation of the portal, establishment of a network of NNCDs/ equivalent chairpersons, and the development of analyses and reports,^{9,10,11} a variety of persistent challenges has led to a general perception that the NNCDs/equivalents are functioning sub-optimally and not living up to their potential.^{10,11,12}

The ongoing COVID-19 pandemic has had a significant negative impact on people living with NCDs (PLWNCDs), who are more likely to have severe disease and die.¹³ Since it was declared in March 2020, the pandemic has exposed and worsened inequities in health, and made efforts towards effective NCD prevention and control even more urgent. The HCC recognised this pressing need and made proposals to address it in the Coalition’s January 2021 call for a [Transformative New NCD Agenda in the Caribbean](#)¹⁴ (TNA-NCDs), underpinned by principles of equity and human

rights, aimed at enhancing human security and human capital, with social activism at its core.

Under the third of five priority areas of focus—‘people-centred, equitable health systems for universal health’—the TNA-NCDs identified “establishing mechanisms for effective multisectoral, integrated, coherent action, including by NNCDs or equivalent bodies” as one of the key interventions to improve leadership and governance for NCD prevention and control, aligned with the HoSG’s commitment in the POSD and WHO recommendations and guidance for the establishment of such multisectoral coordination mechanisms at country level.¹⁵

Through a grant managed by the International Union Against Tuberculosis and Lung Disease and funded by Bloomberg Philanthropies, PAHO instituted a letter of agreement with the HCC to conduct an analysis of NNCDs or their equivalents in the Caribbean in order to determine their status and provide recommendations on how to strengthen their role and performance. In addition, the analysis sought to explore the possibility of NNCDs/ equivalents functioning as national coordination mechanisms for tobacco control where such mechanisms do not exist.

Tobacco use is one of the main risk factors for NCDs, and the 2003 WHO [Framework Convention on Tobacco Control](#) (FCTC),¹⁶ an internationally-agreed, legally-binding treaty, provides comprehensive guidance for States Parties to reduce tobacco use among their populations. In collaborating with

the HCC to analyse the functioning of NNCDs/ equivalents in the Caribbean, PAHO sought to address the recommendation to establish and/ or strengthen multisectoral and multistakeholder collaboration made at an August 2018 meeting aimed at advancing FCTC implementation in CARICOM countries,¹⁷ and simultaneously address FCTC Article 5.2 (a). The latter calls on each State Party to, in accordance with its capabilities, “establish or reinforce and finance a national coordinating mechanism or focal points for tobacco control”. In 2018, the WHO FCTC Secretariat and the United Nations Development Programme (UNDP) produced a Toolkit to guide the establishment of NCMs-TC,¹⁸ a comprehensive document based on the WHO guide for establishing country-level multisectoral coordination bodies for NCD prevention and control.¹⁵ The Toolkit encourages the highest levels of government’s executive branch to establish these entities, advocates for a high-ranking official to chair the NCM-TC, and suggests that the members of the entity hold senior level positions in their institutions.

Several CARICOM countries are classified as middle-, upper middle-, or high-income, based on their gross domestic product (GDP).¹⁹ However, most of the region’s countries fall into the category of small island developing states (SIDS), with peculiar vulnerabilities²⁰ related to, among other factors, their size, geographic location, global economic shocks, economies of scale, dependency on imports, emergencies and disasters aggravated by the climate crisis—which also negatively impacts

¹ <https://www.healthycaribbean.org/>.

² Pan American Health Organization. Strategy for the prevention and control of noncommunicable diseases 2012–2025. Document CSP28/9, 18 September 2012. Washington, D. C.: 2012; PAHO. Available at: <https://www.paho.org/hq/dmdocuments/2012/CSP28-9-e.pdf>.

³ World Health Organization. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: 2013; WHO. Available at: https://apps.who.int/iris/bitstream/handle/10665/94384/9789241506236_eng.pdf;jsessionid=0D9C821ECDF8355EBABF62357EA730C7?sequence=1.

⁴ <https://caricom.org/declaration-of-port-of-spain-uniting-to-stop-the-epidemic-of-chronic-ncds/>.

⁵ <https://www.healthycaribbean.org/national-ncd-commissions-or-equivalents/>.

⁶ <https://caricom.org/member-states-and-associate-members/>.

⁷ Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago.

⁸ Anguilla, Bermuda, and British Virgin Islands.

⁹ Healthy Caribbean Coalition. A civil society regional status report: responses to NCDs in the Caribbean Community. Bridgetown: 2014; HCC. Available at: <http://www.healthycaribbean.org/wp-content/uploads/2017/02/HCC-NCDA-RSR-FINAL-MARCH-2014.pdf>.

¹⁰ Healthy Caribbean Coalition. A civil society report on National NCD Commissions in the Caribbean: towards a more effective multisectoral response to NCDs, Part I. Bridgetown, 2015; HCC. Available at: <http://www.healthycaribbean.org/wp-content/uploads/2016/04/A-Civil-Society-Report-on-National-NCD-Commissions-in-the-Caribbean-Towards-a-more-Effective-Multisectoral-Response-to-NCDs-Part-1.pdf>.

¹¹ Healthy Caribbean Coalition. Getting National NCD Commissions up and running – a framework for the establishment and strengthening of National NCD Commissions in the Caribbean: towards a more effective multisectoral response to NCDs, Part II. Bridgetown, 2017; HCC. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2017/04/Getting-National-NCD-Commissions-Up-and-Running.pdf>.

¹² 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.

¹³ Pan American Health Organization. NCDs and COVID-19. See: <https://www.paho.org/en/ncds-and-covid-19>.

¹⁴ Healthy Caribbean Coalition. NCDs and COVID-19 in the Caribbean: a call to action—the case for a Transformative New Agenda for NCD Prevention and Control in the Caribbean. Bridgetown: HCC; 2020. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2021/01/TNA-NCD-FINAL.pdf>.

¹⁵ World Health Organization Regional Office for South-East Asia (SEARO). Approaches to establishing country-level multisectoral coordination mechanisms for the prevention and control of noncommunicable diseases. New Delhi: 2015; WHO SEARO. Available at: <https://apps.who.int/iris/handle/10665/312110>.

¹⁶ <https://fctc.who.int/>.

¹⁷ Pan American Health Organization. Advancing implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in the Caribbean Community: meeting report. Washington, D.C.: PAHO; August 2018. Available at: https://iris.paho.org/bitstream/handle/10665.2/49544/PAHONMH18038_eng.pdf?sequence=1&isAllowed=y.

¹⁸ World Health Organization Framework Convention on Tobacco Control Secretariat and United Nations Development Programme. National coordinating mechanisms for tobacco control: toolkit for Parties to implement Article 5.2(a) of the World Health Organization Framework Convention on Tobacco Control. Geneva: 2018; WHO and UNDP. Available at: <https://www.who.int/fctc/implementation/publication/FCTC-5-2-coordination-toolkit.pdf?ua=1>.

¹⁹ The World Bank. How does the World Bank classify countries? Available at: <https://datahelpdesk.worldbank.org/knowledgebase/articles/378834-how-does-the-world-bank-classify-countries>.

²⁰ Gomes C. The case of Small Island Developing States of the Caribbean: the challenge of building resilience. Economic Commission for Latin America and the Caribbean (ECLAC). Port of Spain: ECLAC Subregional Headquarters for the Caribbean; April 2014. Available at: <https://www.cepal.org/en/publications/38366-case-small-island-developing-states-caribbean-challenge-building-resilience>.

²¹ Healthy Caribbean Coalition. Climate change, NCDs, and SIDS. Bridgetown: HCC; 2016. Available at: <http://www.healthycaribbean.org/wp-content/uploads/2016/06/Climate-Change-SIDS-and-NCDs.pdf>.

BACKGROUND

NCDs²¹ —and limitations in human resources. Most Caribbean countries—if any—do not have the human, financial, or infrastructural resources to establish separate multisectoral coordination mechanisms for individual NCDs and risk factors. If NNCDs/equivalents can be enhanced to function optimally within their parameters of operation, fulfill their scope of work, and address all aspects of efforts to prevent and control NCDs and their risk factors, Caribbean countries will have taken an important step towards more efficient and effective use of their limited resources in reducing the burden of NCDs.

In essence, this report seeks to identify strategies and mechanisms to enable the NNCDs/equivalents

to be fit-for-purpose,²² to contribute effectively to the acceleration and strengthening of NCD prevention and control in the Caribbean. Though the primary target audience of this document is NNCDs/equivalents, a critical secondary audience comprises policy makers in government, and the analysis is also relevant to development and technical cooperation agencies working in NCD reduction. It is anticipated that the NNCDs/equivalents will not only take action as appropriate to strengthen their functioning, but also advocate strongly with relevant government authorities and key stakeholders for the implementation of the recommendations made.

Overview of NCDs in the Caribbean—burden and responses

NCDs continue to be the main causes of death and illness in the Caribbean, the region that has the dubious distinction of having the greatest burden of NCDs in the Region of the Americas, with 78% of all deaths and 76% of premature deaths (among persons aged 30-70 years) attributable to NCDs.²³ NCDs have tremendous costs related not only to their direct effects on health, but also on productivity, economic progress, and equitable, sustainable development.

A 2015 investment case for NCD prevention and control in Barbados showed that over the 15-year period, 2016-2030, of the United Nations (UN) [Sustainable Development Goals](#)²⁴ (SDGs), scaling up NCD prevention interventions, combined with diagnostic and treatment coverage over the next five years and then holding coverage constant, would give a return on investment of 4.1.²⁵ This represents a total of 580 million Barbados dollars in increased productivity, around 1% of annual GDP. A similar study in Jamaica in 2017 showed that scaling up the recommended package of interventions for NCDs over the period 2017-2032 would avoid labour productivity losses of over 47.3 billion Jamaican

dollars (JMD), save over 29.8 billion JMD of direct medical costs to treat diseases, grow GDP by an extra 0.11% by year 5 alone, and give a minimum return on investment of 2.1.²⁶

NCDs have long been recognised as priorities for joint action in the Caribbean, through the [Caribbean Cooperation in Health](#)²⁷ (CCH), the CARICOM health agenda, now in its fourth iteration, [CCH IV, 2016-2025](#).²⁸ CARICOM HoSG have repeatedly made commitments to NCD prevention and control, exemplified by their [2001 Nassau Declaration](#)²⁹ and the POSD,⁴ the latter paving the way for global recognition of NCDs as barriers to sustainable development through the [Political Declaration of the 2011 High-level Meeting of the United Nations \(UN\) General Assembly on the Prevention and Control of NCDs](#).³⁰

However, despite the political commitments, which have spawned many regional and global frameworks for action, NCD prevention and control is lagging in the Caribbean,³¹ as elsewhere in the world.³² This situation puts at risk the achievement, by 2030, of UN [SDG 3](#)³³ and [target 3.4](#),³⁴ the SDG goal and target most directly related to, respectively, health and NCDs, as well as progress to other SDGs.³⁵ There is great concern regarding

²² Definition of 'fit-for-purpose': (of an institution, facility, etc.) – well equipped or well suited for its designated role or purpose. https://www.lexico.com/definition/fit_for_purpose; (of an institution, a system, a thing, etc.) – suitable for the function or purpose that it was designed for. https://www.oxfordlearnersdictionaries.com/definition/english/fit_2#fit_idmg_1.

²³ 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.

²⁴ <https://sdgs.un.org/goals>.

²⁵ 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; 2017. Available at <https://apps.who.int/iris/handle/10665/259689>.

²⁶ UN Interagency Task Force on NCDs, UN Development Programme, and Pan American Health Organization. The case of 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, PAHO; 2018. Available at: <https://iris.paho.org/handle/10665.2/49693>.

²⁷ <https://caricom.org/documents/caribbean-cooperation-in-health-initiative-phase-1/>.

²⁸ Caribbean Public Health Agency (CARPHA). The Caribbean Cooperation in Health-IV report 2020: regional public goods in focus. Available at: https://www.carpha.org/Portals/0/Publications/CCH-IV-Regional-Public-Good-Report_final.pdf. Port of Spain: 2020; CARPHA.

²⁹ <https://caricom.org/nassau-declaration-on-health-2001-the-health-of-the-region-is-the-wealth-of-the-region/>.

³⁰ https://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf.

³¹ Port of Spain Declaration Evaluation Research Group. Evidence briefs: the evaluation of the 2007 CARICOM Heads of Government Port of Spain NCD Summit Declaration. March 2016. Available at: <https://food4changecaribbean.org/wp-content/uploads/2016/04/POSDEVAL-EVIDENCE-BRIEFS-Apr-2016-v7.pdf>.

³² World Health Organization. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases: mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, executive summary. Report by the Secretariat. Document A74/10, Add.1, 15 April 2021. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_10Add1-en.pdf.

³³ <https://sdgs.un.org/goals/goal3>.

³⁴ <https://unstats.un.org/sdgs/metadata?Text=&Goal=3&Target=3.4>.

³⁵ United Nations Economic and Social Council. Progress towards the SDGs: report of the Secretary-General. 30 April 2021. Document E/2021/58. Available at: <https://undocs.org/en/E/2021/58>.

³⁶ Rambaran K, Teelucksingh S, Sankar SG, et al. High prevalence of childhood overweight and obesity in ten Caribbean countries: 2018 cross-sectional data and a narrative review of trends in Trinidad and Tobago. Child and Adolescent Obesity 2021, 4:1; 23-26. Available at: <https://doi.org/10.1080/2574254X.2020.1847632>.

increasing childhood overweight and obesity in the Caribbean, with one review showing 28.0%-44.5% prevalence of overweight, 14.3%-19.8% prevalence of obesity, and, in Trinidad and Tobago, increases in combined overweight and obesity among school children from 12.0% in 2001 to 51.5% in 2018.³⁶

In addition, data from the Global Youth Tobacco Survey (GYTS) indicated that although the sale of cigarettes to minors is banned in many countries in the Region of the Americas, in 14 of the 32 countries for which GYTS data are available, 20% or more of adolescents aged 13 to 15 years smoked their first cigarette before their tenth birthday, and the countries with the highest levels of experimentation before this age are primarily in the Caribbean.³⁷ These trends set the stage for worsening of the NCD epidemic in the region.

SDG 3 also includes target 3.a³⁸ on strengthening the implementation of the FCTC. As at 19 August 2021, 13 of the 14 independent CARICOM Member States were Parties to the FCTC,³⁹ and several have enacted comprehensive tobacco control legislation (Antigua and Barbuda, Guyana, and Suriname) and/or regulations (Barbados, Jamaica, St. Lucia, and Trinidad and Tobago). In 2017, Guyana created a National Tobacco Control Council and St. Lucia reported having a national multisectoral

coordination mechanism for tobacco control,⁴⁰ but the level of the functioning of these or other tobacco control mechanisms is uncertain. Globally, poor intersectoral coordination has been identified as a constraint to the implementation of the Convention, along with interference by the tobacco industry, the need for better legislative enforcement, and insufficient political support.⁴¹

COVID-19 and NCDs

In common with other regions, the NCD situation in the Caribbean has been worsened by the COVID-19 pandemic and national public health responses to curb the spread of SARS-CoV-2, its causative agent. There have been lockdowns, travel restrictions, and physical distancing, with disruption of essential services for NCDs⁴² and mental, neurological, and substance abuse disorders.⁴³ Persons with obesity or the four major NCDs—cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases—who develop COVID-19 are at increased risk of severe disease and death.^{13,44} PAHO has developed a modelling tool to estimate the proportion of persons at risk of severe COVID-19 due to the presence of underlying conditions,⁴⁵ and it is estimated that 29% of the population in the Caribbean is at risk due to the presence of at least one underlying condition.^{46,47} Furthermore, tobacco

use is a common risk factor for the four major NCDs,³⁷ and it is also a risk factor for severe COVID-19.⁴⁸ The COVID-19 pandemic therefore presents a golden opportunity to strengthen evidence-based tobacco control policies and interventions, including tobacco cessation services⁴⁹ and to establish and/or improve NCMs-TC.

The pandemic has had significant health, social, and economic consequences, and most Caribbean countries have mounted multisectoral responses, led by the HoSG and guided by the health ministry, offering an opportunity for enhanced multisectoral action and stronger positioning of health with regard to other sectors. The pandemic has therefore reinforced and further catalysed HCC's advocacy for, and contribution to, accelerated, enhanced, and effective responses to NCDs in the Caribbean, including through improved functioning of multisectoral NNCDs/equivalents.

NNCDs/equivalents in the Caribbean

Some Caribbean countries, such as Barbados, Grenada, and Guyana, established bodies to advise on issues related to NCD prevention and control even before the call in the POSD for the establishment of NNCDs/equivalents. However, those bodies tended to comprise only persons from the health sector, and the NNCDs/equivalents, with their multisectoral membership, were meant to promote and strengthen critically needed whole-of-government, whole-of-society, health-in-all policies approaches to NCD prevention and control.

However, information in the HCC NNCD/equivalent portal⁵ indicates that, except in the case of Guyana, where the NNCD has been located in the Office of the President since its inception, the NNCDs/equivalents were established under the purview of the MoH. This organisational location was seen by several CSOs and key stakeholders/thought leaders consulted in 2020 for the development of the TNA-NCDs as limiting meaningful, high-level multisectoral planning, implementation, and assessment of interventions for NCD reduction.¹⁴

The NNCDs'/equivalents' terms of reference, mandates, or scopes of work traditionally focused on advice to governments on NCD policy, legislation, and programmes; advocacy; monitoring and evaluation (M&E); promotion of collaboration and partnerships; and, in some instances, resource mobilisation, programme implementation, and promotion of research.⁵ In 2017, when the HCC NNCD database was first developed, no NNCD or equivalent had a code of ethics; only two had conflict of interest policies; three had standard operating procedures; and five had strategic plans or plans of action to guide the Commission's activities. Most were dependent on the MoH for funding, or had no specific funding, and only one had its own secretariat with full-time staff.

During consultations for the development of the TNA-NCDs, CSOs and key stakeholders/thought leaders in the region were asked their opinion on the functioning of NNCDs/equivalents in the Caribbean. Requested to specifically identify reasons for the perceived sub-optimal functioning of these entities, interviewees cited insufficient multisectorality, especially since governments, not ministries of health, are the entities committed to NCD-related regional and international agreements, mandates, and treaties; insufficient authority; 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.¹⁴

Despite these challenges, only two of those consulted thought that the NNCDs/equivalents should be abolished. Suggestions for enhancing the functioning of the entities included provision of more resources—human, financial, and infrastructural; greater authority and autonomy, with easier and more direct access to policymakers, including those in the trade and finance sectors; a focus on policy, rather than implementation; capacity to develop legislative drafts; clear terms of reference and accountability;

³⁷ Pan American Health Organization. Report on tobacco control in the Region of the Americas, 2018. Washington, D.C: 2018; PAHO. Available at: <https://iris.paho.org/handle/10665.2/49237>.

³⁸ <https://unstats.un.org/sdgs/metadata?Text=&Goal=3&Target=3.a>.

³⁹ See https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=_en#6. Haiti signed the FCTC in 2003, but has not ratified or acceded to it.

⁴⁰ World Health Organization. 2018 global progress report on the implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO; 2018. Available at: https://www.who.int/fctc/reporting/WHO-FCTC-2018_global_progress_report.pdf?ua=1.

⁴¹ World Health Organization. 2016 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: WHO; 2016. Available at: https://www.who.int/fctc/reporting/2016_global_progress_report.pdf?ua=1.

⁴² 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: June 2020; PAHO. Available at: <https://iris.paho.org/handle/10665.2/52250>.

⁴³ World Health Organization. The impact of COVID-19 on mental, neurological, and substance use services: results of a rapid assessment, 5 October 2020. Geneva: October 2020; WHO. Available at: <https://www.who.int/publications/i/item/978924012455>.

⁴⁴ Santosh KKY, Praveen KRB, and Chandrashekar JS. Double trouble: a pandemic of obesity and COVID-19. *Lancet Gastroenterology & Hepatology*, August 2021; 6(8): 608. DOI [https://doi.org/10.1016/S2468-1253\(21\)00190-4](https://doi.org/10.1016/S2468-1253(21)00190-4).

⁴⁵ COVID-19 and co-morbidities in the Americas: hands-on tool to estimate the population at increased and high risk of severe COVID-19 due to underlying health conditions for the Americas. Washington, D.C.: 2021; PAHO. Available at: <https://iris.paho.org/handle/10665.2/53254>.

⁴⁶ Trinidad and Tobago Guardian newspaper, October 27, 2021. PAHO: 29% of CARICOM population at higher risk of severe COVID-19. Available at: <https://www.guardian.co.tt/news/paho-29-of-caricom-population-at-higher-risk-of-severe-covid19-6.2.1406039.3aeaf9116d>.

⁴⁷ Video: PAHO weekly press briefing on the COVID-19 situation in the Americas, October 27, 2021. Dr. Sylvan Aldighieri, timeline 14:42. Available at: <https://www.youtube.com/watch?v=SxjvCSt1HcM>.

⁴⁸ Patanavanich R and Glantz SA. Smoking is associated with COVID-19 progression: a meta-analysis. *Nicotine Tob Res* 2020;22(9):1653-1656. DOI: 10.1093/ntr/ntaa082. Available at: <https://pubmed.ncbi.nlm.nih.gov/32399563/>.

⁴⁹ Ahluwalia IB, Myers M, and Cohen JE. COVID-19 and tobacco cessation services. *Lancet* 2020; 5(11). DOI: [https://doi.org/10.1016/S2468-2667\(20\)30236-X](https://doi.org/10.1016/S2468-2667(20)30236-X).

politically neutral and respected leadership, with wide knowledge of NCDs; more partnerships and collaborative efforts; and improved promotion of the Commissions.¹⁴ Other suggestions included implementation of a survey to determine the extent to which the NNCDs/equivalents' message was being properly received by the intended audiences, and implementation of recommendations based on the survey findings; reminders to policymakers that the establishment of NNCDs/equivalents was 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 Caribbean regional body comprising representatives of NNCDs/equivalents.¹⁴

With regard to actions to facilitate meaningful, effective partnerships for NCD prevention and control, the CSOs and key stakeholders/thought leaders suggested the following actions:¹⁴

- Establish a grouping, such as an NNCD or equivalent, ensuring mutuality of interest; conducting due diligence; identifying and managing conflict of interest; operating within a common frame-work, 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;
- Convene 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".

Other recommendations for improved multisectoral action

It has been documented that effective multisectoral action may be difficult to achieve.⁵⁰ Several of the WHO Best Buys, Effective Interventions, and Other Recommended Interventions⁵¹—evidence-based policy options and other actions for NCD prevention and control that include taxation, product reformulation, restrictions on advertising, and school-based programmes—require legislation and regulations outside the direct responsibility of the health sector, reinforcing the critical need for multisectoral action to enable advances in NCD reduction.

The 2016 POSD evaluation found that the whole-of-government and whole-of-society responses required for NCD reduction needed strengthening, and made a recommendation for further

development and support for national multisectoral leadership.⁵²

The 2018 report of the WHO High-level Independent Commission on Noncommunicable Diseases included recommendation 4.f): "Governments should ensure the meaningful engagement and participation of civil society and people living with NCDs and mental disorders, including, where appropriate, by strengthening civil society and alliances, particularly in low- and middle-income countries. Governments should work with civil society to raise awareness, increase advocacy, deliver services, and monitor progress. Beyond civil society, multisectoral mechanisms, such as national NCDs commissions and equivalents of the

Global Coordination Mechanism, can be employed to ensure wide consultation."⁵³

Similarly, the recent mid-point evaluation of the WHO NCD GAP 2013-2020,⁵⁴ which has been extended to 2030,⁵⁵ made a recommendation as follows: "WHO Secretariat and Member States to consider how they can more effectively promote and support multisectoral engagement on NCDs." WHO has produced guidelines for establishing multisectoral coordination mechanisms at country level for both NCD prevention and control¹⁵ and tobacco control.¹⁸ In recommending approaches to establish coordination mechanisms such as NNCDs/equivalents, WHO identifies five elements and five strategies.¹⁵

The **five elements** are

1. high-level political leadership that has the authority and resources, monitors progress, and ensures adherence to international commitments—this is stated to be the most critical element of an effective multisectoral coordination mechanism for NCDs;
2. clear scope and mandate for all the participating sectors;
3. a skilled and well-staffed secretariat—this is critical to providing the necessary operational support to the mechanism—as well as sensitized focal persons in all relevant ministries;
4. a costed, joint workplan and earmarked funds, essential for seamless implementation; and
5. a set of process and outcome indicators against which progress is regularly measured.

The **five strategies** comprise

1. influencing the setting of a political agenda, thereby ensuring high-level political support for action across sectors;
2. generating evidence to make the business case for NCD prevention and control, and showcase the relevance of NCD interventions for the goals of partner ministries;
3. close monitoring of implementation through process indicators and periodic reporting to the highest-level authorities, which could help to galvanise momentum in the mechanism;
4. involving all key stakeholders, not only various ministries within the government, but also intergovernmental agencies, international development partners, and civil society organisations, which can support the work of the mechanism through specific technical and financial inputs; and
5. engaging with the private sector, exploring and identifying the best means to do so in a transparent and accountable manner.

⁵⁰ Murphy MM, Unwin N, Hassell TA, Bishop L, Guell G. Evaluating policy responses to NCDs in seven Caribbean countries: challenges to addressing unhealthy diets and physical inactivity. *Pan American J of Public Health*, 2018; 42:e174. Available at: <https://bit.ly/2F0qADV>.

⁵¹ World Health Organization. Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: 2017; WHO. Available at: <https://apps.who.int/iris/handle/10665/259232>.

⁵² Port of Spain Declaration Evaluation Group. Evaluation of the 2007 CARICOM Heads of Government Port of Spain Summit Declaration: a report on behalf of PAHO/WHO and CARICOM. September 2016. Available at: <https://www.food4changecaribbean.org/wp-content/uploads/2016/10/ACCELERATING-ACTION-ON-NCDs-POSDEVAL-Report-1.pdf>.

⁵³ World Health Organization. Time to deliver: report of the WHO Independent high-level commission on noncommunicable diseases. Geneva: 2018; WHO. Available at: <https://apps.who.int/iris/handle/10665/272710>.

⁵⁴ World Health Organization. Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013-2020 (NCD-GAP), Volume 1: Report. Geneva: November 2020; WHO. Available at: https://cdn.who.int/media/docs/default-source/documents/about-us/evaluation/ncd-gap-final-report.pdf?sfvrsn=55b22b89_22&download=true.

⁵⁵ World Health Organization. WHO discussion paper for the expert regional consultations (version dated 20 August 2021). Development of an implementation roadmap 2023-2030 for the global action plan for the prevention and control of NCDs 2013-2030. Geneva: 2021; WHO. Available at: [https://cdn.who.int/media/docs/default-source/documents/health-topics/non-communicable-diseases/eb150---who-discussion-paper-on-ncd-roadmap-development-\(20-aug-2021\)-for-web.pdf](https://cdn.who.int/media/docs/default-source/documents/health-topics/non-communicable-diseases/eb150---who-discussion-paper-on-ncd-roadmap-development-(20-aug-2021)-for-web.pdf).

METHODOLOGY

The 2018 NCM-TC Toolkit¹⁸ is one of many guidelines produced to assist countries in their implementation of the FCTC. The Toolkit defines an NCM-TC as a “multisectoral institution established by the government to coordinate tobacco control within the country and with international entities such as the Convention Secretariat, and to oversee general governance-related issues for tobacco control”. It further states that “such a mechanism should include key national and subnational actors and stakeholders who play meaningful direct or indirect roles in tobacco control”. The Toolkit is a comprehensive, practical tool that includes tools, templates, models, and examples to support the establishment, effective functioning, and sustainability of tobacco control governance mechanisms, and its primary

audience is governments, particularly ministries of health and tobacco control focal points. It provides model terms of reference and process, output, and outcome indicators adapted from the WHO guidance for establishing multisectoral coordination mechanisms for NCD prevention and control,¹⁵ underscoring its links with, and immediate relevance to, NNCDs/equivalents.

The Toolkit identifies ten best practices for establishing and/or strengthening NCM-TCs, based on country experiences and existing WHO, FCTC Secretariat, and UNDP guidance. These best practices, though developed for NCM-TCs, are directly applicable to entities that consider wider NCD-related issues, such as the NNCDs/equivalents.

The **ten best practices** are:¹⁸

1. Request the highest levels of a government's executive branch to officially establish and announce formation of the NCM.
2. Ensure that a high-ranking official chairs the NCM and that NCM representatives hold senior level positions in their institutions.
3. Seek broad representation from across government sectors and maintain wide consultation with, or consider formally including, representatives from civil society.
4. Ensure continuity in membership and participation.
5. Develop explicit terms of reference or guidelines for NCM representatives, the NCM, the NCM Secretariat and any ancillary bodies.
6. Develop an explicit code of conduct for how all members of an NCM interact and reduce their engagement with tobacco industry representatives.
7. Develop clear scope and mandate, as well as rules and procedures, for the NCM.
8. Make the tobacco control focal point a central member of the NCM and establish a strong secretariat.
9. Prioritize accountability and transparency, including comprehensive, accurate reporting.
10. Create a costed, joint action plan and ensure the NCM is fully and sustainably financed.

The methodology for this assessment of the NNCDs/equivalents, with a view to improving their functioning and determining their potential to act as NCMs-TC, included:

- A desk review of, and online search for, documents and other materials pertinent to the NCD situation in the region and globally; NNCDs/equivalents in the region; and the establishment and functioning of NCMs-TC, including the documents and other materials referenced in the above and subsequent sections of this report.
- Development and administration of a questionnaire to chairpersons of 15 NNCDs/equivalents,⁵⁶ their designated representatives, senior officials working in NCD prevention and control, or NCD focal points, over the period August to September 2021. The instrument was disseminated by the HCC Secretariat via email, and included items related to the ten core NNCD principles⁵⁷ stated in the HCC document *Getting National NCD Commissions UP AND RUNNING—A Framework for the Establishment and Strengthening of National NCD Commissions in the Caribbean: towards a more effective multisectoral response to NCDs, Part II*.¹¹

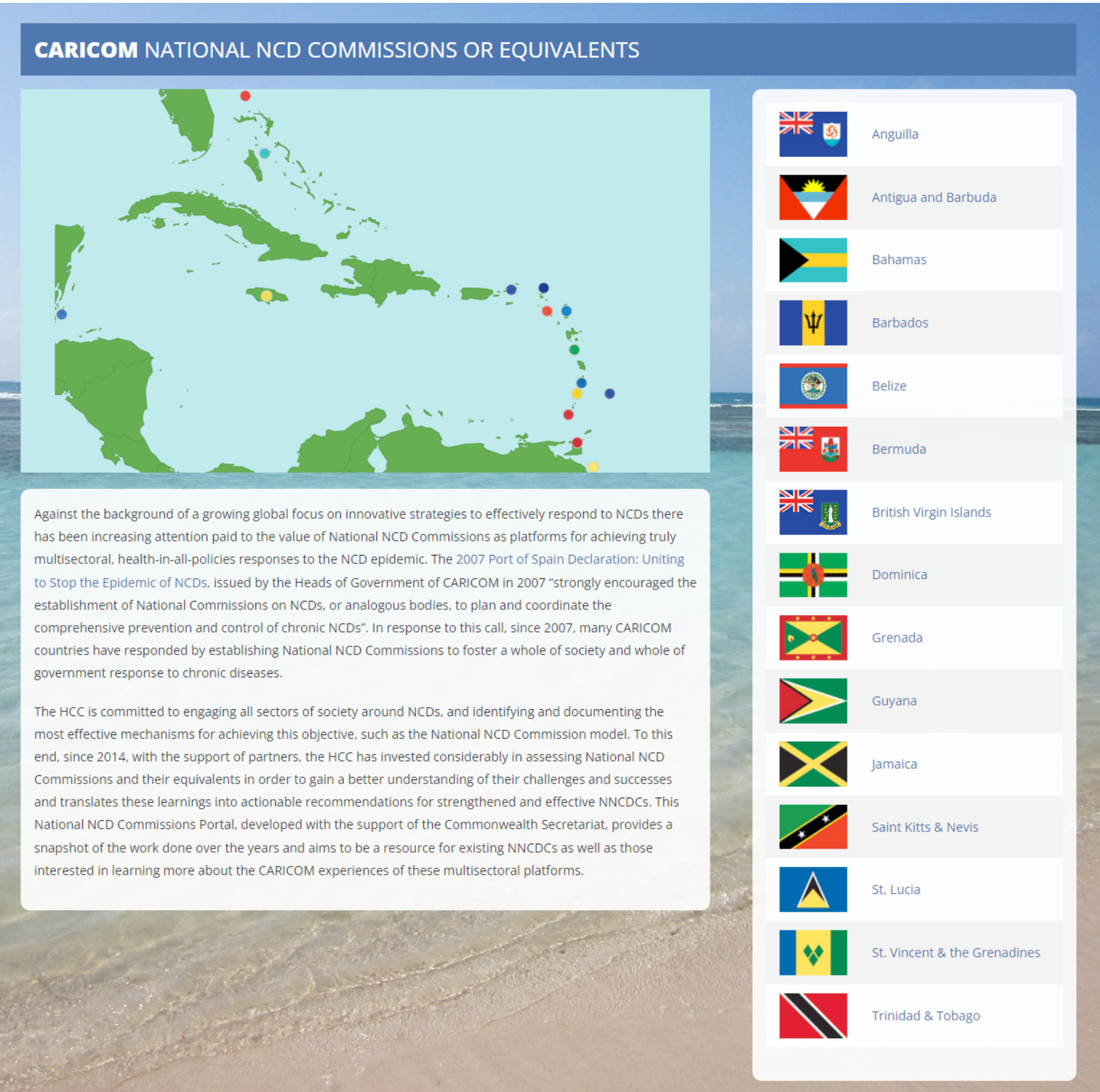


- The questionnaire, which is in **Annex 1**, sought to determine:
 - general information on the entities, including their current status, active or inactive;
 - current and desired membership;
 - operational framework, including terms of reference, accountability and transparency mechanisms, actions taken specifically in response to COVID-19, level of resources, degree of autonomy, and level of influence;
 - partnerships and networks;
 - main successes and success factors;
 - main challenges and gaps;
 - main lessons learned;
 - self-perceived performance and impact on NCD prevention and control in their respective countries;
 - capacity and needs to function as an NCM-TC, if such a mechanism did not already exist; and
 - main recommendations for improved functioning of NNCDs/equivalents, including possible/desired regional and national support.
- Analysis of the responses received, with the development of draft, penultimate, and final reports according to the report outline agreed with the HCC Secretariat, and review of the draft report by representatives of contributing NNCDs/equivalents, PAHO, and HCC.

⁵⁶ The NNCDs or equivalents were selected based on the 15 entities listed in the HCC database at <https://www.healthycaribbean.org/national-ncd-commissions-or-equivalents/>, as at 25 August 2021.

⁵⁷ The core principles comprise legitimacy, authority, multisectorality, credibility, transparency, accountability, conflict of interest procedures, adequacy of resources, sustainability, and strategic planning and management.

SURVEY RESULTS



Screenshot of the HCC National NCD Commissions or Equivalent web portal

Context and status

The NNCDs/equivalents that were invited to complete the survey and those that responded are listed in **Annex 2**, with an indication of the time of their launch or first meeting, their current status—active or inactive—and the person(s) who responded on behalf of the entities.

Of the 15 entities requested to complete the electronic instrument, eight responded—from Antigua and Barbuda, The Bahamas, Bermuda, Belize, Grenada, Guyana, Jamaica, and St. Lucia—for a response rate of 53 percent. Several email reminders were sent to the entities, but only three completed instruments were received by the initial deadline of 17 September 2021. Three more were received 18-20 September, one on 29 September, and the last on 1 October. Responses to some of the items were incomplete or unclear, and though follow-up clarification was requested, not all the NNCDs/equivalents responded to these requests.

No response was received from the Barbados National NCD Commission, which has been one of the few continuously functioning Commissions since its inception in 2007, due to circumstances beyond the chairperson’s control. Further, from informal contacts and knowledge of the situation in the region, **the perception is that the other NNCDs/equivalents that did not respond have been inactive or dormant for some time, making it difficult to find a representative to respond to the survey.**

Of the eight entities that responded, five (5)—Antigua and Barbuda, The Bahamas, Grenada, Guyana, and Jamaica—identified as active, and, as requested, responded to the entire questionnaire. Three (3)—Belize, Bermuda, and St. Lucia—identified as inactive and, as directed, responded only to very limited, specific items on the instrument, mainly addressing reasons for their inactivity, the existence of an NCM-TC in their respective countries, and recommendations for improved functioning of NNCDs/equivalents.

However, one of those identifying as inactive—Bermuda—had only become so since March 2020, the onset of the COVID-19 pandemic, when the entity’s team was mobilised to assist with the pandemic response. This entity indicated its intent to resume meetings, virtually, in November 2021, to “reconnect, give thanks and appreciation for what members did during the ongoing pandemic, and look at the way forward, as we will have to learn to live with COVID-19 and its impact on NCDs.” Bermuda was therefore counted as active and asked to respond to all the items. **Therefore, except where indicated, the results summarised below are based on responses from the six active entities.** The entities in Guyana and Jamaica had been re-constituted and re-established, respectively, in January 2021 and March 2021, and so had relatively new chairpersons and members.

Of note, the two inactive entities were established/launched in 2009 and 2013, and became inactive in, respectively, 2013 and 2019. Reasons given include lack of political will, with limited success in attempts to engage the MoH; failure to re-constitute the NNCDC or equivalent after the expiry of its term; diversion of public health focus and resources due to COVID-19; and change in government.







Only two respondents—The Bahamas and Grenada—had previously participated in HCC information-gathering exercises: one had provided information in informal settings during meetings and through contribution to the HCC NNCDC portal, and the other had contributed to the process to develop the HCC’s TNA-NCDs.

Overview—authority/political mandate, meetings, membership, and operational framework







Table 1 summarises information on the authority/political mandate, meetings, and membership of the six active NNCDs/equivalents, while **Table 2** summarises their operational framework.

Table 1. Authority/political mandate, meetings, and membership of six NNCD/ equivalents in the Caribbean

NS = Not stated

	 Antigua & Barbuda	 Bahamas	 Bermuda	 Grenada	 Guyana	 Jamaica
Authority/political mandate for establishment	MoH	Prime ministerial decree	Established in response to national health promotion strategy	Prime ministerial decree	Presidential decree	Minister of Health & Wellness
Frequency of meetings	Monthly, sometimes more often if needed for programme implementation	Quarterly - core committee meetings, and annually - general meeting	Monthly - action groups; quarterly - action group chairs; and annually - full membership	Monthly	Monthly	Two-monthly
Most recent meeting	8 September 2021	22 July 2021	2018 – last annual meeting; other meetings have been held since	June 2021 – meetings held online more recently due to COVID-19 restrictions; Internet instability led to the postponement of one meeting	August 2021 – meetings held online more recently due to COVID-19 restrictions; only two face-to-face meetings held to date in 2021	8 July 2021
Number of members	12	40-60 - not all are core members	Up to 45	23	28 - 23 commissioners, 4 ex-officio members, 1 secretary	28
Government sector representation	Education, Health; Other: Community Nursing, Nutrition Department, Health Information, Medical Benefits Scheme	Agriculture, Education, Finance, Foreign Affairs, Health, Social Services; Other: Labour & National Insurance, Public Service, Transport & Aviation, Tourism, Works (variable levels of interaction with these entities)	Education, Health, Social Services; Other: Third Sector ⁵⁸	Agriculture, Education, Health, Social Services; Other: Youth, Culture, Food & Nutrition Council, Drug Control Secretariat, National Disaster Management Agency	Agriculture, Education, Finance, Foreign Affairs, Health, Social Services, Trade/Industry/Business	Agriculture, Education, Foreign Affairs, Health, Social Services, Trade/Industry/Business; Other: Planning Institute of Jamaica, Local Government & Rural Development, National Food Industry Task Force, National Health Fund, National Council on Drug Abuse

⁵⁸ <https://www.bermudacommunityfoundation.org/COVID-19ampOther/BermudaEmergencyFund/3rdSectorCoordinatedCrisisResponse.aspx>.




	 Antigua & Barbuda	 Bahamas	 Bermuda	 Grenada	 Guyana	 Jamaica
Civil society representation	Diabetes Association	Atlantic Region Commonwealth Nurses & Midwives Federation, Christian Council, Communications & Public Officers Union, Dental Association, Insurers Association, Sickle Cell Association, Cancer Society, Nurses Association, Sister/Sister Breast Cancer Support Group, Conference of Seventh Day Adventists, Women's Crisis Centre, Southern College, University of The Bahamas	Diabetes Association, Heart Foundation, Cancer and Health Centre, Open Airways, Red Cross, Keep Bermuda Beautiful, The Family Centre	The Connection , ⁵⁹ Heart Foundation, Trade Un-ion Council, Nurses Association, Technical & Allied Workers' Union, Media Workers' Association, Conference of Churches, faith-based organisations, T.A. Marryshow Community College	University of Guyana, Press Association, Red Cross, Medical Council, Diabetes Association	Nurses Association, Medical Association, Press Association, Diabetes Association, Heart Foundation, Cancer Society, University of the West Indies - Caribbean Institute for Health Research, Violence Prevention Alliance
Private sector representation	None	A Healthy Difference - Nutrition Consultants, Chamber of Commerce & Employers Confederation, Electricity Corporation, Central Bank, Commonwealth Bank, Doctors Hospital Health Systems, Elite Fitness Consultants, Royal Bank of Canada, Scotia Bank	Argus Insurance, BFM (Insurer)	Chamber of Industry & Commerce	Private Sector Commission	Private Sector Organisation
Other desired representation	Private sector, youth	None	Finance, International Business, Tourism Authority, faith-based organisations, youth organisations	Bureau of Standards	Health-related NGOs, e.g., Cancer Association	None – other participation facilitated through sub-committees



⁵⁹ <https://theconnectiongrenada.com/>.

Table 2. Operational framework of six NNCD/equivalents in the Caribbean

NS = Not stated

	 Antigua & Barbuda	 Bahamas
Organisational location	MoH	MoH
Organisational structure	NS	Executive Committee comprising Chair and the leads of the 12 subcommittees
Term limits	None	Three years
Specific terms of reference/mandate/scope of work	Yes	Yes
Main functions	Providing advice to government on NCD legislation/policy/regulations/programmes; advocacy; programme development and implementation; M&E; health promotion; communicating for health	Providing advice to government on NCD legislation/policy/regulations/programmes, advocacy, M&E, health promotion, communicating for health
Conflict of interest policy/mechanisms	No	Yes – the entity “does not accept or receive support from any entity that trades in or promotes products that are part of the NCD risk profile”

 Bermuda	 Grenada	 Guyana	 Jamaica
MoH	MoH and St. George’s University	Office of the President	Ministry of Health & Wellness
Lead Agencies - responsible for specific goals in the national health promotion strategy; Action Groups - assist with plan development and review; Executive Committee - oversight of Lead Agencies, support to Action Groups; Health Promotion Office - oversight of coordination and implementation of the national health promotion strategy	Chair; no deputy; no executive positions	His Excellency the President of Guyana, Head of the Presidential Commission on NCDs (or designate); Chairman; Vice Chairman; Secretary; public sector members; private sector members; international and regional health organisation members	Situated under the NCD & Injury Prevention Unit in the Ministry of Health and Wellness; led by a Chair who works in coordination with the Director of that Unit; supported by an administrative secretary and technical officer; nine sub-committees, each with chair and co-chair
NS	Three years	Two years	Two years
Yes	Yes	Yes	Yes
Advocacy, programme development and implementation, M&E, health promotion, communicating for health, resource mobilisation	Providing advice to government on NCD legislation/policy/regulations/programmes; advocacy; promotion of research; health promotion	Providing advice to government on NCD legislation/policy/regulations/programmes, advocacy, programme development and implementation, M&E, promotion of research, health promotion, communicating for health, resource mobilisation; Other: <i>(not specified)</i>	Providing advice to government on NCD legislation/policy/regulations/programmes; advocacy; programme development and implementation; M&E; promotion of research; health promotion; communicating for health; resource mobilisation
No	No	No	No

	 Antigua & Barbuda	 Bahamas
Code of ethics	No	No
Standard operating procedures/rules of procedure	No	Yes
Own strategic workplan	No	Yes
Framework of national NCD prevention and strategy or plan of action	Yes - "outdated"	Yes - 2017-2022
Accountability mechanisms	No	Yes – quarterly written reports, including minutes of meetings, submitted to the MoH
Own resources	No	No
Dedicated secretariat	No	Yes
Decision-making process	NS	Consensus
Own communication strategy	No	Yes
Sustainability mechanisms in place	No	Yes – funding for the entity was included as part of the Cabinet Conclusion that led to its establishment
Specific action related to COVID-19	Yes – public service announcements (PSAs) on national television and five radio stations on domestic violence during a pandemic; webinar on men's health during COVID-19; screening for NCDs; sharing of tips on surviving COVID-19 for various groups, including children, parents, and older persons	Yes – media awareness campaign to highlight the precautions and preventive measures needed to get through the pandemic, including the importance of adhering to safety protocols and other measures

 Bermuda	 Grenada	 Guyana	 Jamaica
No	No	No	No
Yes	No	Yes	No
Yes	Yes	Yes	Yes - in development
Yes	No	Yes - last plan 2013-2020; new plan 2021-2030 in draft, awaiting MoH approval	Yes - last plan completed in 2013, new plan in development
Yes – quarterly monitoring reports that use a stoplight system to assess the level of progress for each action, on a scale of 1 to 5	No	Yes – minutes of meetings and quarterly reports sent to Minister of Health and the Office of the President	Yes – biannual written reports submitted to the Ministry of Health & Wellness
No	Yes	Yes	Yes
No	No	Yes	Yes
Consensus	Consensus	Consensus	Majority
No	No	Yes	No
No	No	No	No
No	Yes - PSAs	No	No

Resources, degree of autonomy/decision-making authority, and level of influence

With regard to **resources**, three entities indicated that they had their own financial, human, and infrastructural resources; three did not.

- The three that did not have their own resources indicated that they obtained resources from, respectively, 'general funds from the MoH, funds from PAHO, the OECS, and other social partners'; the MoH; and 'the health promotion office and the resources of lead agencies'.
- Of the three that had their own resources, one noted that it had received official correspondence from the MoH regarding an annual subvention, but had received nothing from that source, to date. That particular entity mobilised funds from various sources, had been able to receive two small grants from the private sector, and had recently submitted an application to another funding source to engage in training workshops and product development. Another NNCCDC/equivalent anticipated obtaining funds through the MoH based on the workplan being developed, and the third, operating out of an office provided by the MoH, obtained a subvention from the national budget.

Table 3 below summarises the entities' self-assessment of their degree of autonomy/decision-making authority.

Table 3. NNCCDCs'/equivalents' self-assessed degree of autonomy/decision-making authority

Autonomy/decision-making authority	Country 1	Country 2	Country 3	Country 4	Country 5	Country 6
Very high						✓
High					✓	
Medium			✓	✓		
Low	✓	✓				
Very low						

It is perhaps heartening to note that no entity self-assessed its degree of autonomy/decision-making authority as 'very low'. The entity self-assessed as 'very high' was the NNCCDC/equivalent based in the Office of the President, the only one located at such a high level; and the entity that self-assessed as 'high' was the NNCCDC/equivalent focused on the implementation of the national health promotion strategy, a very specific framework for action. **Table 4** opposite summarises the entities' self-assessment of their level of influence on key stakeholders.

Table 4. NNCCDCs'/equivalents' self-assessed level of influence on key stakeholders

Countries and self-assessed levels of influence on key stakeholders	Key stakeholders				
	Policy-makers	Technical personnel	NGOs/CSOs	General public	International development agencies
Country 1					
Very high					
High			✓	✓	
Medium					
Low	✓	✓			✓
Very low					
Country 2					
Very high					
High					
Medium	✓	✓	✓		
Low					
Very low				✓	✓
Country 3					
Very high					
High	✓	✓	✓		
Medium				✓	✓
Low					
Very low					
Country 4					
Very high					
High					
Medium	✓	✓	✓		
Low				✓	✓
Very low					

Countries and self-assessed levels of influence on key stakeholders	Key stakeholders				
	Policy-makers	Technical personnel	NGOs/CSOs	General public	International development agencies
Country 5					
Very high					Not Stated
High				✓	
Medium		✓	✓		
Low	✓				
Very low					
Country 6					
Very high					
High		✓	✓		
Medium	✓			✓	✓
Low					
Very low					

It is worth noting that no NNCDCC/equivalent assessed its influence with policymakers as ‘very high’, and only one assessed its influence with policymakers as ‘high’.

Partnerships/networks

Three entities did not respond to this item. The other three indicated the following agencies or organisations with which they partnered and/or networked:

- Ministry of health; government ministries; NGOs; academia (University of the West Indies, UWI)
- Ministry of health; PAHO

- Ministry of youth, sports, culture and the arts, ministry of health, ministry of agriculture, ministry of tourism and civil aviation, and ministry of education; community college; national disaster management agency; national organisation of women; medical association; conference of churches; media workers’ association; chamber of commerce and industry; drug control secretariat; food and nutrition council; trade union council; and nurses’ association.

Regarding other multistakeholder entities/bodies addressing NCD prevention and control in the country, one entity did not respond, one indicated that there were no other such bodies, and four

entities indicated that there were such bodies, namely:

- Bahamas Healthy Lifestyles Team⁶⁰ (HaLT) targeting NCD prevention and healthy lifestyles in children
- Bermuda First⁶¹
- Grenada Pink Ribbon Society,⁶² Grenada Heart Foundation,⁶³ and Grenada Diabetes Association⁶⁴
- Jamaica National Food Industry Task Force

The extent to which the NNCDCCs/equivalents collaborated/cooperated/interacted with the other multistakeholder bodies varied from ‘to a very significant extent’ and ‘to some extent’, to ‘not at all’.

Several items addressed the work done by the HCC with NNCDCCs/equivalents to foster their development and encourage networking among them:

- Five entities indicated their familiarity with the HCC NNCDCC portal (one entity did not respond to this item) and four of those indicated that they had used the portal within the past five years. The entity that had not used it was one of the recently re-constituted NNCDCCs/equivalents. Of those respondents who had used it, two found it ‘very helpful’, one found it ‘helpful’, and one found it ‘somewhat helpful’.
- Four entities benefitted from HCC’s capacity building exercises. When asked for further information on these exercises, one entity did not respond; one indicated participation in stakeholder meetings; one stated “browsing the HCC website”; and one—a recently

re-constituted entity—was unsure of the exact nature of the exercise.⁶⁵

- All six entities were aware of the HCC network of NNCDCC/equivalent chairpersons, all were members of the network, and all had participated in virtual meetings of the network.
 - One entity found the meetings ‘extremely helpful’, highlighting the sharing of experiences and best practices that took place.
 - Two entities found the meetings ‘very helpful’, one in getting the perspectives of other NNCDCC Chairs and identifying potential challenges to getting things done, and the other noting the meetings’ utility despite having participated in only one meeting.
 - Two entities found the meetings ‘helpful’, one indicating that the experiences shared with others had enabled initiation of different community initiatives, while the other gave no reason for the assessment.
 - One found the meetings ‘somewhat helpful’, noting that the relevance of the scope of work and targets discussed were sometimes not aligned with the prevailing national focus.

Successes/success factors

Five of the NNCDCCs/equivalents indicated their top five successes within the past five years, with one of the recently re-constituted entities declining to do so, given that it had been in operation for less than six months. The five entities indicated the following achievements:

- Advocacy with mothers of school-aged children for low sodium in the diet of the children;

⁶⁰ <https://www.facebook.com/Healthy-Lifestyle-Team-HaLT-Bahamas-2383530805005918/>.
⁶¹ <http://bermudafirst.bm/>.
⁶² <https://www.facebook.com/grenspinkribbon/>.
⁶³ <https://www.facebook.com/GrenadaHeart/>.
⁶⁴ <https://www.facebook.com/GrenadaDiabetesAssociation/>.
⁶⁵ This last entity was the Guyana Presidential NNCDCC, which in June 2018 benefited from a study tour to the Barbados NNCDCC and a visit by the Chair of the Barbados NNCDCC and the HCC Executive Director to Guyana for an in-country capacity-building exercise. See <https://www.healthycaribbean.org/?s=Guyana+NNCDCC+visit+to+Barbados+NNCDCC>.

national stakeholders' meeting on sugar-sweetened beverages; launch of childhood obesity conference; and Art Students against Obesity mural painted at high school by art students and teachers of the school.

- Policy initiatives, including development of a childhood obesity prevention policy for eventual submission to ministries of health and education; public education; and advocacy.
- Establishment and sustained operation of the NNCD; support for the development of a national NCD Strategic Plan and protocols for community screening of hypertension, especially in long-term residential care facilities; healthy workplace and healthy schools initiatives; and national physical activity guidelines.
- Completion of action plans for 15 of the 18 goals in the national health promotion strategy; signing of memoranda of understanding with each Lead Agency; and implementation of a media campaign in support of the health promotion strategy.
- Initiation of a program to distribute glucometers to persons living with diabetes; national communication on NCDs; continuing medical education on NCDs; support for research related to adolescent health; and work with the ministry of education to regulate food vendors around schools.

Success factors identified by four of the entities included:

- Stakeholders' collaboration and communication, and building partnerships.
- The commitment and dedication of a few members of the NNCD; equivalent.
- The composition and membership of the entity; an established and funded Secretariat; support from, and a close working relationship and partnership with, PAHO; and the dedication and passion of the membership to address the tasks identified, around a common purpose.

- Development of a framework for the implementation of the national health promotion strategy.

Main challenges/gaps and mitigating actions

The six entities identified the main challenges and gaps over the past five years as:

- Lack of finances; non-attendance at meetings by some members; inadequate support from some members for the initiatives of the NNCD; equivalent; and competing priorities of the ministry.
- Lack of financing; lack of appreciation of the entity by the MoH and government generally; lack of respect for the entity; lack of acknowledgement of biannual reports sent by the entity to the MoH; and lack of inclusion of the entity in decision-making.
- Responsibilities related to the NNCD; equivalent falling mostly on persons already busy with full-time commitments, requiring them to juggle their regular tasks with entity tasks, making time limitations a major challenge; difficulty in obtaining data on NCD trends, particularly morbidity data, as the systems for routine data collection are not fully functional; possible pushback from industry players who may view the work of the entity as detrimental to their bottom line; difficulty mobilising resources to carry out the tasks of, and proposals from, the entity; and ensuring engagement of all sectors of society.⁶⁶
- Competition with other health challenges; lack of authority to seek independent funding sources; inadequate prioritisation of NCDs in the national health agenda compared with other issues such as natural disasters and the COVID-19 pandemic; and changes in health leadership in the public sector, at both administrative and technical levels.
- Inadequate commitment, given competing agendas; insufficient resources (human and financial); limited political will, due to lack of

understanding of what is needed to change current NCD issues; and COVID-19.

- Lack of resources and small staff.

Four entities indicated actions taken to overcome these challenges and gaps:

- Development and submission of grant proposals to prospective funders, including private sector entities, to mobilise resources.
- Successful requests for assignment of an administrative secretary and technical officers to support the work of the entity (from a recently re-constituted entity). Anticipated actions include obtaining additional support staff for the MoH NCD unit; provision of incentives and training in public engagement and communication strategies for the entity's members, to encourage their efforts; improvements in data collection systems for M&E; and consideration of the creation of NCD fellowships to build the capacity of, and equip, persons to respond to NCD epidemic.
- Continued advocacy where possible; strategic partnerships and conversations; avenues to finance initiatives through arrangements and direct payments to vendors; and weaving NCD priorities into the national disaster response.
- Mobilisation of volunteers and private sector support.⁶⁷

Main lessons learned

Three NNCDs/equivalents identified the main lessons learned as:

- The power of integration; the critical need for mechanisms of communication and stakeholder analysis; and the critical importance of leadership.
- Even small steps are still counted as progress; the achievement of health benefits requires

all players to serve a role; the whole-of-government response does not require all of government acting in concert all the time; relationships should be used to establish rapport and to highlight potential initiatives that propel health-insuring policies; and it pays to be consistent and ever aware of potential opportunities, so that they can be pursued.

- Unless NCDs become a national priority—like COVID-19—progress will never be made; celebrate small wins; and a 'dedicated' NNCD; equivalent is needed, tasked to do the work, and with more time and resources to do so.

Overall assessment of performance and impact on NCDs

In assessing their overall performance and impact on NCD prevention and control in the country over the past five years, there was no response from two entities, one of which was a recently re-constituted NNCD; equivalent. Of the other four entities, two assessed their performance as 'successful', and two as 'somewhat successful'. One of the latter did not respond to a request for justification of the assessment, but the other three noted that:

- The entity was assessed as 'successful' because it had managed to engage the public through the various forms of media and outreach to schools and parent-teacher associations. It had executed two projects related to NCDs in collaboration with the MoH and ministry of education, and was in the final stages of completing a childhood obesity prevention policy for submission to those ministries. The NNCD; equivalent was currently mobilising resources for its "Good Food" initiative, and despite the lack of recognition of its efforts by the MoH, it continued to perform its functions, recognising the importance of its role.

⁶⁶ These constitute "expected challenges" from a recently re-constituted entity.

⁶⁷ Seeking private sector support raises for consideration the issue of 'stakeholder capitalism', a form of capitalism in which companies do not only optimise short-term profits for shareholders, but also seek long-term value creation, by taking into account the needs of all their stakeholders, and society at large. Obtaining such support also emphasises the importance of the identification and management of conflict of interest, and measures to prevent industry interference in progress to public health objectives.

- The entity was assessed as 'successful' because it had been able to sustain advocacy. However, the NNCD/ equivalent had not worked to its potential thus far (recently re-constituted entity).
- The entity was assessed as 'somewhat successful' because a large proportion of the work is targeted at health promotion, and it is very difficult to assess the effect of health promotional activities.

One recently re-constituted NNCD/ equivalent declined to assess its overall impact on NCD prevention and control in the country, given its short time in operation; the other five entities assessed their overall impact as 'medium'. One of the latter did not respond to a request for justification of the assessment, but the other four noted that:

- The entity could have accomplished a lot more and had greater impact, if allowed more involvement in decision-making by the MoH with respect to NCDs and even COVID-19, given the latter's impact on PLWNCDs. The entity's advice had not been solicited and its submissions had been ignored. In addition, the absence of the entity's focal point in the MoH because of the absence of a senior medical officer for health and lack of funding made the entity's role much more challenging.
- A number of initiatives had been formally recognised and incorporated into the actions of the ministries of education and health.
- The entity was established to be a unifying vision and voice for action, but may have lost some ground due to COVID-19 and limited resources due to competing priorities.
- The entity had not actively engaged the NCD Department of the MoH in the past, and this may have limited its impact.

Functioning as national coordination mechanism for tobacco control

All respondents were asked to indicate the existence, or not, of a multisectoral national coordination

mechanism for tobacco control in their respective countries. Of the eight entities that responded to the survey, three—Antigua and Barbuda, Guyana, and Jamaica—indicated that their countries had NCMs-TC; all three countries also had active NNCDs/ equivalents. Regarding collaboration/ cooperation/ interaction between the NNCD/ equivalent and the NCM-TC, Guyana indicated that this occurred 'to a very significant extent', while Antigua and Barbuda and Jamaica stated that it occurred 'to a significant extent'.

Of the three entities in countries that had no NCM-TC, two indicated that the NNCD/ equivalent undertook specific tobacco control activities 'to some extent' and thought it 'somewhat feasible' that the entity could assume the functions of an NCM-TC. The third entity stated that the NNCD/ equivalent did 'not at all' address tobacco control and thought it 'not at all feasible' for the entity to assume such functions. Though not required to address the issue, two of the three countries that had NCMs-TC thought that it would be, respectively, 'somewhat feasible' and 'very feasible' for the NNCD/ equivalent to assume functions related to tobacco control.

Five entities identified requirements for the NNCD/ equivalent to assume NCM-TC functions:

- Greater recognition, respect, and appreciation from the MoH for the entity.
- Positioning of the NCM-TC within one of the sub-committees of the NNCD/ equivalent.
- Formal designation by the government to serve in this role; dedicated funding for activities; training and promotion/ awareness campaigns; commitment from government to adopt tobacco control policies and tobacco legislation; and clear articulation of realistic expectations and associated timelines.
- Human resources and multisectoral action; a clear and defined strategy; and alignment of the strategy with other health efforts.
- No involvement of any NNCD/ equivalent member in any aspect of the tobacco

industry, with members' awareness of the national tobacco law, and their support for, and readiness to implement, interventions according to the FCTC guidelines.

Respondent recommendations

Whether their entities were active or inactive, all respondents were asked to make recommendations for improving the performance of the NNCD/ equivalents. Their recommendations are summarised below.

- **Change in name and structure of the entity.** Of the eight entities that responded, only two thought that a different name and structure for the NNCDs/ equivalents would strengthen their visibility and performance. One of these two entities commented that "the biggest challenge is the term NCDs, defining what it means so that people understand it, and finding a way for it to connect with the people, policymakers, and ministers. If NCDs became a true national priority (just like COVID-19 and HIV), where focused attention was given to it, we would then strengthen its visibility and performance". The other entity suggested that the name of the NNCD/ equivalent be changed to "National Health, Wellness and Happiness Advisory Board".
- **Main functions of the NNCD/ equivalent.** The entities recommended functions in the frequency summarised below:
 - *Providing advice to government on NCD legislation/policy/regulations/programmes* – all eight entities
 - *Advocacy* – six entities
 - *Promotion of research* – six entities
 - *Health promotion* – five entities
 - *Monitoring and evaluation* – five entities
 - *Communicating for health* – four entities
 - *Programme development and implementation* – three entities
 - *Resource mobilisation* – three entities

- *Other, please specify* – no entities
- **Establishment of a Caribbean regional NCD Commission/Task Force/Working Group.** Six of the eight respondents thought this would be a useful complement to the NNCDs/ equivalents. However, one of the two respondents who demurred offered the following comment: "The establishment of such a body is NOT RECOMMENDED as the competition with governments and this entity for funding makes it a less preferred approach. Grouped goals and strategies (as a region) hardly ever have the local impact desired or even promised by the bundled grant applications, as some proportion of the funding invariably is re-directed to support sponsored approaches. One-size DOES NOT and HAS NEVER fitted all." Some of the concurring six entities made recommendations regarding the proposed membership, functions, and organisational location of this theoretical regional body as below:

- *Membership:*
 - Chairs and one to two other members of each NNCD/ equivalent.
 - Decision makers in ministries of health (local CARICOM ambassadors, ministers, directors of health services and their chief executive officers); representatives from civil society; and PLWNCDs.
 - Representation from the existing NNCD chairs; PAHO and Caribbean Public Health Agency (CARPHA); HCC; OECS; private sector; and PLWNCDs.
 - Chairs of NNCDs/ equivalents; UWI; PAHO; CARPHA; NGOs; and private sector.
 - Regional religious organisation; CARICOM Regional Organisation for Standards and Quality (CROSQ); Caribbean health professional societies—cardiology, oncology, psychology; HCC; and academia.

DISCUSSION OF RESULTS

- **Functions:**
 - Sharing best practices and making recommendations to CARICOM/ Caribbean regional bodies.
 - Ensuring that political will in countries is established. The idea would be to push for legislation and budgets for NCD programmes and initiatives; to establish a reporting mechanism for all countries in the region; and to support harmonisation of initiatives and legislation in and among countries.
 - Developing agenda/goals/objectives for NNCDs/equivalents, and providing training on their development and organisation.
 - Monitoring the Port of Spain Declaration.
 - Providing advice and guidance to governments to merge economic policies with health.
- **Organisational location:** CARICOM; CARICOM, with local entity or counterparts in each country; CARPHA; HCC.
- **Other recommendations.** The entities offered additional recommendations and comments to improve the performance of NNCDs/equivalents, including their possible functioning as NCMs-TC, as below:
 - Recognition and support from the country, dedicated finances, secretariat, and committed members.
 - Reviewed terms of reference, greater synergy with the MoH NCD work programme, improved partnership with MoH and other government agencies, and the opportunity to sit at the decision-making table.
 - “The most important requirement is for the leadership/chief policy makers of countries to be serious about their stance on tobacco control. The policy articulated must be government-wide and be accepted as the mantra/final position at the health, social, educational, industrial, and financial levels.
- ‘Lip-service’ does no one any favours and adds to the frustrations of already frustrated health workers and technical advisors. Perhaps meetings at the various CARICOM Caucus of Ministers sessions are necessary for countries to understand what is required, what is at stake, and what appropriate responses or actions are required if a Member State seeks to live up to its FCTC commitment. Leaving the work of convincing ministers of health, foreign affairs, and economy/finance to civil servants or civil society will always result in less-than-optimal outcomes.”
- “Given the country’s abject failure in establishing a coordinated national response to the prevention and control of NCDs, it will be necessary to establish a structure at the CARICOM level that would hold countries accountable for establishing and financing NNCDs/equivalents.”
- More interaction/collaboration between NNCD/equivalent chairs; increased frequency of NNCD/equivalent meetings; one-page newsletter to highlight the NNCDs/equivalents around the region; more training and support on the functioning of an NNCD/equivalent; more collaboration with PAHO and CARPHA, so as to not duplicate efforts; “resurrect a new version of the POSD monitoring grid⁶⁸ to report on NCD progress”; and conduct training on how an NNCD/equivalent would function as an NCM-TC.
- Establishment of an official unit in the MoH; provision of a functional office space with staff, and a budget and support to undertake consultations and execute interventions; validated realistic annual work plans vetted by the MoH and the Office of the Prime Minister/President; and establishment of pre-determined goals or themes that are endorsed and supported by the regional body across all national organisations.

The response rate to the survey of 53%—though higher than the usual average of 33% for this type of enquiry;⁶⁹ the time taken for several NNCDs/equivalents to respond; the inadequate clarity of some responses; and statements by the respondents themselves, confirm the limited time that chairpersons or representatives of these entities are able to dedicate to the work of these bodies. All the chairpersons and representatives of the NNCDs/equivalents have full-time jobs that they must address while trying to do justice to the operations of these entities, though the entities have been recommended and recognised as critical to an effective multisectoral response to NCDs.

Membership, organisational structure, and organisational location

The wide variation in the numbers and categories of membership of the NNCDs/equivalents speaks to the need for clarification of, and agreement on, the functions of the entities to ensure that structure follows function, and underscores the comment by a respondent that “the whole-of-government response does not require all of government acting in concert all the time”. Thus, not all government ministries and departments need be primary members of the entity; there can be sensitisation of all, selection of core membership, and membership of others on sub-committees, with yet others co-opted as appropriate. Some NNCDs/equivalents appear to be overly complex and unwieldy, with numerous members and many sub-committees, and all, regardless of size and structure, gave only a modest assessment of their performance and achievements.

As might be expected, civil society representation encompassed ‘disease-specific’ CSOs/NGOs. Trade unions, academia, health professional organisations, and faith-based organisations were

also represented, but only one entity included representation from a women’s crisis centre, which can be an important ally in addressing gender-related issues.

The organisational location of all except one entity in the ministry of health does not readily lend itself to multisectoral ‘whole-of-government’ action, as has been stated by respondents to this and similar surveys, and emphasised in international guidelines for establishing or strengthening multisectoral bodies for NCD reduction. Other sectors, like many people in general, have a narrow, medicalised view of health, equating health with disease, hospitals, clinics, doctors, and nurses, unaware of the myriad other factors that contribute to, and impact on, health, and their important roles in aggravating or mitigating those factors.

Functions, frameworks, mechanisms for operation, and accountability

Prioritisation and planning are essential to attain a manageable structure that can fulfil the objectives of the entity, which should address policy development and other upstream⁷⁰ issues related to NCDs, that is, underlying causes, including the social, economic, environmental, commercial, and other determinants of health.^{71,72} The NNCD/equivalent should—in time-bound, strategically-determined periods that align with the national NCD prevention and control strategy or plan—execute actions that contribute to outcomes and impact, rather than to more day-to-day, downstream outputs and deliverables. **It is critical that the NNCD/equivalent not be seen as an NCD unit, and that it not usurp the functions of such a unit—a clear distinction is needed, with definition of roles and responsibilities, as well as linkages.**

⁶⁸ See: <https://food4changecaribbean.org/wp-content/uploads/2020/09/2019-POS-grid-20190927.pdf>.

⁶⁹ Lindemann, N. What’s the average survey response rate? [2021 benchmark]. SurveyAnyplace blog, August 9, 2021. Available at: <https://surveyanyplace.com/blog/average-survey-response-rate/>.

⁷⁰ Andresen K. Upstream thinking: how to solve problems before they happen. Article dated March 3, 2020. Available at <https://www.linkedin.com/pulse/upstream-thinking-how-solve-problems-before-happen-katya-andresen>.

⁷¹ World Health Organization. Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

⁷² World Health Organization and Swiss Agency for Development and Cooperation. Social determinants of health to advance equity. Meeting report. 7 May 2021. Available at: <https://www.who.int/publications/m/item/social-determinants-of-health-to-advance-equity>.

The main functions that the NNCDs/equivalents currently performed aligned fairly well with the entities' top five recommendations for NNCD/equivalent functions. The latter were, in order of frequency of selection: providing advice to government on NCD legislation/policy/regulations/programmes; advocacy; promotion of research; health promotion; and monitoring and evaluation. 'Promotion of research' was among the recommended functions, but was not one of the frequently-mentioned current functions, and 'communicating for health', one of the frequently-mentioned current functions, was omitted from the top five recommendations.

Frameworks to guide and direct collective and individual behaviour of NNCD/equivalent members, such as standard operating procedures/rules of procedure, policies or mechanisms to identify and manage conflict of interest, and codes of ethics were not as common as desired. The multisectoral and multidisciplinary nature of the entities make such guides and directives imperative, so that all members are aware of what is expected of them and the parameters in which they can operate to contribute to the effective operation of the entity. This assumes even greater importance with private sector membership in the entities and solicitation of private sector support for NCD prevention and control interventions. It is imperative that the commercial determinants of health^{73,74,75} be taken into consideration, and that public health objectives are not thwarted or derailed in favour of Industry objectives for promotion and profit, especially when the private sector entities produce, in part or in whole, unhealthy commodities.

Most entities had strategic frameworks to guide their interventions, including their own strategic plans/work plans/plans of action and national NCD prevention and control strategies or plans of action, though some of the latter had either expired

or were in the process of renewal/development. Most entities addressed accountability through the provision of periodic written reports to the relevant authority; one of the two entities that indicated no accountability mechanisms did produce and send reports to the health authority, but received no acknowledgement or feedback. With regard to administrative support, only three had a dedicated secretariat/secretary/administrator.

Resources, autonomy/decision-making authority, influence, sustainability, and COVID-19

Sources of funding for the entities varied, with most receiving financial and/or in-kind support from the government through the MoH, though some also received assistance from intergovernmental organisations and one had been able to develop grant proposals to mobilise its own resources.

Most entities admitted to low or medium levels of autonomy/decision-making authority. Only the entity in the Office of the President self-assessed as 'very high' in this category, with the entity focused on implementation of the national health promotion strategy indicating 'high'. However, these two entities indicated their levels of influence on policymakers, a critical group of stakeholders as, respectively, 'medium' and 'low'. Only one entity indicated a high level of influence on policymakers and that NNCD/equivalent had a medium degree of autonomy/decision-making authority. Thus, the entities' levels of influence do not appear to correlate directly with their degree of autonomy/decision-making authority, and their dependence on the MoH and political process is evident.

However, the two entities that indicated low influence on policymakers assessed themselves as having high levels of influence on the general public, and one of them also indicated a high level of

influence on NGOs/CSOs. The level of influence also did not correlate well with the development and implementation of a communication strategy by the entity, since the two NNCDs/equivalents that had such strategies reported medium levels of influence on policymakers, and only one reported a high level of influence on any category of stakeholder, in this case technical personnel and NGOs/CSOs.

However, it must be recognised that several other factors, including the composition of the NNCD/equivalent, its leadership, promotion, visibility, and communication of its functions and actions to various audiences, can affect its level of influence on various stakeholders, including policymakers.

It is instructive to note that only one entity identified sustainability mechanisms for continued functioning. Perhaps the other NNCDs/equivalents make the assumption that they will continue to be relevant, given the burden of, and priority accorded to, NCDs—at least in theory—but the dormancy and inactivity of several NNCDs/equivalents in the Caribbean, despite the raging NCD epidemic, offers a cautionary tale.

In this regard, though the COVID-19 pandemic severely impacted NCD prevention and control services and PLWNCDs, it is noteworthy that only three entities took specific actions related to the pandemic, all at downstream levels (PSAs and media campaigns), rather than addressing upstream policy and related levels; one entity specifically noted that it was not invited to participate in the decision-making process. Though no one can deny the importance of downstream actions, they are perhaps more suited for implementation by the NCD and/or COVID-19 programme implementers, with the NNCD/equivalent having a seat at the advisory or decision-making table in the multisectoral response to the pandemic, championing a focus on PLWNCDs and NCD services, based on evidence. The instance of COVID-19 and the entities' related actions seem to be a lost opportunity for them to have promoted NCD prevention and control,

advocated strongly for accelerated action, and mobilised supporting resources.

However, their relatively low levels of influence on policymakers, limited autonomy/decision-making authority, limited resources, and, perhaps, as stated by one entity, the "lack of appreciation and respect" for the entities and their functions, may have contributed to their apparent marginalisation in the national COVID-19 response.

Partnerships and networks

The NNCDs/equivalents seemed to have limited partnerships and networks, citing mainly their relationships with organisations, agencies, and institutions that are members of, or closely associated with, the entities themselves. This primarily 'inward focus' restricts opportunities for learning from experiences in other countries, exchange of information and technical expertise, and mobilisation of resources.

However, the HCC's efforts to promote regional networking and build capacity among the entities were successful to the extent that most NNCDs/equivalents were familiar with the HCC NNCD/equivalent portal, had used it, and had found it helpful. All participated in the HCC network of chairpersons of NNCDs/equivalents, and highlighted the sharing of perspectives and experiences as benefits. The HCC Secretariat may find it useful to enhance the value of the network by determining the needs and expectations of the entities regarding the NNCD/equivalent portal on its website and other networking and capacity-building initiatives, and continuing to promote national, regional, and international events that may positively impact the entities' functioning.

Successes, success factors, challenges/gaps, and lessons learned

Most of the successes cited related to downstream outputs and deliverables rather than policy advice and development, though one entity indicated that it had undertaken policy initiatives, and later

⁷³ Kickbusch I, Allen L, and Franz C. The commercial determinants of health. Lancet 2016; 4: e895-e896. [https://doi.org/10.1016/S2214-109X\(16\)30217-0](https://doi.org/10.1016/S2214-109X(16)30217-0).

⁷⁴ Lacy-Nichols J and Marten R. Power and the commercial determinants of health: ideas for a research agenda. BMJ Global Health 2021; 6(2): e003850. <http://dx.doi.org/10.1136/bmjgh-2020-003850>.

⁷⁵ World Health Organization. Commercial determinants of health. Fact sheet, 5 November 2021. Available at: <https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health>.

specified development of a childhood obesity prevention policy for eventual submission to the relevant authorities. Success factors emphasised members' commitment, dedication, and passion, as well as communication and partnerships, and one entity also cited its established, funded secretariat. Leadership was not cited as a success factor, but its critical importance was highlighted as a lesson learned, and the value of bold, inspiring, and effective leadership cannot be overstated.

However, a comment from one entity on the apparent lack of commitment and reluctance to participate in meetings on the part of some members emphasises the importance of obtaining buy-in and sparking passion in all members of the NNCD/equivalent. This is particularly relevant for sectors other than health, through sensitisation and demonstration of how they can contribute to the greater good, and the benefits of their participation—that is, 'what's in it for them'.⁷⁶

Challenges/gaps focused significantly on the lack of, or limited, resources—human and financial—but also highlighted the full-time commitments of members of the NNCD/equivalent as limiting the time dedicated to the affairs of the entity and its performance. In resource-limited Caribbean countries, it would not be feasible or practical for all members of the entity to be full-time. However, it appears that it would be advantageous for the chairperson, a technical officer, and an administrative officer to be full-time, or almost so—'dedicated' to the functions of the NNCD/equivalent. Though some entities sought to overcome challenges and fill gaps through volunteer support, innovative financing arrangements, and resource mobilisation, including through private sector support, these initiatives should include strategies for sustainability of functions and outcomes, and

take into consideration conflict of interest and ethical approaches.

Highlights of lessons learned included the power of integration, the need for communication, and awareness of potential opportunities for action, as well as strategies to ensure that NCDs are given the priority they deserve. These underscore the imperative of multisectoral action, not only at the NNCD/equivalent level, but among government sectors and civil society. The advice from entities that "small steps are still counted as progress" and that the entities should "celebrate small wins" is worthy of emphasis.

Performance, impact, and possible NCM-TC functioning

The entities' assessment of their performance and impact was modest—no more than, respectively, 'successful/somewhat successful', as opposed to 'extremely/very successful', and 'medium', rather than 'very high/high', leaving significant room for improvement. It is noteworthy that the self-assessment of performance and impact fell into the stated categories regardless of smaller or larger membership and simpler or more complex organisational structure.

Three of the eight responding entities had national coordination mechanisms for tobacco control in their countries, but even those with NCMs-TC (except one) seemed to indicate that it would be feasible for the NNCD/equivalent itself to perform the functions of NCMs-TC if certain requirements were met. The requirements, which included a clear strategy, provision of adequate resources, government commitment to adopt legislation and policies aligned with the FCTC, and identification and management of conflict of interest, were well aligned with guidance and recommendations in the Toolkit for NCMs-TC.¹⁸

Recommendations for improved functioning and performance

The entities' recommendations for improvement included a call for clear definition of the term "NCDs" and strategies to designate it a "true national priority". The reality of the situation is that, given the non-acute and less 'dramatic' nature of NCDs, which does not garner instant attention from key stakeholders, including policy makers, innovative strategies to capture and hold their attention, even in the face of competing public health priorities, are crucial. One such strategy involves strengthened and sustained activism by PLWNCDs and other segments of civil society, and another is the mobilisation of resources through co-benefit initiatives.

A majority of entities endorsed the idea of a regional NCD Commission/Task Force/Working Group to complement the NNCDs/equivalents, and in that regard it may be instructive to examine the model of, and lessons learned from, the [Pan Caribbean Partnership Against HIV/AIDS](#).⁷⁷ PANCAP, established by CARICOM HoSG in 2001 as part of the regional response to HIV/AIDS, is a Caribbean regional partnership of governments, regional institutions and organisations, including CSOs, bilateral and multilateral agencies, and contributing donor partners. A 2004 report by the Joint UN Programme on HIV/AIDS (UNAIDS) and CARICOM assessed PANCAP as a best practice in collective action toward strengthening the Caribbean regional response to HIV and AIDS.⁷⁸ That report highlights the following:

- The importance of regional HoSG meetings in building support for regional action and introducing the issue of HIV/AIDS into various fora that comprised sectors other than health, such as meetings of CARICOM ministers of education, youth, sport, culture, transport, and tourism.

- The essentiality of other partners, such as:
 - PAHO, a key player in stimulating and supporting the initiatives that led to the establishment of PANCAP, and in undertaking HIV/AIDS-related technical cooperation with its Member States in the region.
 - Caribbean Epidemiology Centre, a former CARICOM institution now subsumed into CARPHA.
 - UWI, in particular the Health Economics Unit, which was instrumental in gathering and analysing data that made the economic case for action on AIDS-related issues, a crucial step in gaining the attention of ministers of finance and development, and then building the commitment of HoSG.
 - Caribbean Regional Network of Persons Living with HIV/AIDS, which was established in 1996 to share information, build capacity among persons living with HIV, and support AIDS advocacy in the countries of the Caribbean.
 - Caribbean Health Research Council, another former CARICOM institution also subsumed into CARPHA.
 - Caribbean Coalition of National AIDS Programme Coordinators, which provided a mechanism for national AIDS coordinators to work together, share their resources and skills, and assist each other in building national capacity, functioning as the primary link within PANCAP between regional and country level action.
- Success factors, including:
 - High-level political commitment.
 - Strong champions.
 - Previous regional experience of working together, through CARICOM.
 - Ability of partners to contribute from their strengths, recognising and building on each other's differing capacities.

⁷⁶ World Health Organization and United Nations Development Programme. What government ministries need to know about noncommunicable diseases: a set of sectoral briefs. 2018, WHO and UNDP. Available at: <https://www.undp.org/publications/what-government-ministries-need-know-about-non-communicable-diseases>.

⁷⁷ <https://pancap.org/>.

⁷⁸ Joint UN Programme on HIV/AIDS and the Caribbean Community. A study of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP: common goals, shared response. Geneva: 2004; UNAIDS. Available at: https://pancap.org/pc/pcc/media/pancap_document/UNAIDS-BEST-PRACTICE-COLLECTION_A-Study-of-PANCAP.pdf.

- Moving beyond the health sphere to drive a truly multisectoral response led by HoSG as they recognised HIV/AIDS as an economic and development issue.
- The existence of a Caribbean Regional Strategic Plan of Action for HIV/AIDS, which provided overall direction for the regional response that supported national responses, until it was superseded by the PANCAP Regional Strategic Framework. Currently, the regional response to HIV/AIDS is guided by the PANCAP [Caribbean Regional Strategic Framework on HIV and AIDS 2019-2025 \(CRSF\)](#),⁷⁹ which is aligned with the [UNAIDS 90-90-90](#)⁸⁰ Targets to test, treat, and defeat AIDS.
- Increase the flow of resources for the fight against HIV/AIDS
- Monitor the impact of programmes in member countries and organisations
- Assist in streamlining programmes and projects to avoid duplication of effort and enable more effective utilisation of resources

PANCAP's core functions and overall structure may also serve to inform the establishment of a regional NCD coordination body. The PANCAP core functions were identified as:

- Provide and maintain collective/unified vision and direction among partners
- Coordinate partners' activities at regional level
- Act as a clearinghouse for information for decision-making
- Build awareness and advocate for elimination of discrimination against persons infected or affected by the disease and the greater participation of persons living with HIV/AIDS, which is an important human rights issue
- Build capacity of partners

NCDs have already gained significant political attention, attracted key partners, and generated myriad frameworks and guidelines for their prevention and control, all stressing the need for multisectoral, whole-of-government, whole-of-society, health-in-all policies approaches. However, they have not attracted a significant level of either national or international resources;^{82,83,84} the voices of PLWNCDs are still relatively muted, despite the excellent work being done by many CSOs and NGOs in and outside of the Caribbean region; the national NCD coordinating entities in the Caribbean, where they exist and are active, are functioning sub-optimally, as is evident in this report; and there are no Caribbean regional supporting frameworks or mechanisms. The last regional strategic plan for NCD prevention and control spanned 2011-2015⁸⁵ and the CCH IV 2016-2025²⁸ is neither widely promoted nor widely known in the region.

Further, consensus and support for regional actions that will catalyse national achievements in support of NCD reduction are far from a foregone conclusion, as evidenced by the recent failure to obtain support from some CARICOM Member States for the PAHO-recommended, evidence-based,

octagonal, 'high-in' front-of-package nutritional warning labelling system^{86,87,88} proposed by CROSQ, a CARICOM institution.

With regard to the issue of NNCDs/equivalents functioning as NCMs-TC, it should be feasible for them to do so, based on the responses of most of the entities. This idea is supported by the similarities in

WHO recommendations for improved functioning of both of these multisectoral entities;^{15,18} by a model developed for NCMs-TC in the African Region in 2015;⁸⁹ and by a 2016 discussion paper on tobacco control governance in sub-Saharan Africa,⁹⁰ as well as a [May 2016 webinar](#)⁹¹ organised around the discussion paper.

⁷⁹ <https://pancap.org/pancap-documents/caribbean-regional-strategic-framework-2019-2025/>.

⁸⁰ <https://www.unaids.org/en/resources/909090>.

⁸¹ Mulusa M and Carpio C. Action through partnerships: The Pan-Caribbean Partnership Against HIV/AIDS (PANCAP). En breve. Washington, D.C.: 2005; World Bank. Available at: <https://openknowledge.worldbank.org/handle/10986/10343>.

⁸² Jailobaeva K, Falconer J, Loffreda G, et al. An analysis of policy and funding priorities of global actors regarding noncommunicable diseases in low- and middle-income countries. *Globalization and Health*, 2021; 17(68). Available at: <https://globalizationandhealth.biomedcentral.com/track/pdf/10.1186/s12992-021-00713-4.pdf>.

⁸³ World Health Organization. WHO Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease (NCD) Prevention and Control. Copenhagen, 9-11 April 2018. Concept Note. Available at: <https://www.who.int/conferences/global-ncd-conference/financing/Financing-Conference.pdf>.

⁸⁴ World Health Organization. Global dialogue on partnerships for sustainable financing of NCD prevention and control. Meeting report, Copenhagen, Denmark, 9-11 April 2018. Geneva: 2019; WHO. Available at: <https://apps.who.int/iris/bitstream/handle/10665/312289/WHO-NMH-NMA-GCM-19.01-eng.pdf?sequence=1&isAllowed=y>.

⁸⁵ Pan American Health Organization and Caribbean Community Secretariat. Strategic action plan for the prevention and control of non-communicable diseases for the countries of the Caribbean Community 2011-2015. Available at: https://caricom.org/documents/12630-ncds_plan_of_action_2011_2015.pdf.

⁸⁶ Pan American Health Organization. Front-of-package labeling as a policy tool for the prevention of noncommunicable diseases in the Americas. Washington, D.C.: 2020; PAHO. Available at: <https://iris.paho.org/handle/10665.2/52740>.

⁸⁷ Pan American Health Organization. Superior efficacy of front-of-package warning labels in Jamaica. Fact sheet, March 2021. Available at: https://iris.paho.org/bitstream/handle/10665.2/53328/PAHONMHRF210002_eng.pdf?sequence=1&isAllowed=y.

⁸⁸ Jamaica Gleaner. Article 'Andrene Chung. Front-of-package labelling—Jamaican consumers trumped by vested interests'. Published August 15, 2021. <https://jamaica-gleaner.com/article/focus/20210815/andrene-chung-front-packaging-labelling-jamaican-consumers-trumped-vested>.

⁸⁹ World Health Organization Regional Office for Africa (AFRO). National coordination mechanism for tobacco control: a model for the African Region. South Africa: 2015; WHO AFRO. Available at: <http://apps.who.int/iris/bitstream/handle/10665/202020/9789290232933.pdf>.

⁹⁰ United Nations Development Programme and World Health Organization Framework Convention on Tobacco Control Secretariat. Tobacco control governance in sub-Saharan Africa: implementing article 5.2(a) of the Framework Convention on Tobacco Control. Discussion paper. New York: 2016; UNDP and WHO FCTC Secretariat. Available at: <https://www.who.int/fctc/FCTC-5.2A-NCM-Africa.pdf?ua=1&ua=1>.

⁹¹ A recording of the May 2016 webinar is available at: <https://www.who.int/fctc/implementation/cooperation/project-Article-5.2-A-National-coordinating-mechanism/en/>.

CONCLUSION

Given all the above findings, it is tempting to draw the conclusion that the organisational location of most of the entities in the MoH; their dependence on that ministry; their vulnerability to the vagaries of the political process; their structure; their composition; and, most importantly, their limited resources, are not conducive to engendering the recognition, respect, authority, and influence that they need in order to effectively underpin, enable, and oversee the needed multisectoral response to NCDs.

It can be claimed, with justification, that NCDs do not readily excite political and societal alarm, despite copious evidence of their deleterious health, social, and economic effects. NCDs are by nature insidious and indolent, as compared with communicable diseases such as HIV and COVID-19, where the health impact is more immediately evident, related illnesses and deaths are noted and reported frequently—daily, in the case of COVID-19, at the time of writing—and the social and economic effects generate significant short-, medium-, and long-term concerns.

Critical factors for the success of national HIV Commissions in the Caribbean, identified by persons familiar with the issues, included location of the Commissions in the Office of the President or Prime Minister, rather than the ministry of health, which not only fostered greater attention to accountability, but also enabled the all-important multisectoral response; provision of significant resources by the Global Fund for the Fight against HIV, Tuberculosis, and Malaria (the Global Fund); activism and advocacy by persons living with, and affected by, HIV; strict accountability for the use of resources awarded by the Global Fund, based on agreed, written plans, timelines, and reporting deadlines; establishment of focal points in key ministries other than health; and support and coordination provided through PANCAP.

Currently, it cannot be convincingly argued that the NNCDs/equivalents are 'fit-for-purpose'. However, they have significant potential to be so, and there are numerous opportunities that can be taken advantage of. If the recommendations below are followed and the NNCDs/equivalents strengthened, it would be feasible for them to function as NCMs-TC, making the most of the limited resources—human, financial, and infrastructural—in Caribbean countries, and improving the efficiency and effectiveness of national multisectoral responses to NCDs and their risk factors.

With *advocacy and activism* from key stakeholders, especially people living with, and affected by NCDs, youth, and other persons in conditions of vulnerability; *political will* to ensure that this key tenet of the Declaration of Port of Spain is fulfilled; *organisational location* of the entities at, and *accountability* to, the highest political and policymaking levels at national and regional levels, commensurate with the devastating impact of NCDs on health, the economy, and national development, as well as the HoSG's POSD mandate; *adequate resource allocation and mobilisation*; and the *contribution and support of strategic and development partners*, with policies, mechanisms, and guidelines to identify and manage conflict of interest, enable ethical actions, prevent Industry interference, and contribute to good governance, the Caribbean region can provide a model for what can be accomplished as resource-constrained countries undertake multisectoral actions to reduce their burden of NCDs.

“If people with NCDs such as diabetes, heart disease, or cancer were to develop the disease today and become severely ill or die tomorrow or next week, the attention paid to the conditions, including the amount of funding and other resources provided, would be sky-high.”

Anonymous contributor

“My concern is the buy-in of Caribbean governments currently, considering all the events with which they now must deal, including climate change. However, there is increasing urgency to address NCDs, which have outcomes closely linked to these events, and the approach should be carefully strategised.”

*Dr. Damian Greaves,
Chair National Chronic
NCDs Commission,
Grenada*

RECOMMENDATIONS

Interventions to strengthen, re-vitalise, and/or re-constitute the NNCDs/equivalents should be aligned with those outlined in the 2018 Toolkit for establishing or strengthening NCMs-TC,¹⁸ which is based on the WHO South-East Asia Regional Office (SEARO) guidelines for establishing multisectoral bodies for NCD prevention and control.¹⁵ Though the Toolkit speaks to NCMs-TC, **most of the concepts and guidance are eminently applicable to NNCDs/equivalents**. Annex 3 of this document provides selected highlights and notes from the Toolkit.

Taking into account the respondents' responses and recommendations, and previous^{9,10,11,12,14} and ongoing observations and reports on NNCDs/equivalents, the following recommendations are made to improve the governance and functioning of these entities in the Caribbean. The recommendations should be considered for implementation by national authorities and other key stakeholders best placed to take, or advocate for, action. Critical actions include the following:

Organisational location and structure

1. Locate the NNCDC/equivalent in the Office of the President or Prime Minister, in order to ensure that its accountability is to the highest political/policymaking level and to boost the autonomy, decision-making authority, and level of influence of the entity.
2. Advocate strongly for, and effect, changes in the composition of the NNCDC or equivalent to ensure that the public sector representatives are high-level officials from key government sectors. The level of permanent secretary in the various ministries is recommended, with recruitment of a retired permanent secretary, preferably—but not necessarily—from health or another social sector, to chair the entity, ensuring full-time attention to, and leadership of, this critical entity. It is imperative that the commissioners not only be passionate about health and NCD prevention and control, but also have significant decision-making authority in their respective sectors, or the authority to interact with, and advocate to, policy makers, including the respective sector ministers, President or Prime Minister, and Cabinet.
3. Ensure that the entity has adequate administrative support, with a secretariat that has at least one full-time member. **A proposed organisational structure for the NNCDC or equivalent that can be tailored to the national situation is in Annex 4;** it includes a Deputy or Vice- Chair who can assume the functions of the Chair when necessary.

Membership

4. Ensure that representatives from civil society and the pro-health private sector are persons in positions of authority in their respective organisations and agencies, able to direct and implement agreed actions, or advocate strongly to those in charge to do so.
5. Ensure that there is representation of PLWNCDs and youth on the NNCDC/equivalent, as meaningful engagement with and involvement of these persons, and other persons and groups in conditions of vulnerability—including persons with disabilities and women—are critical to shaping an effective and equitable response to NCDs.^{92,93}
6. Ensure that the NNCDC/equivalent is representative of key sectors, but manageable and able to co-opt representatives of other agencies and institutions as needed.
7. Build the capacity of members to understand NCD-related issues, especially the imperative of addressing the social and other determinants of health, and reducing inequities, through multisectoral action.

⁹² NCD Alliance. Global charter for meaningful involvement of people living with NCDs. Geneva: 2021; NCDA. Available at: https://www.ourviewsourvoices.org/sites/ovov/files/2021-09/Global%20Charter_English_Final_2%20Sep.pdf.

⁹³ World Health Organization. Nothing for us, without us: opportunities for meaningful engagement of people living with NCDs: meeting report. Geneva: 2020; WHO. Available at: <http://apps.who.int/iris/handle/10665/340737>.

Frameworks for enhanced functioning and accountability

- 8. Ensure that the NNCD/Cequivalent has clear terms of reference that include its relationship with the national NCD unit or programme, with differentiation of roles and responsibilities; a code of ethics/code of conduct; standard operating procedures/rules of procedure; an accountability mechanism; and a robust communication strategy to promote the entity and contribute to its accountability and transparency.
- 9. Raise awareness of the need for, emphasise the importance of, and develop and implement, policies and/or mechanisms to identify and manage conflict of interest, and protect policy development for NCD prevention and control from Industry interference.⁹⁴ This applies especially to the tobacco, alcohol, and food and beverage industries, and action can be based on [FCTC Article 5.3](#)⁹⁵ regarding the protection of tobacco control policies from tobacco industry interference and [guidelines for its implementation](#),⁹⁶ and guidance and tools developed by WHO and PAHO.^{97,98}
- 10. Develop, implement, monitor, and evaluate a realistic, achievable strategic plan/plan of action/work plan for the NNCD/Cequivalent itself that responds to priorities in the national multisectoral NCD prevention and control strategy or plan of action. The entity's strategic plan/plan of action/work plan should include needed resources and costs; the communication strategy; accountability mechanisms; and resource mobilisation strategies, since it is unlikely that resource allocation alone will be adequate for its needs.
- 11. Ensure that the strategic plan/plan of action/work plan of the NNCD/Cequivalent includes advocacy for, and oversight of, the development, implementation, monitoring, and evaluation of a national multisectoral NCD prevention and control strategy or plan of action. Such an evidence-based strategy or plan of action is critical for priority setting, results-based management, effective use of resources, and continuity of action across any changes in political administration that may occur. The development of the national multisectoral NCD prevention and control strategy of plan of action should be guided by the [WHO NCD MAP Tool](#),⁹⁹ should address the lessons learned from COVID-19 and its intersections with NCDs,^{13,14} including the need to enable continuity of NCD services—especially at the first level of care, improve access, and reduce inequities, in the context of advancing universal health¹⁰⁰ and the progressive realisation of the right to health and other human rights; and should be conducted in collaboration with technical cooperation agencies such as PAHO.

- 12. Take advantage of advances in information and communication technology and online platforms to conduct the entity's business, convene meetings, communicate with key stakeholders, and build capacity. These methods proved critical to maintaining contact, improving access, and executing key activities in many spheres during COVID-19, given the physical distancing and travel restrictions that have become an integral part of the response to the pandemic.
- 13. Ensure that accountability mechanisms include reporting on the performance of NNCD/Cs/equivalents at meetings of the CARICOM HoSG and the CARICOM Council for Health and Social Development (COHSOD), to ensure regional oversight at the highest levels and facilitate regional support for national actions as needed.

Resources

- 14. Leverage existing and mobilisable resources from the members of the NNCD/Cequivalent, the agencies and organisations that they represent, and key external partners, the last-mentioned including CARICOM institutions such as CARPHA; UN agencies; academic institutions such as the UWI; international financing institutions, including the Caribbean Development Bank; and regional and international CSOs/NGOs working in NCD prevention and control.
- 15. Explore resource mobilisation from international development/technical cooperation agencies such as the UNIATF on NCDs and PAHO/WHO to assist with strengthening national multisectoral action for NCD prevention and control, and tobacco control.¹⁰¹ This should include justification of the meaningful involvement of sectors other than health⁷⁶ and the imperative of policy coherence in NCD reduction,¹⁰² as well as the development of investment cases to provide evidence of economic impact and return on investment.¹⁰³
- 16. Explore resource mobilisation from the FCTC Secretariat and UNDP to conduct a detailed analysis of the possibility of NNCD/Cs/equivalents serving as NCMs-TC to strengthen the implementation of Article 5.2 (a), through needs assessment of the entities.
- 17. Develop and submit grant and project proposals to take advantage of resources mobilised and being made available to address other issues that impact on NCDs, such as the COVID-19 pandemic, climate change adaptation/mitigation, and food and nutrition security, looking for co-benefits and win-win solutions.

⁹⁴ Mialon M, Vandevijvere S, Carriedo-Lutzenkirchen A, et al. Mechanisms for addressing and managing the influence of corporations on public health policy, research and practice: a scoping review. *BMJ Open* 2020; 10:e034082. DOI: 10.1136/bmjopen-2019-034082. Available at: <https://bmjopen.bmj.com/content/10/7/e034082>.

⁹⁵ <https://www.tobaccofreekids.org/what-we-do/industry-watch/fctc-article>.

⁹⁶ https://www.who.int/fctc/guidelines/article_5_3.pdf.

⁹⁷ World Health Organization. Safeguarding against possible conflicts of interest in nutrition programmes: draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level. Report by the Director-General. Document A71/23, 22 March 2018. Available at: https://apps.who.int/iris/bitstream/handle/10665/276448/A71_23-en.pdf?sequence=1&isAllowed=y.

⁹⁸ Pan American Health Organization. Preventing and managing conflicts of interest in country-level nutrition programs: a roadmap for implementing the World Health Organization's draft approach in the Americas. Washington, D.C.: PAHO; 2021. Available at: <https://iris.paho.org/handle/10665.2/55055>.

⁹⁹ World Health Organization. Tools for national multisectoral action plan for prevention and control of noncommunicable diseases (NCD MAP Tool). Available at: <https://apps.who.int/ncd-multisectoral-plantooll/>.

¹⁰⁰ Pan American Health Organization. Universal health. <https://www.paho.org/en/universal-health> and <https://www.paho.org/en/topics/universal-health>.

¹⁰¹ Pan American Health Organization/World Health Organization. Strengthening multisectoral action for tobacco control in the Region of the Americas. Five virtual sessions 12-23 March 2021. Information available at: <https://www.paho.org/en/strengthening-multisectoral-action-tobacco-control-region-americas>.

¹⁰² NCD Alliance. NCDs across the SDGs: a call for an integrated approach. Geneva: 2017; NCDA. Available at: https://ncdalliance.org/sites/default/files/resource_files/NCDs_Across_SDGs_English_May2017.pdf.

¹⁰³ World Health Organization and United Nations Development Programme. Non-communicable disease prevention and control; a guidance note for investment cases. 2019, WHO and UNDP. Available at: <https://apps.who.int/iris/bitstream/handle/10665/311180/WHO-NMH-NMA-19.95-eng.pdf;sequence=1>.

Partnerships and networks

- 18. Establish links with other entities addressing critical issues related to, and impacting, NCDs, including mental, neurological, and substance use disorders, emergency and disaster preparedness and response, and climate change; collaborate with groups comprising or representing persons in conditions of vulnerability, including persons with disabilities, women, and indigenous people; and advocate for and support coordination, pooling of resources, and joint actions to address shared objectives and the social, economic, environmental, and other determinants of health, including gender issues.
- 19. Explore the possibility of establishing a Caribbean regional coordination mechanism (regional NCD commission/task force/working group) for NCD prevention and control, and tobacco control, located in the CARICOM Secretariat or a CARICOM institution such as CARPHA, taking into consideration the PANCAP model; advocate for, develop, and submit a proposal to explore the feasibility, structure, functions, resources, and sustainability of such a regional mechanism to appropriate funding agencies, including the FCTC Secretariat and UNDP, UNIATF, and international financing institutions.
- 20. Take action to strengthen the network of NNCDs/equivalents, their chairpersons, and their members, perhaps through a CARICOM mechanism or strengthening of the HCC virtual meetings, with streamlining of the meetings, their objectives, and agendas, and establishment of a community of practice for the chairpersons.
- 21. Determine the specific needs and expectations of the NNCDs/equivalents regarding the HCC NNCD/equivalent portal, making improvements and building capacity as appropriate.

ANNEXES

ANNEX 1

Questionnaire for NNCDs/equivalents

ANALYSIS OF NATIONAL NCD COMMISSIONS (OR EQUIVALENTS) IN THE CARIBBEAN WITH AN EMPHASIS ON TOBACCO CONTROL

Introduction

As the Caribbean region grapples with the burden of non-communicable diseases (NCDs), aggravated by the coronavirus disease of 2019 (COVID-19) pandemic, the Healthy Caribbean Coalition (HCC) is continuing its work to contribute to the strengthening of National Non-communicable Disease Commissions (NNCDs) or their equivalents in the region. The current activity builds on previous work done to document responses to the NCD epidemic in the Caribbean, assess the NNCDs or equivalents, and build their capacity to function effectively,^{104,105,106} and aligns with the HCC's January 2021 call to action for a Transformative New Agenda for NCD Prevention and Control in the Caribbean (TNA-NCDs).¹⁰⁷

The TNA-NCDs was developed in light of the COVID-19 pandemic that was declared in March 2020 and which continues at the time of writing. COVID-19 has had devastating effects on persons living with NCDs (PLWNCDs)¹⁰⁸ and has resulted in severe disruptions in essential services for NCDs¹⁰⁹ and mental, neurological, and substance use conditions.¹¹⁰

Through a Letter of Agreement with the Pan American Health Organization (PAHO), the HCC is seeking to determine the status of existing NNCDs or their equivalents in the Caribbean; provide recommendations on how to strengthen their role and performance; and explore the possibility of their functioning as national coordination mechanisms for tobacco control (NCMs-TC) where such mechanisms do not exist, in line with Article 5.2 (a) of the World Health Organization (WHO) [Framework Convention on Tobacco Control](#)¹¹¹ (FCTC).

The HCC would greatly appreciate the completion of this questionnaire by the Chairpersons of NNCDs (or their equivalents), Chairpersons' designees, senior officials working in NCD prevention and control, or NCD focal points. **The questionnaire should be completed electronically—there is space for insertion of text and the check boxes are clickable. Responses will be reported anonymously.**

Please return the completed questionnaire to Ms. Maisha Hutton, HCC Executive Director (maisha.hutton@healthycaribbean.org) with copy to Dr. Beverley Barnett, Consultant (dbevb@hotmail.com) **by 17 September 2021.**

¹⁰⁴ Healthy Caribbean Coalition. A civil society regional status report: responses to NCDs in the Caribbean Community. Bridgetown: 2014; HCC. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2017/02/HCC-NCDA-RSR-FINAL-MARCH-2014.pdf>.

¹⁰⁵ Healthy Caribbean Coalition. A civil society report on National NCD Commissions in the Caribbean: towards a more effective multisectoral response to NCDs, Part 1. Bridgetown, 2015; HCC. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2016/04/A-Civil-Society-Report-on-National-NCD-Commissions-in-the-Caribbean-Towards-a-more-Effective-Multisectoral-Response-to-NCDs-Part-1.pdf>.

¹⁰⁶ Healthy Caribbean Coalition. Getting National NCD Commissions up and running – a framework for the establishment and strengthening of National NCD Commissions in the Caribbean: towards a more effective multisectoral response to NCDs, Part II. Bridgetown, 2017; HCC. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2017/04/Getting-National-NCD-Commissions-Up-and-Running.pdf>.

¹⁰⁷ Healthy Caribbean Coalition. NCDs and COVID-19 in the Caribbean: a call to action—the case for a Transformative New Agenda for NCD Prevention and Control in the Caribbean. Bridgetown: HCC; 2020. Available at: <https://www.healthycaribbean.org/wp-content/uploads/2021/01/TNA-NCD-FINAL.pdf>.

¹⁰⁸ Pan American Health Organization. NCDs and COVID-19. See: <https://www.paho.org/en/ncds-and-covid-19>.

¹⁰⁹ 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: June 2020; PAHO. Available at: <https://iris.paho.org/handle/10665.2/52250>.

¹¹⁰ World Health Organization. The impact of COVID-19 on mental, neurological, and substance use services: results of a rapid assessment, 5 October 2020. Geneva: October 2020; WHO. Available at: <https://www.who.int/publications/i/item/978924012455>.

¹¹¹ https://www.who.int/fctc/text_download/en/.

A. General information

1. Country:
2. Date of completion of questionnaire:
3. Name of person completing the questionnaire:
4. Position/post/title of person completing the questionnaire:
5. Is the NNCD or equivalent currently active? ☐ No ☐ Yes

If **No**, since when has it been inactive?

Please state briefly the main reason(s) for its inactivity:

If you answered No to Question 5 (the NNCD or equivalent is inactive), please go to directly to Section I, Question 54 only (first part) and Section J, Questions 59–62

If you answered Yes to Question 5 (the NNCD or equivalent is active), please continue with Question 6 below and all the other items

6. Name of NNCD or equivalent:
7. Name of Chairperson of the NNCD or equivalent:
8. Name of person completing questionnaire, if different from Chairperson:
9. Position/post/title of person completing the questionnaire, if different from Chairperson:
10. Has the Chairperson or his/her designee participated in any previous HCC information-gathering exercises? ☐ No ☐ Yes

If **Yes**, please state briefly which HCC information-gathering exercises:

11. What is the authority/political mandate under which the NNCD or equivalent was established? (Choose one)
 - ☐ None
 - ☐ Executive order
 - ☐ Legislation/law
 - ☐ Presidential/Prime Ministerial/Cabinet decree
 - ☐ Other (please specify):

12. How often does the NNCD or equivalent meet?

13. When was the last meeting of the NNCCDC or equivalent held?

14. Additional general information/comments:

B. Membership

15. How many members does the NNCCDC or equivalent currently have?

16. Which government sectors are represented on the NNCCDC or equivalent?

- ☐ Agriculture
- ☐ Education
- ☐ Finance
- ☐ Foreign Affairs
- ☐ Health
- ☐ Social services
- ☐ Trade/Industry/Business
- ☐ Other (please specify):

17. Which civil society¹¹² entities are represented on the NNCCDC or equivalent? (Please list)

18. Which private sector entities are represented on the NNCCDC or equivalent? (Please list)

19. Are there any other entities that you think should be represented on the NNCCDC or equivalent?

☐No

☐Yes

If **Yes**, please indicate which entities:

C. Operational framework

20. What is the **organisational location** of the NNCCDC or equivalent /under which authority or ministry does the NNCCDC or equivalent operate?

21. What is the **organisational structure** of the NNCCDC or equivalent? Please describe briefly:

22. Does the NNCCDC or equivalent have **term limits**?

☐No

☐Yes

If **Yes**, what is the term limit?

23. Does the NNCCDC or equivalent have specific **terms of reference/mandate/scope of work**?

☐No

☐Yes

¹¹² Includes non-governmental organisations (NGOs), academia, trade unions, faith-based organisations, youth organisations, sports clubs, and other civil society organisations (CSOs).

If **Yes**, what are the **main functions** envisaged? (Please check all that apply)

- ☐ Providing advice to government on NCD legislation/policy/regulations/programmes
- ☐ Advocacy
- ☐ Programme development and implementation
- ☐ Monitoring and evaluation
- ☐ Promotion of research
- ☐ Health promotion
- ☐ Communicating for health
- ☐ Resource mobilisation
- ☐ Other (please specify):

24. Does the NCNDC or equivalent have a **conflict of interest policy or mechanisms** to identify and manage conflict of interest? ☐No ☐Yes

If Yes, please provide a brief description of the conflict of interest policy or mechanisms:

25. Does the NNCCDC or equivalent have a **code of ethics**? ☐No ☐Yes

26. Does the NNCCDC or equivalent have **standard operating procedures/rules of procedure**?

☐No

☐Yes

27. Does the NNCCDC or equivalent have its own **strategic plan/work plan/plan of action** to guide its activities?

☐No

☐Yes

28. Does the NNCCDC or equivalent conduct its activities in the framework of a **national NCD prevention and control strategy or plan of action**? ☐No ☐Yes

If **Yes**, please state the duration of the strategy or plan of action:

29. Does the NNCCDC or equivalent have mechanism(s) for **accountability**, including monitoring, evaluation, and reporting of its activities? ☐No ☐Yes

If **Yes**, please provide a brief description of the accountability mechanism(s):

30. Does the NNCCDC or equivalent have its own **resources** – financial, human, and infrastructural?

☐No

☐Yes

If **No**, from where/which entity does the NNCCDC or equivalent get resources to function?

If **Yes**, how does the NNCCDC or equivalent obtain/procure its resources?

31 Does the NNCCDC or equivalent have **dedicated secretariat/secretary/administrator**?

☐ No ☐ Yes

32. How would you assess the **degree of autonomy/decision-making authority** of the NNCCDC or equivalent?

☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

33 What is the main **decision making process used by the NNCCDC or equivalent**?

☐ Consensus ☐ Majority ☐ Other (please specify):

34. How would you assess the **level of influence** of the NNCCDC or equivalent on various key stakeholders?

Polymakers ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

Technical personnel ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

NGOs/CSOs ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

General public ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

International development agencies ☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

35. Has the NNCCDC or equivalent developed and implemented its own specific **communication strategy**?

☐ No ☐ Yes

36. Has the NNCCDC or equivalent identified/put in place specific **sustainability mechanisms** for its continued functioning? ☐ No ☐ Yes

If **Yes**, please briefly describe the mechanisms:

37. Has the NNCCDC or equivalent taken any **specific action(s) related to the COVID-19 pandemic**, given the significant negative impact of the pandemic on PLWNCDs and essential NCD services?

☐ No ☐ Yes

If **Yes**, please briefly describe the main action(s) taken:

D. Partnerships and networks

38. Who/which entities comprise the **main partners and networks** of the NNCCDC or equivalent? Please list:

39. Are there any other multi-stakeholder entities/bodies addressing the prevention and control of NCDs or their risk factors in the country? ☐ No ☐ Yes

If **Yes**, which are they? Please list:

40. If there are other multi-stakeholder entities/bodies addressing NCD and risk factor prevention and control in the country, to what extent does the NNCCDC or equivalent collaborate/cooperate/interact with them?

☐ To a very significant extent ☐ To a significant extent ☐ To some extent

☐ Not at all

41. Are you familiar with the NNCCDC portal on the HCC website? ☐ No ☐ Yes

If **Yes** (you are familiar with the NNCCDC portal on the HCC website), have you used it within the last 5 years? ☐ No ☐ Yes

If **No** (you have not used the NNCCDC portal on the HCC website within the last 5 years), please indicate briefly your reasons for not using it:

42. If you have used the NNCCDC portal on the HCC website within the last 5 years, how helpful did you find the portal?

☐ Extremely helpful ☐ Very helpful ☐ Helpful ☐ Somewhat helpful

☐ Not at all helpful

43. Have you or other members of the NNCCDC or equivalent benefitted from HCC capacity building exercises in the past 5 years? ☐ No ☐ Yes

If **Yes**, please briefly describe the type of capacity-building exercise(s) and the impact on the functioning of the NNCCDC or equivalent:

44. Are you aware of the HCC network of Chairpersons of NNCCDCs or equivalents?

☐ No ☐ Yes

45. Are you a member of the HCC network of Chairpersons of NNCDs or equivalents?

☐ No ☐ Yes

If **Yes**, have you participated in the virtual meetings of the Chairpersons of NNCDs or equivalents convened by the HCC Secretariat? ☐ No ☐ Yes

46. If you have participated in the virtual meetings of Chairpersons of NNCDs or equivalents convened by the HCC Secretariat, how helpful have the meetings been to the functioning of the NNCD or equivalent?

☐ Extremely helpful ☐ Very helpful ☐ Helpful ☐ Somewhat helpful

☐ Not at all helpful

Please give reasons for your selection:

E. Main successes/success factors

47. What have been the **top 5 successes/achievements** of the NNCD or equivalent in the past 5 years?

- i.
- ii.
- iii.
- iv.
- v.

48. What were the **top 5 success factors** in accomplishing those successes/achievements?

- i.
- ii.
- iii.
- iv.
- v.

F. Main challenges/gaps

49.What have been the **top 5 challenges/gaps** faced by the NNCD or equivalent in the past 5 years?

- i.
- ii.
- iii.
- iv.
- v.

50. What were the **top 5 specific actions** that the NNCD or equivalent took to overcome these challenges/gaps?

- i.
- ii.
- iii.
- iv.
- v.

G. Main lessons learned

51.What **top 5 lessons** has the NNCD or equivalent learned over the past 5 years?

- i.
- ii.
- iii.
- iv.
- v.

H. Overall assessment of NNCD or equivalent and impact on NCD prevention and control in the country

52. How would you assess the overall performance of the NNCD or equivalent over the past 5 years?

☐ Extremely successful ☐ Very successful ☐ Successful ☐ Somewhat successful

☐ Not at all successful

Please briefly give the justification for your assessment:

53. How would you assess the NNCD’s overall impact on NCD prevention and control in the country over the past 5 years?

☐ Very high ☐ High ☐ Medium ☐ Low ☐ Very low

Please briefly give the justification for your assessment:

I. NNCDs or equivalents as National Coordination Mechanisms for Tobacco Control (NCMs-TC)

54. Is there a multisectoral NCM-TC in your country? ☐ No ☐ Yes

If **Yes** (there is a multisectoral NCM-TC), to what extent does the NNCD or equivalent collaborate/cooperate/interact with the NCM-TC?

☐ To a very significant extent ☐ To a significant extent ☐ To some extent

☐ Not at all

55. If **No** (there is no NCM-TC), does the NNCCDC or equivalent undertake specific tobacco control activities?
☐No ☐Yes

56. If **Yes** (the NNCCDC or equivalent undertakes specific tobacco control activities), to what degree does the NNCCDC or equivalent address tobacco control?

- ☐To a very significant extent ☐To a significant extent ☐To some extent
☐Not at all

57. As an already existing multisectoral body, how feasible it would be for the NNCCDC or equivalent to assume the functions of an NCM-TC,¹¹³ where the latter does not exist?

- ☐Extremely feasible ☐Very feasible ☐Somewhat feasible
☐Not at all feasible ☐Not applicable – an NCM-TC exists

58. If the NNCCDC or equivalent were to assume NCM-TC functions, what would be the **top 5 requirements** for its effective functioning as such?

- i.
ii.
iii.
iv.
v.

J. Recommendations

59. Do you think a different name and structure for NNCCDCs or equivalents would strengthen their visibility and performance? ☐No ☐Yes

If **Yes**, please describe briefly the preferred/proposed name and structure:

60. What are the **top 5 functions** that you think NNCCDCs or equivalents should perform?

- ☐ Providing advice to government on NCD legislation/policy/regulations/programmes
☐ Advocacy
☐ Programme development and implementation
☐ Monitoring and evaluation
☐ Promotion of research
☐ Health promotion
☐ Communicating for health
☐ Resource mobilisation
☐ Other (please specify):

¹¹³ See model terms of reference for an NCM-TC on page 39, National Coordinating Mechanisms for Tobacco Control: Toolkit for Parties to Implement Article 5.2 (a) of the WHO Framework Convention on Tobacco Control. Available at: <https://www.who.int/fctc/implementation/publication/FCTC-5-2-coordination-toolkit.pdf?ua=1>.

61. Do you think a Caribbean **regional** NCD Commission/Task Force/Working Group would be a useful complement to NNCCDCs or equivalents? ☐No ☐Yes

If **Yes**, please describe briefly the following:

Proposed membership of the regional NCD body:

Proposed functions of the regional NCD body:

Proposed organisational location of the regional NCD body, e.g., Caribbean Community (CARICOM), Organisation of Eastern Caribbean States (OECS), or other regional institution/entity):

62. What other recommendations would you make to improve the performance of NNCCDCs or equivalents, including their possible functioning as NCM-TCs? Please list **no more than 10 recommendations**.

- i.
ii.
iii.
iv.
v.
vi.
vii.
viii.
ix.
x.

This completes the questionnaire. Thank you for your responses and your continued contribution to NCD prevention and control in the Caribbean!

ANNEX 2

List of NNCDs/equivalents in the Caribbean

*The eight entities in bold completed the questionnaire in Annex 1

Country	Name	Date launched/first meeting
Anguilla	Anguilla National NCD Commission	First meeting July 2015
Antigua and Barbuda	Ministry of Health, Wellness and the Environment Wellness Committee	-
Bahamas	Healthy Bahamas Coalition (HBC)	First meeting September 2015
Barbados	Barbados National Commission for Chronic NCDs	Launched January 2007, first meeting March 2007
Belize	Belize National NCD Commission	First meeting 2009
Bermuda	Well Bermuda (WB)	Established 2006, first meeting November 2006
British Virgin Islands	British Virgin Islands Health and Wellness Advisory Council	Established November 2012, first meeting January 2013
Dominica	Dominica NCD Commission	Established 2008 and again in February 2016
Grenada	Grenada National Chronic NCDs Commission	Established June 2010, first meeting July 2010
Guyana	Presidential Commission for the Prevention and Control of NCDs in Guyana	Launched September 2014

Date last meeting	Person(s) who completed the questionnaire	Status/Comments
-	-	The Commission is deemed to be INACTIVE .
8 September 2021	Ms. Valarie Williams, NCD Coordinator	The Committee is currently ACTIVE .
22 July 2021	Dr. Phillip Swann, HBC Chair	The Coalition is currently ACTIVE .
-	-	The Commission was active up to 2021. Its chairperson is currently on extended leave and the survey was not completed.
-	Ms. Laura Tucker-Longsworth, President, Belize Cancer Society, Former NNCDC Member	The Commission has been inactive since 2013. The Commission is currently INACTIVE
Last annual meeting 2018; subcommittees have met since then	Dr. Virloy Lewin, WB Chair, Health Promotion Coordinator, NCD Focal Point	Well Bermuda was active up to March 2020, when the COVID-19 pandemic put a temporary halt to its functioning, as the team was mobilised to assist in the response. It plans to resume (virtual) functioning in November 2021. Well Bermuda is deemed to be ACTIVE .
-	-	The Commission is deemed to be INACTIVE .
-	-	Dormant 2010-2016. The Commission is deemed to be INACTIVE .
June 2021	Dr. Damian Greaves, NNCDC Chair	The Commission is currently ACTIVE .
August 2021	Dr. Leslie Ramsammy, NNCDC Chair	Dormant for varying periods after terms expired, but was re-constituted and met on 20 January 2021. ¹¹⁴ The Commission is Currently ACTIVE .

¹¹⁴ Department of Public Information, Guyana. January 20, 2021. <https://dpi.gov.gy/the-presidential-commission-on-the-prevention-and-control-of-non-communicable-diseases-reconstituted/#>.

Country	Name	Date launched/first meeting
Jamaica	National Committee on NCDs	First meeting December 2011
St. Kitts and Nevis	Alliance for Health Actions St. Kitts and Nevis	First meeting May 2014
St. Lucia	St. Lucia National Commission on Chronic NCDs	First meeting December 2013
St. Vincent and the Grenadines	National Health and Wellness Commission	-
Trinidad and Tobago	Trinidad and Tobago Partners' Forum for Chronic NCDs	First meeting September 2011

Date last meeting	Person(s) who completed the questionnaire	Status/Comments
8 July 2021	Professor Trevor Ferguson, Committee Chair, in collaboration with Ms. Peta-Gaye Taylor, Administrative Secretary and Ms. Vanessa O'Meally, Technical Officer	Dormant after initial term, but was re-launched on 23 March 2021. ^{115,116} The Committee is currently ACTIVE
-	-	The Alliance is deemed to be INACTIVE .
-	Dr. Owen O. Gabriel, NNCDCC Immediate Past Chair	The Commission has been inactive since 2019. The Commission is currently INACTIVE .
-	-	The Commission is deemed to be INACTIVE .
-	-	The Partners' Forum is deemed to be INACTIVE .

¹¹⁵ A video recording of the launch is at <https://www.facebook.com/themohgovjm/videos/launch-of-national-ncds-committee/872088816684823/>.

¹¹⁶ Jamaica Observer. National committee launched to tackle NCDs. March 23, 2021. https://www.jamaicaobserver.com/latestnews/National_committee_launched_to_tackle_NCDs.

ANNEX 3

Selected highlights and notes from the NCM-TC Toolkit

NATIONAL COORDINATING MECHANISMS FOR TOBACCO CONTROL: TOOLKIT FOR PARTIES TO IMPLEMENT ARTICLE 5.2 (a) OF THE WORLD HEALTH ORGANIZATION FRAMEWORK CONVENTION ON TOBACCO CONTROL

A. Introduction

The document, developed in 2018 by the WHO FCTC Secretariat and UNDP, is available at: <https://www.who.int/fctc/implementation/cooperation/5-2-toolkit/en/>. It includes ten tools, each with samples and examples that can be adopted or adapted according to the national situation. The tools are:

- Tool 1: Guidelines for conducting a tobacco control situation analysis
- Tool 2: Stakeholder-specific arguments for tobacco control
- Tool 3: Entities to consider for inclusion on the NCM, and their potential roles and responsibilities
- Tool 4: Options for establishing or strengthening the NCM, including sample legislation, a sample decree, and a sample letter to the executive branch
- Tool 5: Model terms of reference for the NCM, NCM representatives, NCD secretariat, tobacco control focal point, and NCM chair or president
- Tool 6: Draft invitation letter to convene an initial NCM meeting
- Tool 7: Sample agenda for the initial and second meeting of the NCM
- Tool 8: Sample rules of procedure for the NCM
- Tool 9: Sample initial workplan for the NCM, including transparency, accountability, and reporting
- Tool 10: Model code of conduct for NCM members

B. Selected highlights and notes (page numbers refer to numbering in the Toolkit found at the link above)

- **Page 12:** Parties can request support from FCTC Secretariat to conduct an official WHO FCTC needs assessment. Such an assessment could go into greater detail regarding NNCDs/equivalents as NCMs-TC, and the value of a regional NNCD/NCM-TC.
- **Page 14:** Note the FCTC Secretariat-UNDP 2017 paper [WHO FCTC as an Accelerator of Sustainable Development](#)¹¹⁷ and associated references in footnote 22.¹¹⁸
- **Pages 24-29:** Note the ministries and their potential roles deemed (for the NCM-TC, but definitely applicable to NNCDs/equivalents).¹¹⁹
 - *Essential:* Health*; Justice/Law/Attorney General’s Office*; Finance and Planning*; Food and Drugs Regulatory Authority/Standards Authority; Foreign Affairs*; Trade*; Labour*; National Revenue Authority and Customs

¹¹⁷ <https://www.undp.org/publications/who-framework-convention-tobacco-control-accelerator-sustainable-development>.
¹¹⁸ Footnote 22 in the Toolkit states: “This analysis complements a set of sectoral briefs by UNDP and WHO on What Government Ministries Need to Know about Non-communicable Diseases. Other useful resources include: UNDP and WHO’s policy briefs on Health Promotion in the Sustainable Development Goals; The Tobacco Atlas (Fifth Edition), produced by the American Cancer Society and World Lung Foundation; the FCA’s advocacy toolkit, How to take ‘FCTC implementation’ from the Sustainable Development Goals (SDGs) and translate it into action in-country; and the NCD Alliance’s infographic, NCDs across the SDGs – a call for an integrated approach.”
¹¹⁹ Those with asterisks (*) are suggested for inclusion as essential members of NNCDs/equivalents/NCMs-TC in the Caribbean, for a core of approximately 18 members.

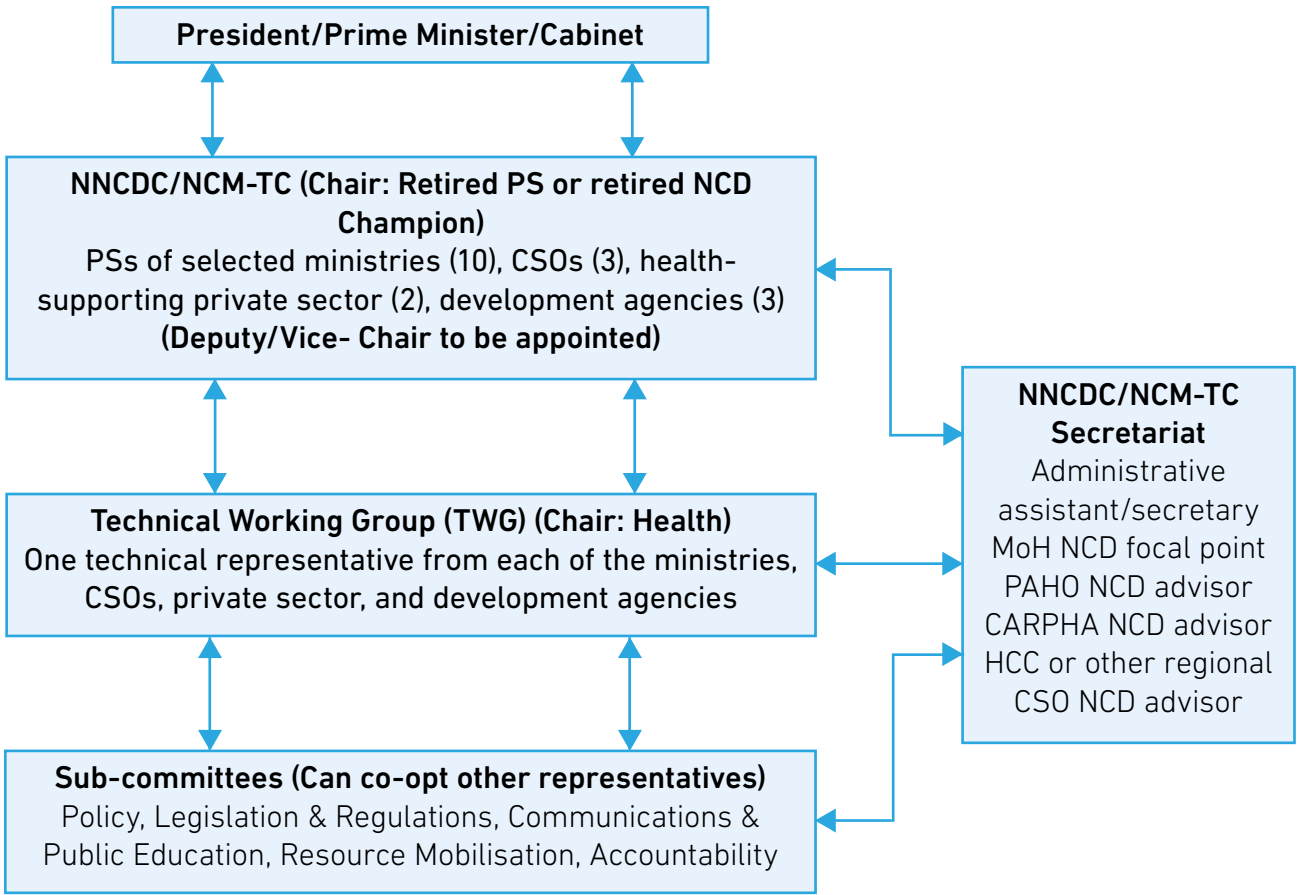
- *Recommended:* Heads of State and Government (Office of); Legislative body (Parliament, Congress, Senate); Communication and Information/Media Authority*; Interior and Local Government; Education*; Sport, Children and Youth*; Agriculture/Agribusiness*; Social and Family Welfare; Gender; Urban Planning/Transport; CSOs (at least three needed in Caribbean NNCDs/equivalents/NCMs-TC); NGO working in NCD(s)*, FBO*, and academia*.
- *Optional:* Academic organisations (these are not optional for the Caribbean). Caribbean NNCDs/equivalents/NCMs-TC should include representatives of the health-supporting private sector (at least two): insurance company*, bank*.
- *Supported by:* WHO FCTC Secretariat, WHO, FCTC Knowledge Hub, international financing institutions, and development partners such as UN agencies. In the Caribbean, the NNCDs/equivalents/NCMs-TC should include technical cooperation/development agencies (at least three): CARPHA*, PAHO* and the UN Children’s Fund (UNICEF)*.
- **Page 30:** *Options for establishing/strengthening the NCM-TC*, such as legislation, decree, or other binding mandate, and direct convening by the president/prime minister/executive branch. The latter is quicker, but legislation, though more painstaking, is better for sustainability; legislation is the gold standard. Also, note the *essential elements of the NCM-TC*: membership and multisectorality; terms of membership and codes of conduct for members; lines of authority; funding; roles and responsibilities of the NCM-TC and minister or chair.
- **Page 31:** High-level membership renders the NCM-TC more effective. This supports the suggestion of permanent secretaries (PS) as government members of the NNCD/equivalent/NCM-TC, chaired by a retired PS from health or another social sector, or a retired NCD Champion, supported by a technical working group (TWG) comprising technical officers from the respective ministries and other entities on the NNCD/equivalent/NCM-TC. The TWG could coordinate/oversee subcommittees to deal with specific topics. A possible NNCD/equivalent/NCM-TC organisational chart is in Annex 4 of this report.
- **Page 36-38:** Sample letter from the minister of health to the president/prime minister that could be used to justify the establishment/strengthening of the NNCD/equivalent and the incorporation of tobacco control into its remit. The letter should emphasise the availability of technical support from the FCTC secretariat and development partners. The letter should also emphasise the impact of COVID-19 on NCDs, citing the need to accelerate NCD reduction; reduce associated health, social, and economic costs (referring to the TNA-NCDs and various PAHO, Economic Commission on Latin America and the Caribbean (ECLAC) and WHO publications; promote NCD investment cases, noting the results of those conducted in Barbados and Jamaica; underscore the need for new sources of revenue, in light of amounts spent on COVID-19 – a feasible source is taxation on unhealthy products.¹²⁰
- **Pages 39-42:** General terms of reference for NNCD/equivalent/NCM-TC; for representatives on the entity; and for the secretariat (see organisational structure below). The secretariat would oversee implementation of the NNCD/equivalent/NCM-TC plan of action and liaise with subcommittees and those responsible for implementing the national NCD strategic plan or plan of action, including the NCD focal point, PAHO, and others.

¹²⁰ World Health Organization. Health taxes: a primer (a WHO policy brief). Geneva: 2019; WHO. Available at: https://www.who.int/health-topics/health-taxes#tab=tab_1.

ANNEX 4

- **Page 58-59:** Process, output, and outcome indicators for NCM-TC can be adapted for application to the NNCD/CM/TC.
- **Page 60:** Note the model code of conduct/code of ethics; issues of tobacco industry interference and [guidelines for Article 5.3 of the FCTC](#),¹²¹ which address protection of policies from tobacco industry interference. These can be used as a model for other unhealthy commodity industries, such as the food and beverage industry. Note also that the HCC has developed a working document to guide conflict of interest policies, which can be obtained through the HCC Secretariat.
- **Pages 66-70:** Note the ten best practices for establishing and strengthening NCMs, and the Kenya case study.





Possible organisational structure for NNCD/CM/TC¹²²



¹²¹ https://www.who.int/fctc/guidelines/article_5_3.pdf.

¹²² To be tailored to the national situation, including country size and resources available. Sub-committees may not be necessary in all circumstances, and the secretariat may be considerably reduced.

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